TEN PROMISING PRACTICES
TO GUIDE LOCAL PUBLIC HEALTH PRACTICE TO REDUCE SOCIAL INEQUITIES IN HEALTH

TECHNICAL BRIEFING

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Ten Promising Practices
To Guide Local Public Health Practice To Reduce Social Inequities In Health

Our review and analysis of the literature yielded ten public health practices, relevant at a local public health level, that are at least "promising" in their potential to contribute to reductions in social inequities in health: 1) Targeting with universalism, 2) Purposeful reporting 3) Social marketing, 4) Health equity target setting/goals, 5) Equity-focused health impact assessment, 6) Competencies/ organizational standards, 7) Contribution to evidence base, 8) Early childhood development, 9) Community engagement, and 10) Intersectoral action. Key supporting evidence is summarized below.

1 Targeting with universalism

Debates about the relative effectiveness of targeted versus universal approaches to address poverty and social inequity are usually held in the context of government social and fiscal policy discussions. Under universalism, the entire population is the beneficiary, while under targeting, some form of means-testing is used to determine eligibility for the benefit (p. 63)[1]. Decisions about which approach to take reflect underlying assumptions about values and responsibilities to citizens. Skocpol (quoted in Solar & Irwin p. 64)[1] notes that in more successful [sic] countries, social policy is more universalistic, with targeting used as an instrument to make universalism more effective. This "targeting within universalism" ensures that extra benefits are directed to poorer groups and acts to "fine-tune" essentially universal policies.

As applied to local public health practices, decisions about universal versus targeted approaches reflect basic underlying goals. If the goal is to "level up", then some targeting must occur. In their Levelling-up Report, Parts 1 and 2, Dahlgren and Whitehead[2, 3] describe the need to improve disproportionately the health of more disadvantaged groups while at the same time improving the health of the entire population. To make strides in reducing health inequities, public health practice must strive to balance selective or targeted approaches with universal strategies.

The WHO CSDH[4] recommended that within a framework of universal access, special attention be provided to the socially disadvantaged and, especially, children who are lagging behind in their development. Targeting, also, may be effective during times of life transition. Blackman[5] has suggested, for instance, the integration of smoking cessation programs during times of transitioning to employment.

It is noted that targeting must entail careful identification of disadvantaged populations[6]. This requires the availability of equity-based epidemiological information. The careful analysis of such data can then be used to inform, monitor and evaluate programs and policies that target disadvantaged populations[7].

2 Purposeful reporting

The WHO, among others, identifies the importance of reporting purposefully on the relationship between health and social inequities in all health status reporting. The WHO document: The Social Determinants of Health: Developing an evidence base for political action, highlights the link between reporting on health inequities and political action[14]. Similarly, Closing the Gap in a Generation4, notes that "ensuring that health inequity is measured…is a vital platform for action." (p. 2). Thus, evidence about health inequities presented publicly and intentionally may be considered part of a strategy for change.

In Health for All[8], the authors describe the importance of stratifying data by socioeconomic status (SES) as one example, rather than controlling for the effect of SES as many analyses do. By stratifying, the differential effect of income on health status becomes apparent. Similar analyses could be undertaken for links between health and unemployment, social exclusion, education, deprivation, and other variables.

An additional benefit to reporting in a way that presents, rather than masks, the effect of social inequities in health, is that evidence of progress, or lack thereof, can also be brought to the fore and can guide future interventions.

3 Social marketing

Social marketing is "the systematic application of marketing alongside other concepts and techniques, to achieve specific behavioural goals, for a social good"(National Social Marketing Centre 2007 as quoted in Farr p. 451)[9]. Target audience segmentation and tailored interventions, including health communications, are key steps within the social marketing process. This approach is considered a promising practice for creating positive social change and improving the health of vulnerable populations. With the objective of reducing health inequalities, social marketing interventions for local public health practice can be thought of in two ways. One is the more conventional tailoring of behaviour change interventions to more disadvantaged populations (with the goal of leveling up). The second, less conventional approach, is to use social marketing to change the understanding and ultimate behaviour of decision makers and the public to take or support action to improve the social determinants of health inequities[10].

Regarding the more conventional approach, the literature identifies the importance of tailored messages within a multilevel approach (a socioecological framework) for changing voluntary health practices, especially among minority populations[11, 12]. There is also evidence to suggest that integrating culture into tailored prevention and control interventions may enhance their effectiveness in diverse populations[13].

A criticism of social marketing is the predominant use of the methods to promote individual behaviour change and the relative infrequency of targeting of policy makers (and the public) to take action to support health equity[10]. This less conventional approach to social marketing is potentially very powerful, especially if combined with individual behaviour change approaches[14, 15].

4 Health equity target setting

The WHO CSDH recognizes that "good evidence on levels of health and its distribution, and on the social determinants of health, is essential for understanding the scale of the problem, assessing the effects of actions, and monitoring progress" (p. 20)[4]. The value of evidence to track change is emphasized; they stop short, however, of recommending target setting as a strategy.

The World Health Organization[16], although recognizing that many countries have incorporated target setting into their intersectoral work on social inequities in health, questions whether there is a demonstrated benefit to target setting for intersectoral work (p. 22). In this commentary, they distinguish between the valuable practice of setting clear and measurable objectives and the setting of time-based outcome objectives. Thus, the exact nature of the targets appears to be important, since some targets may be more enabling of progress than others.

Gardner , in a discussion paper for the Toronto Central Local Health Integration Network (LHIN)[7], frames a health equity strategy around "concrete targets to drive action" (p. 8). The strategy suggests developing and monitoring health equity targets in broad health indicators, specific targets for certain conditions, and targets for health service provision. The context of this target setting within the accountability structure of LHINs is distinct from public health, but may still be informative about public health approaches at the local level.

Lemstra and Neudorf, in Health Disparity in Saskatoon[17], suggest targets as an option for addressing social determinants of health. The National Health Service in the UK has used health inequity targets as part of their overall strategy for reducing health inequities: "targets are a way of ensuring that resources and effort are directed at tackling health inequalities in an explicit and measurable way" (p. 9)[18]. However, they also recognize several challenges to setting inequity reduction targets.

Overall, target setting, although not wholeheartedly supported in the literature, appears to hold some promise as part of a strategy for reducing health inequities, and may have a role at the local public health level. It seems important to focus those targets on areas shown to be remediable, as opposed to setting lofty but perhaps unattainable targets. Target setting as part of a community engagement process, as used by the NHS, connects target setting to other identified aspects of health inequity practice.

5 Equity-focused health impact assessment*

Health Impact Assessment (HIA) is a structured method to assess the potential health impacts of proposed policies and practices. When applied correctly, HIA enables decision-makers to highlight and enhance the positive elements of a proposal, and minimize the aspects that may result in negative health outcomes[19]. By evaluating a broad range of evidence, HIAs are a useful way to assess the impact of proposals (either policy or specific practice) at the general population level. However, they are also recognized as a promising method to address the underlying social and economic determinants of health and resulting health inequities[20].

* This section draws extensively on Stephanie Lefebvre's (Sudbury & District Health Unit, 2009) unpublished summary of the literature on equity-focused health impact assessment.

As distinct from HIA, an Equity-focused Health Impact Assessment (EfHIA) includes questions such as: Is this proposal likely to affect those who are already disadvantaged? Is it likely to impose new health burdens on specific groups? Is it likely to change exposure to, and/or distribution of risk factors or specific determinants of health (e.g. living conditions, access to services)[20]? By applying an equity lens to HIAs, it becomes clear that virtually every policy has winners and losers, some groups who will benefit more than others. With the goal of reducing social inequities in health, this knowledge can assist decision-makers to minimize negative health outcomes, compensate those affected with other benefits, and/or ensure that those affected are not already disadvantaged[21]. Furthermore, increasing awareness of the determinants of social inequities in health among decision-makers and other stakeholders has the potential of influencing both immediate and long-term policy decisions[20, 21]. Finally, a truly participatory approach to conducting EfHIAs can build the capacity of individuals and communities and foster social networks among diverse community members.

Health Impact Assessments are a promising tool for public health practitioners and for a variety of diverse sectors and stakeholders. They can be applied to specific projects as well as broad-reaching policies and in a variety of contexts. Although HIAs could be led by many groups, the public health sector with its knowledge of health determinants is well-poised to promote the use of HIAs (and specifically EfHIAs) and to assist with their application[22].

Challenges for the public health sector in effectively undertaking EfHIAs include resources, professional competencies and the institutional nature of public health agencies. A comprehensive and participatory EfHIA requires intensive investment of resources for evidence collection and assessment, stakeholder consultations, and the development of community profiles. EfHIAs require very specific skill sets, especially related to engaging communities and involving diverse stakeholders in a participatory HIA process. Although the potential of a participatory approach is significant in terms of community capacity-building, it can pose challenges for established institutions with little experience with the power issues involved in such community development-type work.

It is important to acknowledge the limitations of HIAs when considering the objectivity of the HIA process. The function of HIAs is to assess a broad range of evidence related to a proposal's impact on health (both positive and negative). However, the HIA itself is merely a tool to inform the decision-making process. The interpretation of the evidence lies with decision-makers, especially in the case of EbHIAs which require value-judgments as to the fairness or avoidability of health outcomes[23].

6 Competencies/organizational standards

Acting in accordance with the approaches identified in our literature review will require new or enhanced skill sets and capacity building among the public health workforce[4]. The skills base required to work effectively on social inequities in health includes community planning and partnership and coalition building, among other skills[16, 24]— not a common knowledge or experience base for most public health staff. This shift will mean changes in public health recruitment, training, professional development, job orientation and job descriptions. Given that assessing inequities implicitly requires a value judgement, the willingness of public health practitioners to act in accordance with social justice values and

beliefs is also important in creating a work force that can respond to the demands of social inequities work[4].

The Public Health Agency of Canada[24] identified 36 core competencies for public health encompassing essential knowledge, attitudes and skills. Most importantly, these competencies were developed for practice within the context of the values of public health and include, for example, equity, social justice, community participation, and determinants of health. As such, the core competencies for public heath offer a solid foundation for local public health staff recruitment and skill development.

Potvin et al[25] note that public health programs for social change will require an enabling change to the "bureaucratic/structural model upon which public health practice has been traditionally based" (p. 592). Public health organizations will have to make social inequities work a priority, and commit to working intersectorally and with community engagement as a foundation, something that may amount to a paradigm shift for public health.

7 Contribution to evidence base

Petticrew and Roberts[26] describe the:

under-populated, dispersed, and different [from the medical literature] nature of the public health evidence base…. It is under-populated because there are few outcome evaluations of public health interventions and fewer still that examine the distributive effects of interventions across different social groups—and can that shed light on the effective means of reducing health inequalities. (p. 199)

We can certainly attest to the gaps in the evidence base with respect to effective local public health practices to reduce social inequities in health. Much of this knowledge is produced by practitioners working in a service delivery context in which publishing is not a priority. Furthermore, any evidence produced is often preliminary, small in scale and specific to a particular context and setting, and might not be accepted for publication in the traditional academic outlets. Grey literature (reports and evaluations) form part of the knowledge base for local public health interventions, but even these do not represent a complete picture of the practice knowledge that exists, and such literature is often difficult to access.

Raphael[27] identifies a series of actions that should be taken to address determinants of health, and includes in this list the need to "contribute papers to academic and professional journals on developments in Canada and their potential for affecting the health of Canadians" (p. vi). It is important that the burgeoning knowledge base on addressing social inequities through local public health action be strengthened by intentional dissemination of knowledge, whether through traditional mechanisms such as journal publications, through reports, or through other knowledge exchange mechanisms such as communities of practice.

8 Early childhood development

That early child experiences establish the foundational building blocks for development across the life stages is widely recognized[4, 28]. Furthermore, with the greatest gains experienced by the most deprived children, investments in early child development have been referred to as powerful equalizers4.

Simply living under unfavourable socioeconomic conditions during childhood and adolescence increased the risk of health problems later in life…living conditions during childhood are among the greatest determinants of health…their effects are cumulative and have very long term ramifications (p.39)[29].

Early child experiences influence language, physical, social, emotional and cognitive development, which in turn, and throughout the lifecourse, affect learning, educational, economic and social success and health[4, 30-33]. The literature is consistent on the importance of early childhood development, nurturing environments and quality childhood experiences for positive human development[32, 34] and health. Early child experiences are understood to contribute to the positive developmental outcomes and subsequently health through a number of pathways, including psychological, behavioural and physical[32, 35, 36]. Multiple reports have noted that a comprehensive continuum of approaches to ECD is required in order to reduce health inequities[4, 37]. This includes policies, programs and services that are designed through intersectoral collaboration, that are based on "targeted universalism" and that involve communities, especially the most vulnerable communities, in their development, implementation and monitoring[30, 38]. Some of the specific interventions noted in the literature include: prevention of Fetal Alcohol Spectrum Disorder[36], promotion and support of breastfeeding[29, 30], home visiting[30, 36], positive parenting practices[36, 39], school-based interventions for low-income youth[17], detection of depression, including in pregnant and postpartum women[29], and detection of family violence29. Policy options frequently cited in the literature as effective practice include: a system of high quality childcare and learning[4, 17, 31, 36, 39, 40], housing quality[6], integrated child development services[30], National Child Benefit[6], food security, Mother Baby Nutrition Supplement[6], smoking cessation and prevention[6, 29], youth sexual education and consultation[29], promotion of equity between rural and urban areas[4, 41], elimination of child poverty[17] and reducing exposure to inappropriate models in the media including violence[29].

9 Community engagement

As noted in other subsections of this report, community engagement is a key cross-cutting strategy in reducing social inequities in health. Public health professionals should involve communities in the development and implementation of policies, programs and services[4, 30, 37]. Frohlich and Potvin[38] emphasize in particular the participation of members of vulnerable populations in problem identification, intervention development and evaluation. The MEKN Final Report[42] notes the dearth of rigorous evaluations of social interventions aimed at reducing health inequalities. However, the authors list the key characteristics identified from others' reviews of successful programs—each of these eight characteristics includes community consultation, involvement, support and/or engagement as essential (p. 63).

As noted in the equity-focused health impact assessment subsection of this report, significant community engagement can pose challenges for established public health institutions. Community engagement may require levels of shared power and control that are not necessarily comfortable for public health practitioners. Implementation of an inclusive practice at all levels of the planning cycle will require evidence to further inform decisions regarding the optimal intensity of this practice (p. 63–64)[42]. A careful assessment of required public health workforce skills-based competencies and values[24] will also be necessary.

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Intersectoral action

Intersectoral action is critical, as many of the solutions to addressing social inequities in health lie outside of the health sector. Building strong and durable relationships between public health and other sectors (e.g. education, municipal, transportation, environment, finance, etc.) will be necessary for effective action (p. 62)[42]. Public health champions have a key role in assisting other sectors to understand how their decisions impact on health equity. The prevailing view is that complex problems require complex solutions that can only be generated through governments and sectors working together to identify problems, share resources and evaluate outcomes[43]. Intersectoral action requires synergy, coordination, sharing, participatory approaches, time and long term commitment to a common vision[40].

Public health has a longstanding history of providing leadership on health issues and working through coalition structures. The opportunity to provide leadership for intersectoral action on the reduction of health inequities may not be within the scope of practice, authority or competency for all public health practitioners and would require reflection to ensure the enablers are in place to maximize the opportunity for success.

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