National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

PART OF THE
LEARNING FROM PRACTICE
SERIES

LEARNING TO WORK DIFFERENTLY:

IMPLEMENTING ONTARIO'S SOCIAL DETERMINANTS OF HEALTH PUBLIC HEALTH NURSE INITIATIVE

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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.

Contents

> Funding from the Ministry had a dual benefit. It served as a catalyst for health units that had not yet begun to reorient their practice to align with health equity. Many PHUs were clear that their local level work would not have been possible without funding. For those units already acting on SDH and health equity, the funding enhanced their capacity to do so.

Summary

INTRODUCTION

This report presents results of a case study on the development and implementation of public health nurse (PHN) positions focused on the social determinants of health (SDH) across Ontario public health agencies. These positions were funded by the Ministry of Health and Long Term Care to improve the capacity of public health agencies to act on SDH and advance health equity. This is a strategy of interest to many public health organizations across Canada.

Our findings identify leadership, organizational change management, organizational culture (including values and ideology), provincial standards, and the need for active engagement in policy development and implementation across multiple levels as key factors to the success of the initiative. A summary of recommendations from case study findings is presented here for consideration by policy-makers, public health agencies, educators, and researchers.

RECOMMENDATIONS

Policy- makers

Involving local public health agencies in policy development at the provincial level may help reduce the gap between policy expectations and local implementation. Increased dialogue and communication across levels about requirements and expectations prior to role creation and funding could enhance clarity across the public health system.

Providing guidance to public health agencies on how to implement health equity mandates while maintaining flexibility for local adaptation enhances implementation.

Ongoing feedback mechanisms between systems and organizational stakeholders can help ensure that local public health agencies have the support needed to fully implement health equity positions and related activities.

Accountability measures help ensure that positions are used to meet the intended mandate of increasing organizational health equity capacity.

A multidisciplinary approach that draws from a range of disciplines to take action on the social determinants of health and health equity provides diverse skills and perspectives.

Support for knowledge exchange and network development for those in similar roles enhances information sharing and joint planning, and will amplify gains across the public health system.

Public Health Agencies

Clearly defining responsibilities for health equity positions and drawing explicit links between provincial mandates and locally planned actions, minimizes the disconnect between what the province plans and what is perceived by local public health agencies.

Including health equity considerations in program planning and delivery supports public health unit staff to explicitly and consistently address SDH and health equity. This helps to address doubts about the role of public health in addressing SDH/health equity, alleviate tension in the practice environment, and demonstrates organizational leadership support. It underlines the need to shift public health from a largely behavioural and biomedical focus to a broader SDH and health equity focus.

Aligning workplace values, culture, and practices with equity and social justice supports organizations seeking to better address the social determinants of health and health equity. By doing so, they create an environment for professionals to develop a reflexive public health practice.

- Characteristics essential for public health organizations to support staff, including PHNs, include developing and promoting a shared vision, mission, and goals that prioritize health equity and are understood and valued throughout the organization; and
- fostering a culture of creativity and responsiveness that will supports PHNs and other staff to practice the full scope of their competencies.

A supportive learning environment in which there is continued development enables staff to gain the skills required to be effective in their roles. This means cultivating a healthy organizational culture in public health by

- transforming power relationships within the organization and beyond;
- encouraging access to and free flow of information;
- supporting innovation and new methods; and
- creating a learning environment.

Ensuring that internal structures are in place brings public health staff together and helps reduce siloes that exist between roles in a public health unit. Given that most SDH lie outside the direct mandate of public health, working in collaboration with communities, health and non-health partners is an essential part of the health equity role and well within the scope of public health practice.

Visionary and empowering leadership supports the integration of health equity as part of everyday public health practice. Enhancing these leadership styles will help further organizational action.

Educators

Continuing education and professional development that addresses SDH and health equity is needed by all disciplines in public health to support the development of knowledge and skills. Competency development with all positions across public health agencies would ease concerns of being siloed, diffuse collegial tension, and position health equity specialist roles within a supportive agency framework.

Competencies necessary to address SDH and health equity that are highlighted in this study include

- knowledge of SDH and health equity;
- organizational change and development;
- systems change strategies;
- program development and evaluation with specific consideration to equity;
- advocacy;
- policy development;
- community engagement;
- intersectoral action; and
- leadership.

Researchers

The critical yet still-emerging area of health equity and addressing SDH would benefit from further research that explores the following:

1. the relationship between organizational culture (including values and ideology) and an organization's capacity to work on a health equity agenda;
2. the impact of workplace inequities (e.g., disempowerment of nurses) on health inequity priorities;
3. the activities of PHNs focused on SDH and their influence on their respective organization's capacity to address health equity work;
4. the disciplines and public health professionals best positioned to effectively advance the health equity agenda and how best to prepare/educate these disciplines and professionals; and
5. the development of similar public health roles in other jurisdictions to strengthen the science behind public health equity work and to increase the strength of the transferability of the findings.

METHODS

We used case study methods to examine how the Ontario Ministry of Health and Long Term Care's initiative on SDH nurses was developed and implemented at the local public health level. We explored the concept of leadership and what can be learned from this case about building the capacity for public health organizations in other settings. We conducted individual interviews with 42 participants (SDH PHNs, managers, directors, chief nursing officers, and medical officers of health) and examined 226 documents.

Introduction

In 2012 the National Collaborating Centre for Determinants of Health (NCCDH) launched a multi-year Public Health Leadership Initiative on the social determinants of health (SDH) and health equity. This leadership initiative contributes to the Centre's overall goal to assist public health organizations to more effectively apply evidence-informed practices as leaders in addressing SDH and advancing health equity.

As an integral part of the Public Health Leadership Initiative, this case study explored the strategy of developing and implementing equity-focused positions to improve public health organizational capacity to act on SDH and advance health equity. Currently, public health organizations across Canada are adopting this approach.[1] As a result, we used case study methods to examine the Ontario Ministry of Health and Long-Term Care's initiative on SDH nurses. In particular, we examined how this initiative was developed and implemented at the local public health level. We explored the concept of leadership and what can be learned from this case about building the capacity for public health organizations in other jurisdictions to address SDH and health equity.

The findings of this case study are relevant to a wide range of stakeholders interested in SDH and health equity, including:

- policy makers at the provincial and national level to develop, fund, implement, and adapt human resource initiatives;
- decision makers at local public health organizations to consider how best to support organizational change and action with a health equity focus;
- health equity focused staff and their immediate managers to reflect on the support required to be effective in their positions;
- public health and nursing educators to identify the competencies required for those working or intending to work in this area;
- public health professionals to understand the need for a collaborative organizational approach to address health equity; and
- community and intersectoral partners to improve working relationships with public health organizations.

Background

Health equity and SDH are key concepts and approaches in public health practice. According to Raphael, "SDH are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole."[2] Further, as stated by Braveman and Gruskin, "Health equity means the absence of systematic disparities in health, or in the major SDH, between groups with different levels of underlying social advantage or disadvantage..."[3] Health equity embraces fairness and justice in policy-related issues, such as service access and affordability, housing, and employment.[4] Clearly, health equity and SDH are key considerations in improving and maintaining population health.

To this end, leadership in public health is essential to carrying out the functions associated with improving SDH and health equity.[5-8] Leadership ensures that the core concepts of human rights and social justice are central in planning and implementing activities, specifically through a focus on those at the margins of society.[9] The Public Health Agency of Canada identifies leadership as one of the core competency areas for public health practice.[10]

Leadership in this case can be defined as "the process of persuasion or example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his or her followers."[11] However, there are many approaches to leadership and to leadership in public health specifically. Leadership in public health can occur at multiple levels: individual, organizational, and systemic. Tackling health equity at any level will only come through leadership that integrates science, practice, and policy.[12] The four key factors identified by Koh and Nowinski[12] for effective leadership to achieve health equity are science, social strategy, political will, and interpersonal skill. Canadian public health figures described effective public health leaders as possessing individual competencies such as the essential knowledge, skills, and attitudes required to advocate for health equity; organizational supports, including allocation of funds, human resources, high-quality population health data, and adherence to external policies and standards; and the ability to connect organizational activities with community action, such as partnering/engaging with community organizations.[13] Leadership must be innovative, strategic, and collaborative across several structural levels to effect positive change on complex health and public system issues, such as health inequities.[14]

Leadership is necessary for public health practitioners to engage in direct practice on health equity within organizations.[1,7] The values, culture and methods of working of the organization are important to understand public health leadership[15] and shape if and how the organizations acts on SDH and health equity. Leadership roles in public health can also serve as catalysts for accelerating innovation and strengthening partnerships.[15] Leadership is demonstrated by the potential to contribute to how other sectors understand SDH and health inequities and knowledge of the political context. Leadership is a critical factor for the significant reallocation of resources and the shifting of priorities that is needed within health organizations in order to tackle the SDH and health equity.

Contextual factors, both external (environmental) and internal (organizational), have a significant effect on the success of equity initiatives.[13,16] These factors consist of structural, human, political, and cultural elements surrounding the initiative. Examples include institutional policies, organizational hierarchy, decision-making processes, and leadership.[16] Expertise in organizational change is a critical skill for leadership in public health, as leaders often have to implement or respond to changes in the systems within which they operate. During the change process, dissonance sometimes exists between different bureaucratic layers within public health organizations. This creates a challenge for health equity practice as public health institutions are called to transition from a largely biomedical and behavioural focus to one that embraces the broader determinants of health.

As the largest group of health professionals in Ontario's (and more broadly Canada's) public health system, nurses are well positioned to lead an "increased focus on disease prevention and health promotion, particularly for vulnerable and underserved communities."[17]

The Research

This study examined a province-wide public health initiative to enhance local public health capacity to address SDH and health equity. Particularly, we identified and analyzed the key supports and barriers to developing and implementing a novel, far-reaching health equity policy initiative in public health and the role leadership played in that development and implementation.

The case study posed the primary research question: What factors influence the development and implementation of the SDH PHN initiative in public health?

The study's sub-questions examined more closely the possible contextual conditions related to that policy, posed as follows:

- What key supports and barriers exist in developing the policy?
- What key supports and barriers exist in implementing the policy? and
- Which key elements of public health leadership are crucial for developing and implementing the policy?

The Policy: In 2012, the Ontario Ministry of Health and Long-term Care (Ministry), used the *9000 Nurses Commitment*, an existing health human resource strategy, to support Ontario public health units (PHUs)[a] to address health inequities and meet the needs of locally identified priority populations. The *9000 Nurses Commitment* was a key component of Ontario's pledge to increase the overall number of full-time equivalent nursing positions in the health care system.[18] Under the commitment, a broad range of health sectors could apply for funding through the Ministry for specific nursing initiatives. Sectors were able to create innovative nursing initiatives to address various gaps in the health care system. Although not a mandatory program, all PHUs in the province responded to the Ministry's invitation to apply for funding. Through this funding opportunity the Ministry's Public Health Division was able to secure fiscal resources for each of the province's 36 PHUs to hire two new full-time equivalent public health nurse (PHN) positions (for a total of 72 new positions provincially) that were to focus solely on SDH.

The Public Health Division set requirements that the funding was to enhance PHU capacity to address SDH through the recruitment of nurses with SDH-specific knowledge and expertise. This expertise, in turn, would "enhance supports to program and services needs of specific priority populations impacted most negatively by determinants of health."[19] The position (SDH PHN) would focus on health equity and SDH, including an emphasis on populations most affected by inequities to help make health equity more central to the work of public health.

Many nurses in the public health sector are engaged in program and service delivery mandated by public health legislation, including mandatory guidelines issued by the Minister of Health and Long-Term Care. These mandatory program and service delivery guidelines, called the Ontario Public Health Standards (OPHS), articulate the minimum requirements of boards of health in Ontario to implement public health core functions through the delivery of public health programs and services.[20] The OPHS provide for "a broad range of population-based activities designed to promote the health of the population as a whole,

a In Ontario, public health units are official health agencies established by municipalities to provide community health programs. PHUs administer health promotion and disease prevention programs and are governed by boards of health. PHUs are led by the medical officer of health, who reports to the local board of health. The board is largely made up of elected representatives from the local municipal councils. The Ministry shares the cost of expenses with the municipalities.

and with community partners to reduce health inequities".[20] These standards make explicit that "addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario".[20] Through activities such as surveillance and epidemiology, the OPHS note the importance of identifying 'priority populations' at risk of poor health outcomes, particularly those most negatively affected by health inequities and SDH, who might benefit most from public health interventions and to improve the health status of such populations. Local PHUs are required to assess local population health needs, and plan and deliver public health programs and services based on that need; therefore, program and service delivery varies across regions and is based on population health needs within each jurisdiction, including those needs of identified priority populations or health equity issues identified.

This study examined the development and implementation of these SDH/equity-focused nurse positions across Ontario PHUs.

Methods

We used a case study approach[21] to examine this unique initiative, which was implemented from April 2012. To date, Ontario is the first known Canadian province to implement a province-wide public health policy initiative of this nature. Case study design was appropriate to understand a complex social system, such as the implementation of a new initiative across multiple PHUs simultaneously in a relatively short period of time.[22]

The interview data were analyzed using Framework Analysis,[23] a method designed in the UK for public policy studies. The document data were analyzed using Prior's approach,[24] which extends analysis beyond static content to the active practice elements of documents. The qualitative methodological rigour was assessed through trustworthiness criteria that included assessments of credibility, transferability, dependability, and confirmability.[25] See Appendix 1 for detailed explanation of methods.

The St. Francis Xavier University Research Ethics Board approved the study. We complied with standard ethics review processes for each organization where participants were recruited.

Findings

This section provides an overview of the study findings. We present the participant demographics and document data types, the three major study themes, the role of leadership-related findings, and the key supports and barriers to developing and implementing the policy.

We conducted individual interviews (see Appendix 2 for Interview Guide) with 42 participants and examined 226 documents. Participants were staff from PHUs across Ontario: SDH PHNs, managers, directors, chief nursing officers, and medical officers of health. We also interviewed participants external to the PHUs; however, the numbers were too low to identify agencies in this 'other' category (see Table 1). We reviewed 226 various documents, including SDH PHN position descriptions, PHU strategic plans, project reports, websites, and SDH PHN workplans (see Table 2).

Major Themes

Three major themes emerged in this study:

- Learning to work differently;
- Shifting organizational practice environments; and
- Bridging policy implementation gaps.

Theme 1: Learning to work differently

The creation of this equity-focused nurse position across Ontario PHUs represented a change at the system (provincial) and organizational (local PHU) level. With this change came an imperative to *learn to work differently*. This challenged organizations in several different ways as they implemented the new role.

PHILOSOPHICAL PRACTICE TENSION

For many PHUs, developing and implementing the new nurse position created a philosophical tension. Many participants reported that PHUs had to shift their approach to health care from largely biomedical and behavioural (e.g., a focus on lifestyle choices) towards acknowledging and acting on the social conditions that affect health and improve health equity (e.g., a focus on social exclusion, early childhood development, income, and education). The tension this philosophy shift created was most apparent in PHUs where the leaders' values and ideologies were not already oriented towards social justice. As one participant put it:

> *We've got a long way to go in public health. The system is not prepared to be client-centred, that is, meet the SDH; this needs political will and service providers' will, not putting people in our traditional public health box.* (PARTICIPANT #37)

However, for some units, the new SDH PHN role validated health equity work that was already underway, as described by this participant:

> *Everybody has their own take on the new SDH initiative…some say that it has helped bring practice together – it adds to the breadth and legitimacy to our work.* (PARTICIPANT #20)

COMPETENCY DEVELOPMENT FOR HEALTH EQUITY

Participants indicated that at the outset of the initiative, there was limited evidence to guide their practice regarding health equity, being yet a still-emerging area of attention. This presented a challenge for public health organizations as they made decisions about which practices, programs and policies were needed. The vast majority of SDH PHNs went through considerable competency development (i.e., knowledge and skills) as they evolved in their roles. This participant reported the following:

> *[There is] not a lot of solid evidence in this area about what worked and we needed validation. It was stressful when we started because of the knowledge gap. …. I think I was very naïve and did not anticipate how the role would evolve. There was a definite learning curve for the first 3-6 months.* (PARTICIPANT #20)

This was true even for experienced PHNs. However, PHNs with Masters-level training required less knowledge and skill development.

To address knowledge and competency gaps, nurses and their organizations looked to PHUs that were further ahead in their implementation as examples. They also consulted researchers and provincial and national public organizations, such as the Ministry, Public Health Ontario, and the NCCDH for knowledge and expertise.

COLLEGIAL SUPPORT FOR ROLE

In some units, the new role received positive support from colleagues. In units where health equity work was already underway, colleagues saw these new positions as further support for their well-defined efforts. However, in many PHUs, participants described tension between colleagues; some felt this work was already being done and questioned whether these SDH PHNs would now be the only SDH/health equity experts, which had implications for their own competencies and roles. Participants described the stressful professional position they were placed in as they launched these new, relatively undefined roles. Some nurses reported that colleagues believed they were already doing SDH and health equity work, and that this new initiative was a duplication. For example:

> *The role implementation was controversial in the beginning…there was lack of role clarity from the province and in the health unit itself, and lack of clear communications internally. This led to many assumptions about what we should or should not be doing. Early on this devalued the role. This shifted over time – there is less role confusion as health equity has become a strategic direction, so who owns what, whose portfolio this is in is clearer.* (PARTICIPANT #5)

Furthermore, some SDH PHNs reported receiving clear messages from colleagues that addressing SDH, was intractable and beyond the scope of public health practice.

EXISTING PUBLIC HEALTH STANDARDS

Data supported the claim that some PHUs had already begun to address SDH in their programs prior to the creation of the SDH PHN roles, but the degree of programming varied. The support for this work was evident in document data such as the OPHS[20] and the Ontario Public Health Organizational Standards.[26] These documents mandate boards of health to incorporate strategies that address health equity in their strategic plans, specifically, to develop a strategic plan that "describes how equity issues will be addressed in the delivery and outcomes of programs and services."[26] The OPHS were released in 2008, and the work of some PHUs on health equity was well ahead of others and well ahead of the implementation of the province-wide SDH PHN initiative. Most participants recognized that health equity work was already embedded in these standards, although many commented on the lack of practice direction and the mismatch with the current public health practice environment. For example:

> *Adding health equity was required…it is embedded in our public health standards anyway. Where we are left though is it just feels like square peg in a round hole compared to how we traditionally work. We are in a huge panic to get indicators, outcomes – how do we measure success for this? One size is not fitting all across the province.* (PARTICIPANT #3)

Nurses were able to leverage the standards as a rationale for program and organizational change and to gain support across their organizations.

EMBEDDING THE WORK AT THE UNIT LEVEL

Part of learning to work differently included developing organizational documents, such as mission and vision statements, strategic plans, health equity strategies, workplans, and websites (for example, Documents # 1.11, 2.10. 3.26). These documents represented the developing paradigm shift within their public health practice. Participants noted the inclusion of health equity in regular meetings, reports, and other communications. For example:

> *At the health unit we redid our strategic plan to include SDH and health equity. We are treated like any other department now. We didn't think about it before, but we can't ignore it now. This has really taken our unit out of its comfort zone. The whole municipality is recognizing this work.* (PARTICIPANT #2)

Research revealed that the SDH PHN roles supported the broad-based work of all PHU staff. This had implications for how the nurses worked with others in their units, as reported by this participant:

> *We are building internal capacity for the work, staff seem to be soaking it up, the level of awareness is increasing and I'm seeing a paradigm shift. We make time to talk about the SDH and health equity at every staff meeting, so it is seen as always a learning opportunity now.* (PARTICIPANT #12)

Nurses and their organizations also spent a considerable time at the outset of role development in planning SDH and health equity related work.

> *So I think there's been a lot of start-up time and it's been a bit of a problem enhanced because we've had to start up two different people.* (PARTICIPANT #27)

> *The key informant interviews internally and in the community took way longer, and the analysis way longer, and we didn't have a sufficient epidemiology support built in at the beginning.* (PARTICIPANT #35)

MULTIPLE SECTORS, MULTIPLE PARTNERS, AND MULTIPLE SYSTEM LEVELS

Learning to work on SDH and health equity, many SDH PHNs began interacting with internal and external stakeholders in new and creative ways. This data showed that the nurses supported health equity work at multiple levels and with multiple stakeholders. SDH PHNs worked with their unit's senior leadership team, including the Ministry, in ways that had not been present before. Many SDH PHNs worked broadly across their units to develop and implement a collaborative health equity agenda. Additionally, PHNs met with municipal officials on issues such as strategic plans and policy change related to health equity. For many units, deep and broad-based coordinated efforts for health equity occurred for the first time. Many documents depicted the stakeholder and system level engagement (for example, Documents #1.17, 2.23, 3.20), and participants describe many of these relations. For example:

> *Our Director facilitated us going directly to our Board of Health. Our engagement with our municipal councillors wasn't part of the initial plan - that involvement grew organically with the councillors who sit on the Board of Health, the influential level – the movers and shakers we tried to involve them in the work engaging in real upstream[b] thinking.* (PARTICIPANT #3)

b Upstream refers to acting on 1) the structural determinants of health by implementing policies and practices that shift the distribution of power and resources, and 2) the causes of social disadvantage.

Participants recognized intersectoral collaboration and community engagement as necessary and essential to their activities. The SDH PHN positions provided an opportunity for many organizations to leverage community partnerships and add a public health voice to multisectoral initiatives, as this participant describes:

> *A support was the existing work of committees in the community. This helped us to link externally and we need to do the systems level work about 50% of the time and then the other 50% internally building capacity with our front line group, building team champions.* (PARTICIPANT #4)

The SDH nurses formed working relationships with various partners and sectors, including other municipal departments (e.g., welfare and social services, transportation), poverty reduction coalitions, child welfare organizations, community health centres, social planning councils, libraries, and the education sector.

WORKING DIFFERENTLY WITH PROVINCIAL PHN COLLEAGUES

This initiative also sparked a shift in how many SDH PHNs worked with their public health colleagues across the province. Many participants talked about the network of support with other SDH PHNs. This network provided access to nursing leaders and resources (e.g., a Wiki site updated regularly by members). As this participant describes, regional and provincial SDH PHN networks developed as communities of practice:

> *We developed the provincial network of SDH nurses and from that we have a regional group that was extremely supportive. There was nobody to talk to before this. Now we have good information sharing and a safe zone for brainstorming.* (PARTICIPANT #32)

While self-organized, the practice networks received support from organizations such as the Ministry and the NCCDH through financial or in-kind contributions (e.g., teleconference line for meetings, travel subsidies for in-person meetings, and staff time for workshop planning and delivery).

WORKING DIFFERENTLY WITH THE MINISTRY

The notion of learning to work differently also had implications at the Ministry level. Participants reported that the Ministry and staff were flexible and supportive in their approach to this initiative. The parameters for the SDH PHN roles were not overly prescriptive, were supported by the OPHS, and were based on local planning priorities and principles; the Ministry supported a broad array of plans, priorities, and interventions. For example:

> *The way this [introduction of the SDH PHN role] was rolled out provincially was a positive thing for us… we had support but not micro level interference…it could have come with more heat to it though because so much evidence that this impacts health outcomes…this legitimized or authorized some of the things that we were already doing…this gave more clear expectations that this is an expected role of public health…takes a strong public health position on the [health equity] issue.* (PARTICIPANT #3)

Some participants did indicate, however, that this flexibility relied on local leadership to drive the implementation (as intended by the Ministry), and was impeded where leadership was absent. As these participants stated:

> *The Ministry leaves a lot of latitude…there are pros and cons to this because it is left to the senior leadership team at unit level. We did ok over time but not for others where unit leadership was not supportive.* (PARTICIPANT #5)

> *The way the Ministry did this worked at the local level for us. Management may be better motivated over time if this is part of an accountability agreement. They are very motivated by those agreements to buy in.* (PARTICIPANT #6)

Theme 2: Shifting organizational practice environments

Study data highlighted the shifting environments within which practice occurred, including changing organizational structures. It was clear that organizational culture and practice environments shaped how work was structured, which activities occurred, and who was involved in these activities. Further, the data directed us to consider the role of modifiable organizational features and, ultimately, leadership in health equity as a priority area.

DECISION-MAKING

At the PHU level, senior leadership (i.e., senior management/administration) made most decisions about the early development of the SDH PHN role. This included the position's scope and overall focus and its placement within the organizational structure. Many participants identified a key issue: lack of consistency in how the role was positioned within different units. This affected the role's decision-making power base, level of practice independence, and acceptance by colleagues. Participants reported that senior leadership made early decisions based on existing PHU work on health equity (e.g., existence of health equity team; SDH and health equity as an organizational priority), the requirements in the OPHS[20] and/or by general operational concerns. In PHUs where little or no consideration for SDH and health equity had already been made, decisions regarding role focus and placement were not optimal and, in time, required operational shifts. This participant described how early decisions about the roles were made:

> *I don't think we really had a clear plan for how this was going to roll out. It was largely the director in consultation with our management group where we kind of discussed if these positions would fit within an existing team, if they needed to be pulled out to kind of work laterally across the different programming areas.* (PARTICIPANT #24)

SHIFTING OF INTERNAL STRUCTURES

As largely front-line staff, SDH PHNs had to work within their existing PHU organizational hierarchies. This affected the influence they had on organizational change processes, as indicated by one participant:

> *We are battling the system all the way. I know what needs to be done, but we cannot get people [unit management and staff] to bend…there is frustration and I feel helpless against the system. I know that I am a better nurse because of this [initiative], but it is not acknowledged. I am very discouraged. I am thinking more broadly about health equity, but nobody wants to acknowledge that. It's an 'old boys club' in public health.* (PARTICIPANT #2)

Decisions about how SDH PHNs were positioned within PHUs related to the degree that health equity work was already embedded within the structure of the organization. In some instances, the SDH PHN position was placed within specific program areas, while in others the position was designed to work laterally across program areas and across the PHU. In many units, there was an evolution over time where SDH PHN positions were moved from program-specific assignments to cross-organizational positions, acknowledging that the entire organization needed to be transformed to better tackle health equity. Two general patterns were described by participants and were corroborated by study documents.

SDH PHNs were assigned to cross-organizational positions where they:

- worked closely with senior leadership;
- were offered an open-door policy and open communication between SDH PHNs and senior leadership;
- worked across organizational departments providing capacity building and technical assistance for other staff, connecting with other staff also working on heath equity;
- were perceived as SDH/health equity leaders; and
- experienced a selected organizational approach designed to build internal capacity.

SDH PHNs had program-specific assignments where they:

- were assigned solely to specific departments;
- worked within programs or with specific population groups;
- had less explicit influence on organizational change; and
- experienced SDH/health equity related activities that were more siloed within the organization

Document data (for example, Documents #1.13, 2.4, 4.7) and participant data corroborated the link among organizational structural placement of the SDH PHN role, level of practice autonomy, and level of influence for organizational health equity change, as noted by this participant:

> *The role has changed significantly in terms of whom I report to – from when I started to this time. And so my role has changed in terms of hierarchical changes, where I'm placed, and as a result that's influenced the level of influence in creating change within the organization.*
>
> (PARTICIPANT #31)

As the new SDH PHN positions were filled, and depending on the position's organizational placement and senior administrative support, some SDH PHNs began to be involved in determining overall organizational activity around health equity. Participants described support from middle and senior management, encouraging autonomous practice for the SDH PHNs and deliberately building the position into the organizational structure so they could have a critical role in the planning process. Planning autonomy was more apparent in units where senior management supported the role. Some PHUs developed health equity teams and/or advisory committees to provide leadership and guidance for the organizations' initiatives. Some structural supports predated the SDH PHN position initiative; in many organizations these supportive structures were created after the initiative was implemented.

> *Initially we were bogged down when placed in two different programs, needing to learn program roles, new reporting structure and the two SDH PHNs were separated. We needed to be able to do broader, system-level work and to support each other. The new reporting structure has shifted this role to the senior leadership team with our [senior health equity working group] and working across the unit has made a huge difference. I pushed the health equity agenda – this was greater than working through two program teams.*
>
> (PARTICIPANT #4)

Advisory bodies or working groups typically had broad organizational representation. These structures provided a direct link to senior decision makers and multidisciplinary staff who supported the SDH PHNs and SDH work across the organization. Senior leaders demonstrated their support for SDH activities and created legitimacy for the ongoing work, as noted by this participant:

> *The structure and culture of the health unit is very important. You need a Medical Officer of Health who is in tune with the staff, where nurses are able to approach them, no filtering needed. When the MOH chairs the committee it gives clout, power.* (PARTICIPANT #4)

However, some participants clearly indicated that a lack of senior administrative support was detrimental for the role and for the health equity agenda, and so management became a focus for change. For example:

> *There is middle management opposition. They say they already know this and are already doing this. We need to win them over with evidence and best practice. We see them have their 'ah-ha' moments though.* (PARTICIPANT #3)

Theme 3: Bridging policy implementation gaps

Public health policies that are developed by systems level actors like provincial ministries are typically highly prescriptive and micromanaged. This warranted a closer look at provincial policy development and local implementation at the PHU level. Participants reported that *policy implementation gaps* (between policy visions at one level and actual implementation at another) inhibited the initiative. Participants considered these policy implementation gaps (e.g., lack of implementation plans at the local level) barriers to the long-term sustainability of the SDH PHN initiative, for the health equity agenda, and for other future initiatives because they felt that such gaps jeopardized future project possibilities.

VARIED LOCAL UNDERSTANDING AND IMPLEMENTATION

Document data revealed wide variation between local level interpretation, planning, and implementation of the SDH initiative and the Ministry's vision (for example, Documents # 2.1, 2.13, 2.23). Some PHUs embraced the new nurse position to address health equity issues, coupled with much effort and internal change. However, other PHUs viewed the positions as just the additional of more full-time equivalent positions and, as a result, added them to existing programs without an enhanced or expanded broader plan and strategic priority for health equity. The OPHS mandate to support "priority populations" was typically easy for any PHU to meet given that this fit easily into the service delivery model of many PHUs. However, the perceived impact of the new position was reported as minimal when local management decided to add the two positions to existing PHN complements with no broader health equity mission.

Many PHUs had different interpretations of the provincial guidelines for the initiative, whereas the Ministry intention was for locally-informed planning, as per the OPHS.[20] This created tension within many PHUs, as described by this participant:

> *Many people do not believe in it [health equity work in public health] because it is not so well defined. People are not so overly engaged with the role and they don't really buy into it. They say 'What's the point? Where are we going with this?* (PARTICIPANT # 39)

Some participants described how the broad guidelines developed at the provincial level created a gap between the Ministry's vision and the actual implementation at the local health unit level. Many participants perceived this as a lack of direction or clarity. The lack of clear guidance was different

from the typical experience health units have with the Ministry. Participants did not always see this intentional shift in approach as an increase in Ministry flexibility and movement to more locally driven planning as outlined in the OPHS.[20] Notably, this perception of limited guidance from the Ministry was primarily an issue for those units that were not already advanced in health equity work. This sense of disconnect from the OPHS and the locally-driven approach of the provincial initiative was described by this participant:

> *There was too much flexibility. Units are all over the map with this…they need goals, need to go back and measure what we really did; need more of a sense of what they wanted out of the project.* (PARTICIPANT #37)

Some PHUs embraced the broadness of the initiative and welcomed the new positions as validating and enhancing their existing work. They tailored the new positions to their local needs and stage of development and capacity. Some participants noted that even more flexibility, pertaining to the staff (not limited to nurses), would have been welcome. At these PHUs, the local health equity agenda matched the provincial policy (i.e., there was no policy implementation gap), as these participants articulated:

> *Fortunately, for our health unit, the SDH were a priority [before the SDH PHN role was introduced], the SDH positions were the real impetus to move this along. This has really put SDH on the agenda and made health equity a priority. There is a trickle-down effect into programs and other professions. There is momentum as it is now a priority. The Ministry flexibility was key from the beginning…* (PARTICIPANT #20)

> *The parameters were broad. I think this is always very good so each health unit can take it and customize it. Some health units may have struggled because they needed more direction. The Ministry put it out to the field and let us work with it.* (PARTICIPANT #21)

REPORTING PROCESSES – WHO ACCOUNTS FOR THE WORK?

The person designated at the unit level to report to the Ministry on the initiative varied across PHUs. Many SDH PHNs reported having neither input into the regular report to the Ministry, nor access to the final submitted reports, despite the Ministry reporting requirements (Document # 2.45) The Ministry required that both front-line staff and management directly involved with the SDH PHN role contribute to these reports, to provide detail and nuanced information that might not be captured by senior leadership (who may not be familiar with day-to-day operations of the role). A gap formed between what the nurses were doing in practice and the communication of their work within the provincial accountability structure. This situation was clearly described by several participants, for example:

> *My manager did the Ministry report for year 2 without my input. I asked if I could see it because other SDH PHNs were talking about it. I didn't even see the year 1 report.* (PARTICIPANT #37)

On the other hand, PHUs that were already demonstrating leadership in health equity modeled equity-like engagement at the unit level. As a result, the nurses either authored or co-authored unit reports to the Ministry, as described by this SDH PHN:

> *We wrote our Ministry reports from day 1. Who else would know the detail required for this? We collaborated with other staff and senior leadership to do this of course.* (PARTICIPANT # 8)

Leadership

This study explored the influence of leadership on SDH and health equity work, and the role leadership played in developing and implementing the new nurse positions. We explored leadership at the individual, organizational (PHU), and systems (provincial) levels.

Participants consistently indicated that leadership was critical to action on the SDH and health equity, as expressed by this participant:

> *So for me I think it's the cornerstone of what we do, and if you look at the core competencies for public health that were articulated by Public Health Agency of Canada, it's grounded. So it's foundational to all the work that we do, looking at encompassing the values of public health, like equity, social justice, community participation and the whole determinants of health framework, that's where all of that comes from, and so I think that that offered a very solid foundation for leadership.* (PARTICIPANT #33).

Many participants reported that PHU leadership consistently adapted to the emerging SDH PHN role and the associated work. These leaders, described as strong, engaged, trusting, and risk-taking, enabled the nurses to reorganize as they learned and grew. Further, participants described leadership as forward-looking, authentic, and critically introspective, as indicated by these participants:

> *I think it's the push, to me leadership would be out there pushing the edge and the envelope, not just doing things just when it's been made easy for you in a sense.* (PARTICIPANT # 35)

> *Leadership would begin with acknowledging where we're not doing a good job, and then be willing to engage in an authentic discussion of where we might not be doing a good job and be willing to actually take some responsibility for that… So I think leadership would be being willing to take that conversation on and say this is how we make ourselves available at a population health level through public education or mass media or whatever and these are our targeted initiatives. Knowing that that's going to mean saying no to some things.* (PARTICIPANT #40)

Many individual SDH PHNs emerged as leaders within their organizations. At the level of implementation (i.e., PHUs), SDH PHN leadership was most often described as "doing the work" and fulfilling the requirements of the role. These nurses guided their colleagues and organizations, worked with community and intersectoral partners, and were involved in advocacy and public policy.

In particular, the SDH PHNs were considered leaders when they acted in ways that championed health equity. This was described by one participant as follows:

> *I think they demonstrate leadership because they've become sort of like champions, they are very knowledgeable, and they are very connected in the community around the specific issues. They're really passionate about it and they want to move the agenda forward.* (PARTICIPANT # 27)

Formal leadership was generally thought to be essential to SDH/health equity activities. Formal leaders who acted as champions at the governance and senior management levels enabled action.

These leaders embedded SDH and health equity in the overall direction of the organization in a deliberate and purposeful manner. This took various forms including health equity in strategic priorities, mission statements and programs. Strong leadership empowered PHUs to take a nuanced approach to their work, to establish public health's unique role in improving SDH. These leaders also considered work on SDH and health equity a natural part of public health, as demonstrated by this participant:

> *I think public health always wrestles with how much we should be influencing or can be influencing the SDH. We recognize that the foundation that everything in public health is related to the SDH... within an organization having leadership understand how important social determinants are, are really important to move it forward and make it more integrated in how all your programs are delivered.* (PARTICIPANT # 27)

At the organizational level, leadership was demonstrated through a range of practices and activities, such as raising awareness and supporting capacity building within the organization, direct service delivery including redesigning public health programs, identifying and working with priority populations affected by inequities, working intersectorally, developing strategic or programmatic guidance and direction, naming health equity issues publically outside of the organizations, and through policy advocacy. Participants provided examples of local PHUs and provincial and national organizations they considered health equity leaders. These organizations acted both internally and externally on the SDH and health equity, as indicated by this participant:

> *I know that public health plays a pivotal role in providing some of this leadership across our catchment area. And it is a natural fit for public health, it really is some of the core of what we do and why public health exists in the first place, the foundation of what it is. So for us it's not only how we deliver our services, but how we work with our community partners and some of the initiatives that we participate in even though we might not be a direct service provider that we help to facilitate or support in order to address some of the health equity issues within our community.*
>
> (PARTICIPANT #26)

Participants preferred leadership that was distributed across the organization, in other sectors, and within the community, rather than directed at one particular person or sector. The initiative supported organizations in demonstrating their ability to work on SDH issues and build credibility with intersectoral and community partners.

Some participants raised leadership challenges related to the role of public health in addressing the SDH/health equity, noting the ability to address capacity needs, and being an equal partner for intersectoral action versus the leader. SDH/health equity was not always widely accepted as the "business" of public health, which impacted the ability of SDH PHNs and their organizations to move forward internally.

> *Internally there wasn't initially great support for this concept. I think initially some of the senior team was thinking well everything we do is SDH, so we'll just do more of what we're already doing, versus really wanting to carve this out as separate work. And so there wasn't widespread commitment across the board early on.*
>
> (PARTICIPANT #35)

As highlighted in the previous section, local perception of provincial leadership varied. Some saw provincial funding as a clear sign of leadership by the Ministry and as a means to further action on directions laid out in the OPHS. Others had mixed feelings and some perceived the limited guidance and action at the provincial level as a lack of leadership, as this participant indicated:

> *No I don't. Well in what ways is it leadership? I hadn't heard of the SDH before? Or two extra nurses on SDH is going to make any difference. We do this stuff anyway, if you're not doing this stuff you shouldn't be in the business. So that's how I see it. I've got two extra FTEs that's great, it's not enough but it's better than zero.* (PARTICIPANT #34)

Supports and Barriers

This section summarizes the supports and barriers as identified by participants and through document data. These issues stem from the themes discussed above and can help guide public health organizations looking to develop and implement SDH/health equity roles.

Supports

Participants cited the **OPHS** and the **Ontario Public Health Organizational Standards** as providing the foundation, support, and clear mandate for local PHUs to prioritize SDH and health equity. PHUs leveraged the inclusion of these concepts in the OPHS as a rationale for health equity activities.

Funding from the Ministry had a dual benefit. It served as a catalyst for health units that had not yet begun to reorient their practice to align with health equity. Many PHUs were clear that their local level work would not have been possible without funding. As this participant expressed:

> *This [SDH activities in the health unit] wouldn't have happened without these new positions. The Ministry enabled this work...* (PARTICIPANT #5)

> *If this initiative had not been created, I don't think any of this work, that entire list of work that had been done as result of the initiative, would have been moved forward.* (PARTICIPANT # 31)

For those units already acting on SDH and health equity, the funding enhanced their capacity to do so.

Skilled and knowledgeable SDH PHNs were instrumental in ensuring that the roles were implemented smoothly. PHNs with Masters-level training and/or a longer time in the field were more likely to have the required skills for the positions. Investing in training SDH PHNs and other staff ensured that PHU staff could develop the necessary skills to make program and policy change. Often, this required investing time (and in some cases financial resources) at the role's inception. Access to expertise, both internally and externally, supported competency development and knowledge acquisition.

Strong leadership at governance and senior management levels enabled action. In instances where strong leadership was present, SDH PHNs were empowered to collaboratively influence the organization's health equity direction at a broad level.

Internal organizational structures such as working groups, steering committees or departments provided a centralized position for SDH/health equity priorities within the organization. These structures were usually multidisciplinary with representation from senior leaders, managers, specialists, and front-line staff. Participants noted that processes such as integrating key equity concepts into strategic plans and health unit vision statements were critical to integrating health equity into daily practice. A flexible and adaptive approach allowed

organizations to learn and adapt to changing needs and requirements.

Open communication and information flow facilitated the role of the SDH nurses by providing access to staff in all programs, as this participant expressed:

> *I think probably the most important is ensuring that they have access to all of the programs and staff and their role is supported by both middle and senior management so that they can interact with staff at all levels both to provide information and then also make recommendations, and then that I think is important on a day to day working.* (PARTICIPANT #30)

Participants reported that **SDH PHN involvement in decision-making** was necessary to implement health equity activities. **Breaking down siloes** as part of the planning process facilitated cross-organizational networking and shifts in organizational structure. This supported addressing SDH across programs.

Knowledge exchange among nurses and other stakeholders assisted SDH PHNs and their organizations to build relationships with those doing similar work, to learn from the experiences of others, and to access information and knowledge. Nurses demonstrated leadership in self-organizing **knowledge exchange and network development** opportunities (e.g., regular meeting of the nurses across the province). These activities required some support from provincial and national organizations like the Ministry and NCCDH. This participant noted:

> *The leadership of other health units, what other health units have done, having some experts internally on the senior leadership team, that's been very helpful, and the staff have been very helpful.* (PARTICIPANT # 27)

By **partnering** with health and non-health organizations and networks PHUs were better able to identify a focus for the SDH PHNs and be responsive to the local context. The SDH PHNs often exercised policy development and advocacy roles in these intersectoral groups.

PHUs with a history of action on SDH and health implemented the roles more easily, as these were viewed to support and enhance ongoing work. For example, some organizations already had SDH/health equity strategies and programs in place and used the SDH PHN positions to further these strategies.

Barriers

Participants reported a clash between the **biomedical and behavioural/lifestyle paradigm** and shifting public health practice to address health equity. Participants noted that many public health nurses were trained traditionally and addressing SDH may result in resistance to change, both among the SDH nurses and other public health staff who may not have the required knowledge, skills, and attitudes. According to participants, the barriers to integrating SDH related to what they considered the **broad scope of practice and a sense that influencing social systems in the service of equity was extremely difficult**. Participants questioned what to do and how to support change within public health and beyond. This concern was more prominent in health units without pre-existing health equity programs that were approaching this work in a concerted manner for the first time.

The perceived **lack of clarity** about provincial expectations was a stumbling block especially for PHUs in the early phases of health equity action. Despite the existence of the OPHS, many PHUs felt there was a lack of clear guidance for their activities.

Staff or management transitions and instability related to the position created uncertainty about continuity of the work and support at different levels of the organization. Some staff changes in the SDH PHN role were the result of normal turnover while others were related to the skills and competencies of the individual in that position.

Limited knowledge of evidence to support local public health action meant that health units spent time trying to identify what to do and how to do it. This was often pre-empted by the need to make the case for health equity action where this was considered an extra responsibility.

Participants mentioned that **lack of internal coordinatio**n within the organization impeded role implementation. In some cases, the nurses could have been better linked to other work going on in the health unit to move out of siloes.

Discipline-specific funding led to some internal frustration and tension, especially during the initial phases of the initiative as other disciplines felt excluded. While participants understood why the funding was nurse-specific, some organizations would have preferred to focus on the skills and competencies required and have the ability to draw from the multidisciplinary perspectives that are often required for SDH/health equity work.

Discussion

This case study explored the development and implementation of the SDH PHN initiative in Ontario. The implementation of specialized nurse positions across Ontario PHUs required a visible shift in public health practice. Our findings identify leadership, organizational change management, organizational culture (including values and ideology), provincial standards, and the need for active engagement at multiple levels to enhance policy clarity as key factors to the success of the initiative.

These findings yield important insights for developing and implementing SDH/health equity specialists broadly, especially in terms of enhancing traditional PHN practice roles, the sharing of power within the public health setting, and organizational readiness for equity work. A key finding suggests that it was **valuable to design and place the SDH/health equity specific roles as positions that worked across the organization**. This positions health equity as a priority issue for the organization, increases staff competencies around health equity, and provides support for integrating SDH/health equity across the organization. In contrast, assigning the positions to specific program areas at the outset, where they tended to be submerged in day-to-day front-line and often individual service provision, albeit with vulnerable populations, resulted in a

lack of visibility of equity work. This was especially detrimental in organizations without any broader health equity strategy. The organization-wide option offered the SDH PHNs 'permission' to do the work and enhanced the power base from which they operate. This built the health equity agenda more quickly and strategically within the organization, including peer engagement and professional growth in the health equity domain. The SDH PHNs were supported in building an evidence-based equity plan that was cross-disciplinary in nature, which is essential to building healthy public policy.[27]

A key issue identified in this study was the pivotal nature of the organizational culture as either a support or barrier in SDH PHN role implementation. Organizational culture includes those basic values and assumptions and behaviours that influence the functioning of the organization. These are often taken for granted and represent a powerful force affecting the activities of an organization.28 Organizational culture emerged as a key factor that supported a PHU's ultimate ability and motivation to advance the health equity agenda within. Our findings are similar to recent Ontario research highlighting the influence of the Medical Officer of Health and staff ideology and organizational structures on public health action on health equity.[29] The notion of **organizational culture and embracing the health equity challenge, and more fundamentally, prioritizing health equity** was profiled in our findings.

This study examined the SDH PHN role within its embedded organizational context. **Organizational culture affected the ability of the SDH PHNs to develop their roles and the equity priority.** The value (or lack thereof) placed on nursing roles in some PHUs, compounded with the struggle to embrace health equity as an integral part of public health practice, influenced the role development and implementation. This inevitably had an impact on health equity aims. Organizational oppression and power was a barrier in some units, which slowed progress towards a unit-wide health equity agenda. Organizations can be a site of empowerment or oppression, and power within organizations limits or enhances the actions and capacities of the professionals within the system.[15] The structure of the work environment and access to power and opportunity influences the attitudes and behaviours of individuals within organizations. Historically, power and empowerment tensions have existed for the nursing profession. Nurses may be more reluctant than most to discuss power because 95% of all nurses are women,[30] and women have not been socialized to exert power.[31] Definitions of power can include the ability to get things done and to mobilize resources,[32] so negative structural power issues in clinical practice can have major implications for effective practice and client outcomes. Empowerment for nurses may consist of three components: a workplace that has the requisite structures to promote empowerment; a psychological belief in one's ability to be empowered; and acknowledgement that there is power in the relationships and caring that nurses provide.[32]

In organizations that demonstrated empowering attributes, the SDH nurses were better positioned to grow the new role and contribute to (in many instances to lead) an enhanced health equity agenda. These organizations structured the opportunity for SDH PHNs to increase their knowledge and skills, access and mobilize resources, and to develop and implement plans to make equity practice change. These findings are consistent with other public health research that examines Canadian public health nurses' practice from a management perspective. Constraining structures, operations, and governance, in addition to insufficient infrastructure support are part of the unique "day-to-day contested realities of public health and PHN practice."[33]

Leadership issues influenced the impact of organizational culture on developing and implementing the new positions—senior leaders had the power to structure the role for effective implementation. We know that leadership style and organizational empowerment are intricately linked.[34] Organizational culture and management and leadership practices have been identified as being supportive to successful public health nursing practice.[35,36] When effective leadership permeates an organization, its members feel empowered and motivated to be effective in their roles. Without this type of leadership, the organization may miss opportunities to integrate new methods of solving problems or learning.[28] Managers need to understand the role of the public health nurses who work for them and make it possible for nurses to use the full scope of their competencies.[36] Local organizational culture that supports PHNs to best practice the full scope of their competencies includes effective leadership that values diverse public health roles, demonstrating respect, trust, and support for PHNs.[35] Underwood and colleagues[36] and Meagher-Stewart and colleagues[37] underscored particular organizational attributes in public health that are relevant to community health nursing capacity in Canada. Attributes that contribute to this focus on work processes and relationships include shared vision and goals, partnerships and collaboration, creativity and responsiveness, learning, and information sharing. Consistent with the findings in this study, others have identified the benefits of having the time to build partnerships, respond to new program opportunities, and pursue ongoing professional development.[35]

The study findings highlight the need to make public health organizational changes to make room for a health equity agenda. There is a growing recognition that changes to health care systems and organizations require integrated action, with each system area incrementally reinforcing and developing other interdependent areas.[35] The results of this study highlight areas for public health organizational development and offer recommendations for supporting effective public health practice to support health equity.

The nature of PHU senior leadership styles was crucial in this investigation.

Annett 15 notes the importance of understanding the values, culture, and methods of working of the home organization; the potential to contribute to the understanding of determinants of health and health inequities in other sectors; and knowledge of the political context. Leadership roles in public health can also serve as catalysts for accelerating innovation and strengthening partnerships. Public health leadership also requires being "attentive to social conscience and scientific intent."[15]

Significantly, it was evident throughout the investigation that there are passionate and committed SDH PHNs and managers who have the capacity to effect health equity change and who are actively pursuing such change. They focused on organizational health equity capacity building, and ultimately on improving health equity outcomes for their communities at large and equity-seeking populations specifically.

Many PHUs used the opportunity to develop the SDH PHN positions to increase their strategic focus on health equity—far beyond where they were working before the introduction of the positions—others to create a new strategic focus on the issue. It was clear that the SDH PHN initiative had a significant positive impact on the capacity of many PHUs to advance strategically focused health equity plans. However, despite the explicit nature of the OPHS[20] and the Ontario Public Health Organizational Standards[26] as directives to address health inequity and SDH, many at the local PHU level perceived that provincial guidance on these issues was lacking. This contributed to frustration at the local level, notably for PHUs at the early stages of health equity action. What was originally intended as leeway to support local, evidence-based decision-making, which is fundamental to contemporary public health practice, was interpreted by some as lack of direction by provincial public health policy makers. This suggests that standards alone are not sufficient to shift practice at the local level, especially considering the stronghold of traditional public health programming.

Conclusion

We conducted a case study of a province-wide initiative designed to increase the capacity of local public health agencies to address the social determinants of health and health equity. Our findings suggest that many public health units benefitted greatly from this resource investment in the form of SDH PHNs—the funding served as a catalyst in some PHUs and enhanced existing work in others. As has been identified in other research, leadership, change management, differing philosophies of the place of health equity in public health practice were important factors in implementing the new roles. It was also clear that organizations needed cross-functional health equity positions to ensure that health equity work was not limited to select programs but was a visible organizational priority. A disconnect existed between the province and local public health units, pointing to policy implementation gaps. The findings of this case study have implications for policy, practice, education, and research, which are highlighted below.

Recommendations

Policy

Local involvement in policy development at the provincial level may help reduce policy implementation gaps. Increased dialogue and communication about requirements and expectations prior to role creation and funding could enhance clarity across the public health system. Further, ongoing engagement through discussion across multiple system levels can also help avoid and address major policy implementation gaps.

Providing guidance to PHUs on how to implement health equity mandates while maintaining flexibility for local adaptation will support implementation.

Accountability measures can help ensure that positions are used to meet the intended mandate of increasing organizational health equity capacity.

Ongoing feedback mechanisms between systems and organizational stakeholders can help ensure that local public health organizations have the support needed to fully implement health equity positions and related activities.

Taking action on the social determinants of health and health equity requires a multidisciplinary approach. Human resource initiatives that draw from a range of disciplines will benefit from diverse skills and perspectives.

Support for knowledge exchange and network development for those in similar roles enhances information sharing, and joint planning, and will amplify gains across organizations.

Practice

Including health equity considerations in program planning and delivery supports public health unit staff, including SDH nurses, to consistently and explicitly work to address SDH and health equity. This would help to address doubts about the role of public health in addressing SDH/health equity, alleviate tension in the practice environment, and demonstrate organizational and leadership support for the work. It would also underline the need to shift approaches, from a largely behavioural and biomedical to SDH and health equity focused.

Clearly defined responsibilities for health equity positions, drawing explicit links between provincial mandates and locally planned actions, would minimize the disconnect between what the province plans and what the health unit perceives.

Organizations seeking to better address the social determinants of health and health equity must look internally and align their workplace values, culture, and practices with equity and social justice. By doing so, they create an environment for professionals to develop a reflexive public health practice.

Public health organizations that 1) develop and promote cultural attributes (such as a shared vision, mission, and goals) that prioritize health equity and are understood and valued throughout the organization, and 2) foster a culture of creativity and responsiveness, that will supports PHNs and other staff to practice the full scope of their competencies. A supportive learning environment in which there is continued development enables staff to gain the skills required to be effective in their roles. This

means cultivating a healthy organizational culture in public health by:

- transforming power relationships within the organization and beyond;
- encouraging access to and free flow of information;
- supporting innovation and new methods; and
- creating a learning environment.

Internal and external activities serve to bolster the work of the organization. Ensuring that internal structures are in place brings public health staff together and helps reduce internal siloes. Given that the SDH lie outside public health, working in collaboration with communities, health partners and non-health partners is an essential part of the health equity role.

Visionary and empowering leadership supports the integration of health equity as part of everyday public health practice. Enhancing these leadership styles will help further organizational action.

Education

All disciplines in public health must receive continuing education and professional development in addressing SDH and health equity to support the development of knowledge and skills. Competency development across the organization would allay concerns of being siloed, disperse collegial tension, and position health equity specialist roles within a supportive framework. This allows for "leadership from within" on health equity.

Competencies highlighted in this study include:

- knowledge of SDH and health equity;
- organizational change/development;
- systems change strategies;
- program development and evaluation with specific consideration to equity;
- advocacy;
- policy development;
- community engagement; and
- leadership.

Research

The critical yet still-emerging area of health equity and addressing SDH would benefit from further research that explores the following:

- the relationship between organizational culture (including values and ideology) and an organization's capacity to work on a health equity agenda;
- the impact of structurally embedded workplace inequities (e.g., disempowerment of nurses) on health inequity priorities;
- the activities of SDH PHN and their influence on their respective organization's capacity to address health equity work;
- the disciplines and public health professionals best positioned to effectively advance the health equity agenda and how best to prepare/educate these disciplines and professionals; and
- the development of similar public health roles in other jurisdictions to strengthen the science behind public health equity work and to increase the strength of the transferability of the findings reported here.

TABLES

Table 1

Socio-demographic Characteristics of Study Participants (n=42)

Characteristic	No. of Participants	% of Total
Gender		
Female	37	88%
Male	5	12%
Age		
‹40	11	26%
40-50	14	33%
›50	17	41%
Role[a]		
Public Health Nurse	24	57%
Other	18	43%
Years in Profession		
‹10	10	23.8%
10-19	9	21.4%
›20	23	54.8%
Years in Public Health Practice		
‹5	11	26.2%
5-10	6	14.3 %
›10	25	59.5%
No. of PHUs represented by participants	22/36[b]	61.1%
No. of PHUs where both SDH-PHNs interviewed	4/22[c]	18%
No. of PHUs where more than one role interviewed (always included PHN)	11/22	50%

Note: Actual numbers according to the original categories in the sampling frame cannot be disclosed in an effort to protect participants' identities.

[a] Other role category includes Chief Nursing Officers, Directors, Managers, Chief Executive Officers, (Associate) Medical Officers of Health, and Ministry staff (numbers per role too small to report).

[b] 36 = Number of PHUs in Ontario.

[c] 22 = Number PHUs represented by study participants.

Table 2

Characteristics of Study Documents (n=226)

Document Type	Examples	Total No.	% of Total
PHU Websites	• X homepage • SDH or Health Equity specific initiative	57	25.2%
Policy and Planning Documents	• Health Unit Strategic Plan • SDH PHN Report to Ministry	95	42%
Programming Materials	• Pamphlet • Video	28	12.4%
Other Communication Materials	• Presentation • Facebook page	46	20.4%

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APPENDIX 1

METHODS

Case study methods[21] guided this project. Case study is used to understand complex social phenomena when a 'how' or 'why' question is posed about a set of events over which the investigator has little or no control, and when trying to trace operational links over time. This approach is particularly desirable when examining a complex system, such as the implementation of a new initiative across multiple PHUs simultaneously in a relatively short period of time.[22] Further, case study supports understanding of policy development and implementation at multiple levels: micro- (individual PHN), meso- (organizational), and macro-level (system, provincial).[22,38] This multi-level approach is critical for complex public systems and health systems change in particular.[14,22]

This section details standard case study methodological concerns, including theoretical propositions, case selection, and justification for the selected case, data sources, data sampling, data analysis, research rigour, and research ethics.

This was a two-year case study that examined the development and implementation of a province-wide public health policy initiative to address health equity in Ontario. Consistent with a case study approach, **theoretical propositions** were used in lieu of a theoretical framework to: (1) direct attention to particular concepts to be examined within the scope of the study, and (2) support study feasibility because propositions focus the team's attention by narrowing the relevant evidence during data collection and analysis.[21,39] Propositions related to the main research question and subquestions were drawn from existing theory and empirical research[23] on health equity, SDH, and public health leadership.

Proposition 1: Leadership at **multiple levels** and **by multiple actors** is essential for public health actions to address social determinants of health and health equity.[12,22]

Proposition 2: Public health leadership for social determinants of health and health equity is **context-specific** and is highly **relational** in nature.

The Case used in this study was a current event, that of a provincial Ministry public health initiative in Ontario. To date, Ontario is the first known Canadian province to attempt a province-wide public health policy implementation of this nature. As such, this makes the case a *unique case* type,[21] which is important in tracing novel policy development and implementation. The specific case parameters of time, organizational boundaries, geography/place, and context established the unit of analysis for this case event. This case was bounded in the timeframe beginning in April 2012 with the events that sparked the funding availability for the new SDH PHN positions in Ontario, ending in August 2014. The case organizational parameters were bounded by each PHU and the Ministry legislative boundaries, and by the province as a whole. Similarly, the geographical/place boundaries for the case were the province of Ontario and respective PHU municipal boundaries. The definition of SDH PHN as established in position descriptions by each PHU and by the Ministry was adopted. Case contexts also included other international, national, provincial/territorial, and regional trends related to SDH and health equity public health practice trends of relevance.

Data Sources and Sampling Strategies

In case study methodology, triangulation of multiple data sources, collection methods, investigators, and theory is optimal to establish rigour.[21] The two main data sources for the case study were documents and people.

Participant data from staff (e.g., SDH PHNs, Managers, Directors, Chief Nursing Officers, Medical Officers of Health) in local PHUs as well as other stakeholders (e.g., Ministry staff) were collected through individual, semi-structured interviews that were 30-60 minutes long. We sought maximum variation in a systematic manner using criterion sampling with specific pre-defined criteria within a sampling frame (e.g., location, position, gender, number of years of service) to obtain a sample that crossed as many PHUs, regions, and roles as possible, including representation from the provincial level context, to sample the breadth and diversity needed for the research questions. Consistent with Yin,[21] sampling and data analysis were iterative processes, with analysis guiding further data collection. For both data sources (i.e., documents and people), sampling was initially purposeful and then more targeted in an effort to reach theoretical saturation.[21,24,40] Multiple investigators from the research team collected the data to support triangulation.

Document sources included policy documents, websites, background documents, policy implementation materials, and other contextual sources recommended by participants. ***Document sampling*** was purposeful, with pre-defined criteria, including document type and geographical origin, and was bound by the pre-established time parameters in the case definition. For case studies, the most important use of documents is to corroborate and augment data from other sources,[21] so document sources that converged on the same issues identified by study participants were sought. The document sample size was determined when a fully saturated sampling frame was achieved such that themes began to repeat themselves across data units with no new themes arising.

Data Analysis

It is important that the analysis and product be congruent with the definition of the case so that the specific unit of analysis is at the case level[21] (i.e., the policy implementation as a current event). A time-series/chronology analysis technique[21,40] was used for the transcript data. This allowed us to trace case study events over time and to examine temporal conditions related to the study questions and propositions. *Framework Analysis*,[23] including conceptual scaffolding, guided analysis of the transcript data. Framework analysis was explicitly developed in the context of applied policy research at the UK National Centre for Social Research[41] and is used in conjunction with case study applications. Framework analysis allows for inclusion of *a priori* (e.g., propositions) as well as emergent concepts, while the overall approach is inductive. N-Vivo 10© software was used for interview data management and manipulation. Prior's guidelines[24] were used for document analysis. We considered the following aspects of the document data: (a) content; (b) how they were produced; and (c) how they functioned or were used such that content is not the only or primary determinant of function. The documents were viewed as representations that make issues visible, and that construct and stabilize ideas, identities, and processes. The documents were used to trace out patterns of social exchange and the social networks that lie behind them.

APPENDIX 2:

INTERVIEW GUIDE

PART I: BACKGROUND

Some of these initial questions are about your particular role as you participated in the SDH-PHN initiative. Please note that if there are any questions and answers that would clearly indicate your identity (e.g., you are a SDH PHN in a particular health unit), then we will report information associated with you in a manner that maintains your anonymity. Also remember that you are free to answer or not answer any of the questions or to stop the interview at any time.

1. In which role are you currently employed?
2. Has your role changed since entering into this role?
    - If yes, describe this.

PART II: THE SDH PHN INITIATIVE

These questions are about the SDH initiative, its implementation history and issues that may have been unique to your experience.

3. Describe the SDH PHN initiative in your own words.
4. Most of this interview is about the implementation of the SDH PHN role. Implementation is considered to be from the time that people are hired into the PHN position under the SDH initiative. However, I will ask you one question here about the time before you were hired, that is, when the SDH role was being developed. You may or may not have any information to offer about this time period:

Tell me about how the SDH role was considered in your workplace in its early development stage. [For example, consider: What happened when your unit agreed to accept the funding for the SDH PHN positions? How was the role developed in your unit? Was a role description written?]

5. Now, we'll move to the SDH PHN role implementation period. Please tell me a story about the initial implementation activities. Use a timeline of events that stood out for you if this helps.
6. Were there important or controversial issues that arose early on in role implementation?
    - Please describe some key issues.
    - How were these issues resolved?
7. Processes are often important in new role development. Processes include activities as well as the details surrounding how those activities are managed or supported. For example, regular meetings supported by time to attend the meetings. Which processes supported early SDH PHN role implementation?
    - Which processes inhibited it?
    - Were there some processes that were more (or less) important at different points in time?
8. There may be factors, other than processes, that may have also had an impact on the role implementation. If you were to prioritize the MOST IMPORTANT factors that supported the SDH-PHN implementation, what would be your top 3?
    - Which factors inhibited it?
    - Were there some factors that were more (or less) important at different points in time?
9. The SDH PHN initiative was initially developed at a provincial level. Describe how you think this may or may not have affected the SDH-PHN initiative.

PART III: LEADERSHIP

10. How do you define leadership in the public health context?
11. Describe how you understand leadership for health equity and the social determinants of health occurring in public health.
12. Do you see the SDH-PHN initiative as an example of public health leadership?
    - If so, then describe why. (and continue on to question #13)
    - If not, then describe why not. (if no then go to Part IV)

If 12 is YES, then

13. How are you demonstrating leadership in your SDH/Health Equity role?
    - Provide 2 examples.
14. What are some other examples of how public health leadership may have supported the SDH PHN role in your unit? In other units? Regionally or provincially?
15. What have been the most important successes of the SDH-PHN initiative relative to the Social Determinants of Health and health equity?
    - How has leadership contributed to this success?
    - Consider this at individual, organizational and broader system levels.
16. What have been the opportunities that you have taken advantage of in terms of supporting the SDH PHN initiative?
17. What are the most important leadership challenges affecting progress on the Social Determinants of Health and health equity in your workplace/unit?
    - How were those challenges addressed?
    - What do you suggest might support progress in this area?
18. There may be factors that have impacted your leadership within the SDH PHN role. If you were to prioritize the MOST IMPORTANT factors that supported your leadership in the SDH role, what would be your top 3?
    - Which factors inhibited it?
    - Were there some factors that were more (or less) important at different points in time in relation to your leadership role?

PART IV: IMPLICATIONS FOR YOUR ORGANIZATION

19. Has the SDH PHN role had an impact on your organization? If so, in what ways?
20. How has the SDH PHN role impacted the broader public health mission? (for example, public health standards? Programming?)
21. What has your organization gained from participating in the SDH PHN initiative?
22. What costs were there to your organization (resources or time) for participation?
    - Has this changed over time? How?
23. Has it been worth it for you to participate in the SDH PHN initiative?
    - For your organization?

PART V: WRAP UP

24. Part of this study includes document review. Are there documents that you are aware of that deal with any of the issues that we have discussed here today?
    - Are there any others that you would recommend I review?
    - What would be important for me to review in these documents?
25. Are there any other thoughts that you would like to add before we finish the interview?

NOTES

NOTES

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for Determinants of Health

Centre de collaboration nationale
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