COMMENTARY

A Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA)

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ABSTRACT

The Canadian public health sector's foundational values of social justice and equity, and its mandate to promote population health, make it ideally situated to take a strong lead in addressing persistent and unacceptable inequities in health between socially disadvantaged, marginalized or excluded groups and the general population. There is currently much attention paid to improving understanding of pathways to health equity and development of effective population health interventions to reduce health inequities. Strengthening the capacity of the public health sector to develop, implement and sustain equity-focused population health initiatives – including readiness to engage in a social justice-based equity framework for public health – is an equally essential area that has received less attention. Unfortunately, there is evidence that current capacity of the Canadian public health sector to address inequities is highly variable. The first step in developing a sustained approach to improving capacity for health equity action is the identification of what this type of capacity entails. This paper outlines a Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA), grounded in the experience of Canadian public health equity champions, that can guide research, dialogue, reflection and action on public health capacity development to achieve health equity goals.

KEY WORDS: Public health practice; capacity building; health services research; disparities, health status; vulnerable populations

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The need to address growing health inequities – those disparities or inequalities in health between population groups that are systematically associated with underlying social disadvantage[1] – is an increasingly articulated global health priority.[2] In Canada, persistent inequities between socially disadvantaged, marginalized or excluded groups and the general population have led to renewed calls for action to address their root causes.[3,4] The public health sector's foundational values of social justice and equity,[5] and its mandate to promote population health,[6] make it ideally situated to take a strong lead in health equity action.[7] A 2011 report by the National Collaborating Centre for Determinants of Health[7] documented notable examples of Canadian public health initiatives to address inequities which "represent early adopters/innovators versus being reflective of typical or widespread public health practice in this country" (p.15). The report noted that population health interventions targeting inequities and the social determinants of health are often not fully institutionalized and that there is a "continuing preoccupation by public health with behaviour and lifestyle approaches" (p.17). It concluded that current *capacity* of public health organizations to address inequities is "highly variable" (p.18); for example, some regional health authorities and public health units have limited epidemiologic capacity for assessment/surveillance, or few staff with the skills required for community engagement and advocacy work, whereas others might have much greater capacity in these areas.

Stronger organizational capacity for health equity action in the public health sector is essential to develop, implement and particularly to sustain population health interventions specifically designed to address health inequities, including taking action on underlying causes. Although there is literature on frameworks and indicators to measure capacity, performance, and capacity-building processes in health systems in general,[8,9] and for health promotion in particular,[10,11] there is currently no framework, nor indicators, of capacity for *public health equity action* in the Canadian context.

This paper presents a Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA), grounded in the experience of Canadian public health equity champions, that can be used as a tool to guide research, dialogue, reflection and action on public health capacity development to achieve health equity goals.

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Table 1. Key Themes* That Informed Development of OC-PHEA Framework

Dimensions of organizational capacity	Intra- and extra-organizational values and ethics; will or commitment to act; leadership; knowledge, skills, attitudes and professional development; infrastructure, including resources, policies and processes.
Critical role of equity champions	Individuals with credibility and respect whose commitment is inspiring, and who consistently advocate within and outside of their organizations by creating opportunities to put health equity front and centre of those with decision-making capabilities[10] – particularly in senior management and governance positions both within and outside the organization.
Centrality of partnerships, collaborative relationships and networks	These occur among health organizations and between public health, civil society organizations and other government sectors, with the purpose of 1) addressing broad social/structural determinants of health and health inequities (e.g., education, a living wage, housing and food security) and 2) promoting population health – especially among socially disadvantaged, excluded, or marginalized population groups.
Complexity of intra- and extra-organizational influences on OC-PHEA	A multiplicity of factors (originating at the individual, organizational and environmental levels) create unique organizational contexts that determine how and which aspects of capacity are developed. Constraints to equity action identified by health equity champions included: tension around the organization's priorities; role overload; dominance of an acute care culture; challenges of measuring capacity. Facilitators included: a favourable political agenda and support at the community level.

* Many of the themes identified by health equity champions were supported by the literature on organizational capacity. A full reference list is available upon request.

Table 2. Public Health Equity Actions (PHEAs)*

Actions to mitigate health inequities include:	• Using data on inequities to design and evaluate policies, programs, services • Planning and delivering programs and services specifically for equity-seeking populations • Increasing access to public health services by equity-seeking populations • Developing knowledge, skills, and attitudes in the public health workforce related to addressing health inequities • Using equity-focused organizational planning, management and evaluation tools
Actions to influence social and structural conditions that currently lead to health inequities include:	• Building capacity within priority populations (community development) • Engaging in advocacy with or on behalf of equity-seeking populations • Collaborating with other sectors to address social/structural determinants of health such as housing and food security, education and a living wage (through increased minimum wage and social assistance rates or, ideally, a guaranteed minimum income) • Educating and raising awareness about equity issues among the public, decision-makers in other sectors, government departments and within health departments • Conducting equity-focused health impact assessments on public policies
Core actions to achieve both purposes:	• Monitoring health inequities • Setting targets to reduce health inequities • Evaluating the outcomes of health equity actions (intermediate and long-term impacts)

* Identified in the literature[7,13-15] and by health equity champions who were interviewed.

Method used to develop OC-PHEA Framework

Two sources of data were used to develop the OC-PHEA Framework: interviews with key informants and a review of the literature. We deliberately sought to interview individuals who were known as "health equity champions" (HECs) because they, or the public health organization they represent, had demonstrated leadership through either equity-focused strategic planning or programming initiatives, or their collaborative, community-based work with socially disadvantaged populations. We used a two-part strategy to select key informants. First, our team members identified 10 individuals with strong reputations as HECs in the Canadian public health community, and we began interviews with them. Second, each interviewee was asked to suggest others from their public health networks whom they considered to be HECs. Six additional individuals were identified and interviewed.

Between July and October 2010, the project manager conducted telephone interviews with 16 HECs from 16 different local or regional public health programs in seven Canadian provinces (human ethics approval was obtained from the University of Manitoba's Nursing-Education Research Ethics Board). The sample included senior public health administrators, public health practitioners and program managers. Seven individuals were from local, stand-alone (i.e., non-regionalized) public health units in Ontario; the remainder worked within regionalized health systems across Canada. Although we asked some contextual questions, it was the HECs' perspectives about core elements of OC-PHEA and factors that enable or constrain OC-PHEA that were especially pertinent to the development of the OC-PHEA framework.

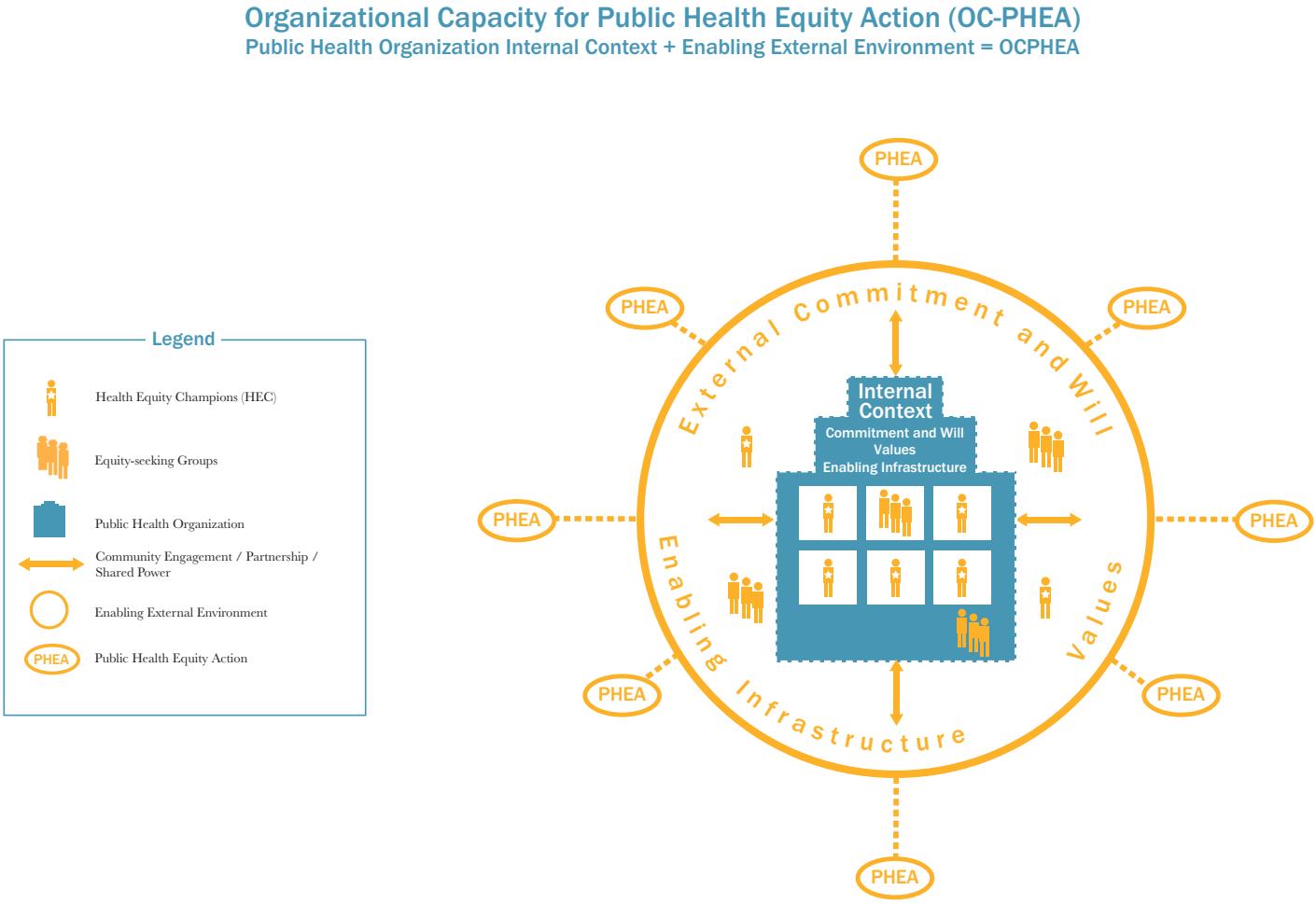
The interviews were supplemented by a review of literature published after 2000, including i) academic literature, retrieved using PubMed and EBSCOhost databases; and ii) relevant reports retrieved using a Google search. The main purpose was to identify concepts and frameworks related to public health system or organizational capacity and to determine which key elements should be considered in developing a framework of OC-PHEA. Another objective was to identify public health equity actions (PHEAs) described in the literature.

Incorporating both of these data sources (interviews with key informants and a literature review), we were able to meet our goal of creating a conceptual framework that is contextually relevant at the Canadian local or regional public health level.

Data Analysis and Drafting of Framework

Key themes were identified in the interview data and in the literature review findings. These findings were presented by the first author and project manager at a two-day face-to-face meeting where the project team – consisting of five academic researchers (three from nursing, two from sociology) and three collaborators with a range of public health sector experience (clinical, research, knowledge translation) from nursing, medicine, and organizational change background – engaged in further analysis, and drafted a preliminary framework (see Table 1 for key themes that influenced development of the draft Framework). The team continued to refine the Framework through group conference calls and electronic communications until there was consensus and the draft was distributed to the interviewees for review and feedback.

Figure 1. Conceptual Framework of Organizational Capacity for Public Health Equity Action



Feedback on Draft Framework

Participant feedback on the draft OC-PHEA Framework is an important feature of this project. Each HEC was provided with their interview transcript and the draft Framework and was asked to respond in writing to a series of questions. Most significantly, they were asked to confirm that the Framework included the key elements and characteristics of OC-PHEA they had identified, and they were invited to suggest changes to the Framework. Fourteen of the 16 HECs responded. All indicated that the Framework reflected their input, and many provided further suggestions. The team considered all suggestions before finalizing the Framework, incorporating many, while making note of others for consideration in future work.

Key concepts used in the OC-PHEA Framework

Organizational Capacity for Public Health Equity Action (OC-PHEA): The capability of a public health organization to identify health inequities, mobilize resources, and take effective action to reduce inequities (defined by the project team).

Health equity: The absence of differences in health that are not only unnecessary and avoidable but are also considered unfair and unjust. Health equity does not imply that everyone should have identical health outcomes, but does imply that all population groups should have equal opportunities for health and therefore that there should not be systematic differences in health status between groups.[12]

Public health organization: The organization and delivery of public health programs and services varies across Canada. The term refers to both stand-alone public health units (in Ontario) and public or population health departments that are part of integrated regional health systems (in the rest of Canada).

Public health equity actions (PHEAs): PHEAs that were identified in the literature[7,13-15] and by HECs whom we interviewed can be broadly categorized as: a) actions to mitigate health inequities by assuring the equitable uptake of public health programs and services that are designed to promote health equity, b) actions to influence systemic changes that will improve the social conditions currently resulting in inequities, and c) actions to achieve both purposes. See Table 2 for a detailed list.

Overview and key components of OC-PHEA Framework

Recognizing the significance of the relationships and influences between public health, its communities, and the structures and systems within which both are situated, the OC-PHEA Framework depicts two key domains (see Figure 1): 1) Internal Context, referring to dimensions within an organization that influence its capability to act, and 2) Enabling External Environment, representing dimensions of the local community and broader systems that influence the capability of the public health organization to act. Both internal and external domains are characterized by similar dimensions: shared values; demonstrated

commitment and will; and a supportive infrastructure (described in further detail below).

Internal Context

An organization's *values* are central to its culture and provide guidance for the establishment of its priorities and goals. Values provide a context for individual behaviour and are reflected in how the organization conducts its internal business and how it relates to its communities. The OC-PHEA Framework identifies a number of shared values: fair distribution of power, respectful relationships, shared societal responsibility for equitable opportunities for health. In particular, capacity for PHEA is strengthened when the organization values social justice, which focuses on direct attention to the root causes of inequities in health and health care in different social groups.[16]

Commitment to PHEA is evidenced when an organization prioritizes and follows through with equity-focused action; provides satisfactory structures and resources necessary to support PHEA; and encourages participatory processes that fairly distribute power and generate trust and respect. Commitment is also evidenced by the presence of health equity champions at all levels of the organization who energize and motivate staff for PHEA. These relationships, structures, resources and processes are known as *organizational infrastructure.* Examples of the distinctive elements of organizational infrastructure required for successful PHEA include access and ability to interpret local data on inequities, advocacy skills among the workforce, and processes to ensure that members of equity-seeking populations can influence organizational decision-making.

Enabling External Environment

This domain consists of dimensions of the broader social, political, cultural and economic context (local, regional, provincial/territorial or federal) that empower public health to develop and sustain PHEA. Conceptually, these are similar to those of Internal Context (e.g., values, commitment, supportive infrastructure), but are represented at a level broader than the organization. For example, *commitment/will* in an Enabling External Environment for OC-PHEA would be characterized by government resource allocations that support equity-based public policy across sectors, including legislation and policies that shape the social determinants of health (e.g., availability/accessibility of affordable housing, a living wage). Community leadership would seek accountability of public health for PHEA. A *supportive infrastructure* would include equity champions and others outside public health who can access decision-makers and resources for PHEA at all jurisdictional levels, and positive relationships between public health, equity-seeking groups, and civil society and government organizations. Fundamental to the Framework is the necessity of recognizing like-minded forces in the external environment and building coalitions for success.

Relationship Between Components

The OC-PHEA Framework shows characteristics which together are believed to be necessary for public health to be *fully functional* as a societal driver toward the elimination of health inequities; that is, it represents an *ideal* level of organizational capacity. The two-way arrows in Figure 1 highlight the reciprocal influence between public health and the broader environment (*ideally* in the form of community engagement, cross-sectoral partnerships, and shared power). Champions and members of equity-seeking populations are actively engaged in PHEA both within and outside the public health organization.

An important aspect of this Framework is that we view the Enabling External Environment as essential to optimize OC-PHEA. The most favourable conditions for OC-PHEA would exist if both the internal and external domains of OC-PHEA were strong and well supported. In reality there are often barriers to health equity action, resulting in differing levels of capacity *among* organizations and also *within* organizations at different points in time and in relation to the equity issue being addressed. Even without *optimal* capacity, an organization may possess various elements and degrees of OC-PHEA (e.g., supportive values, or commitment, or skills for community engagement) and thus be able to take action to address health inequities.

DISCUSSION

Addressing social and structural determinants of health and health inequities is an overall system performance issue. It requires a strategy to measure and assess current capacity and to develop a sustained approach to improving capacity.[17] Processes to assess existing capacity are likely to be most successful when assessment tools or guidelines *reflect elements identified as important by those working in the field.*[18] The OC-PHEA Framework is grounded in the experience of Canadian public health professionals who are actively developing OC-PHEA in their organizations. The Framework may be viewed as a first step toward theory-building in the area of OC-PHEA and an attempt to bring a health equity lens to public health systems research. For example, it could be used by researchers to understand what underpins more successful health equity initiatives in comparison to others. On a more immediate level, public health organizations that choose to focus their actions toward health equity goals could use the Framework to identify indicators of OC-PHEA in their organizations, identify and address areas of weakness and barriers to OC-PHEA, and monitor changes in capacity over time.

Although we spoke with many frontrunners in the development of OC-PHEA, we did not capture views from all Canadian health equity champions. We welcome the input of other public health leaders as they strive to institutionalize their health equity practice. We hope that reflection and dialogue on the concepts presented in the OC-PHEA Framework will extend the health equity discourse, facilitate the evolution of the Framework and help to advance the mainstreaming of social justice and health equity action into public health organizational practice.[19]

Note: a version of the Framework containing a more extensive list of examples for each capacity domain is available by contacting the first author.

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RÉSUMÉ

Le secteur canadien de la santé publique, avec ses valeurs fondamentales de justice sociale et d'équité et son mandat de promotion de la santé des populations, est idéalement situé pour jouer un rôle de premier plan face aux iniquités en santé persistantes et inacceptables entre les groupes socialement défavorisés, marginalisés ou exclus et la population générale. On essaie beaucoup, en ce moment, de mieux comprendre les voies de l'équité en santé et d'élaborer des interventions efficaces en santé des populations pour réduire les iniquités en santé. Une mesure tout aussi essentielle et pourtant moins reconnue est de renforcer les capacités du secteur de la santé publique à élaborer, à mettre en œuvre et à soutenir des initiatives de santé des populations axées sur l'équité – y compris la volonté d'employer en santé publique une grille d'équité basée sur la justice sociale. Malheureusement, il semble que la capacité actuelle du secteur canadien de la santé publique d'aborder les iniquités varie considérablement. La première étape, si l'on veut mettre au point une approche soutenue en vue d'améliorer les capacités d'agir sur l'équité en santé, est de déterminer ce qu'une telle capacité implique. Notre article définit un « cadre conceptuel de la capacité organisationnelle pour une action de la santé publique en matière d'équité », ancré dans l'expérience des champions de la santé publique canadienne sur la question de l'équité, pour orienter la recherche, le dialogue, la réflexion et l'action sur le renforcement des capacités en santé publique et atteindre les objectifs d'équité en santé.

MOTS CLÉS : pratique en santé publique; renforcement des capacités; recherche en services de santé; disparités d'état sanitaire; populations vulnérables