Strategies for Eliminating Health Inequities:
A Framework for Change

by

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Abstract

The most important challenge for health professionals is promoting *health equity*. The WHO (2008) asserts better living conditions, equitable distribution of wealth, and mechanisms to prevent and monitor inequities will result in health equity. The problem at the center of this capstone is how difficult it is to promote health equity and implement strategies for change. Barriers to promoting health equity include political, economical, epistemological and ideological differences; identifying barriers supports efforts to institute strategies that promote health for all. By focusing efforts on educating civil society about health equity, public health professionals can broaden the reach of their work. First steps are being undertaken at Fraser Health in B.C. with efforts to produce messaging for staff and leaders to shift the cultural climate. What is required is a shift in the way society appreciates the social determinants of health and action from the public to demand healthy public policy.

Keywords: advocacy, barriers, health equity, public health, social determinants of health, social change.

Dedication

This paper is dedicated to the many people throughout my Master's who shaped and influenced my ideas, work, and future path. I am forever indebted for the amazing mentorship provided at SFU, my senior supervisor Dr. Morrow, my second reader Dr. Gislason, my preceptor at Fraser Health, Samantha Tong, and my supportive family and friends. I also dedicate this paper to all those who champion health equity in their work and everyday lives, it is not easy work, but it is critical to eliminating health inequities here in B.C. and around the world.

Acknowledgements

Table of Contents

1. Introduction

> *"We have located the underlying source of the problem: political inequities & policies that have commodified & corrupted our democracy. It is only engaged citizens who can fight to restore a fairer America, & they can do so only if they understand the depths & dimensions of the challenge… Widening & deepening inequality is not driven by immutable economic laws, but by laws we have written ourselves."*
>
> Joseph E. Stiglitz - Nobel laureate in economics, (2014)

The most important challenge for public health professionals in Canada is promoting *health equity*. Health equity occurs when unfair and unjust gaps in health outcomes, stemming from avoidable socioeconomic or sociological inequities, are eliminated. These inequities are often the result of social, environmental, and economic conditions affecting the health of people and their communities: otherwise known as the social determinants of health (SDoH) (Mikkonen & Raphael, 2010). In Canada, many vulnerable populations experience health disparities such as Aboriginals, children, immigrants, people of colour, sexual minorities, and those living in poverty (Mikkonen & Raphael, 2010).

The WHO (2008) asserts health inequities can be eliminated within a generation if there are better living conditions, equitable distribution of power, money, and resources, and strong mechanisms to prevent inequities in health systems and monitor progress. Public health professionals are well positioned to address this last recommendation, however, the first two are largely beyond the scope of practice for most. However, public heath professionals can address <u>all</u> WHO recommendations by promoting health equity to the public. A motivated and educated civil society can pressure policy makers to address living conditions and inequitable distributions of power, money, and resources through healthy public policy.

As public health professionals it is our duty to work towards preventing disease, prolonging life, and advocating for conditions that promote health for all (WHO, 2015[1]), in other words, health equity. However, there are many barriers preventing public health professionals from promoting health equity that reflect ideological and epistemological differences and the current political economy. Identifying barriers to promoting health equity is important because it supports efforts to institute strategies that will remove such barriers and promote health for all.

According to Raphael (2012), the road to achieving health equity is paved with healthy public policy, fueled by efforts to galvanize civil society to address health inequities. Healthy public policy occurs when policies in <u>all areas of society</u> are crafted explicitly to create environments that enable everyone to lead a healthy life (Raphael, 2012). Stiglitz (2014) states that healthy public policy addresses "*political inequities and policies that have commodified and corrupted our democracy*" (para. 25). Strategies to promote health equity and overcome barriers include efforts to shift public health professionals and civil attitudes toward health equity using communication and education tactics.

Communication and education strategies are key to eliminating health inequities. As stated above, health inequities arise due to social, environmental, and economic processes that persist despite the fact these processes are unfair and avoidable (Mikkonen & Raphael, 2010). The fact that unfair and avoidable processes are driving health inequities unchecked, points to deep seated ideological or epistemological divergences that are difficult to address such as individualistic ideas about reasons for poor health. It is critical that public heath professionals find new and compelling ways to communicate the importance of situating health socially to the public to break down these ideological differences. Without a shift in the way civil society views health equity and the SDoH, public health efforts to promote health equity will be unsuccessful (Raphael, 2007; Raphael, 2012; Farrer, Marinetti, Cavaco, & Costongs, 2015).

Communication and education were central aspects of my practicum with the Fraser Health Authority in B.C. in 2013 and this capstone is based on my experiences, learning, and critical questions that emerged during my practicum. My practicum involved working on a health equity messaging project, part of larger efforts to shift the culture

within Fraser Health to be more accepting of health equity. The short-term goals of this health equity messaging work are to help Fraser Health staff understand the importance of health equity and SDoH and to encourage the adoption of a health equity lens within the scope of practice (Fraser Health Practicum Report [Internal document]: Lammersten, 2012). The ultimate goals of this work are to ensure care and services are accessible, acceptable, available, and ultimately achieve equitable health outcomes in the Fraser Health Region (Fraser Health Practicum Report [Internal document]: Burley, 2015).

During my time at Fraser Health I worked closely with an internal health equity working group (HEWG). I was struck by how difficult it is to get any real traction on promoting equity and positioning health disparities as symptomatic of a larger problem, not something inevitable. I developed a survey as part of my practicum where a central aspect was gauging attitudes towards values related to health (in)equity such as right to healthcare and individualism, and looking for common ground among Fraser Health staff for the purpose of crafting messages. As I moved through the literature I began to realize the lack of health equity promotion we see in BC is not limited to this region and is a global problem facing many health practitioners. I became very interested in the barriers health practioners face when promoting health equity and strategies we can use to overcome these barriers, which leads to the central question for this capstone: <u>What are the barriers to promoting health equity?</u>

The problem at the center of this capstone is how difficult it is to promote health equity perspectives. To explore this problem, this capstone will describe and reflect on my practicum at Fraser Health, while critically exploring barriers to promoting health equity and possibilities for expanding the work at Fraser Health. I will also explore national and international guiding principles for health equity, the state of health equity in Canada, and investigate barriers and strategies for achieving health equity. Central to this capstone is considering pathways to change and presenting a framework for promoting equity that positions the work at Fraser Health within a broader framework for achieving attitudinal shifts on a societal scale. I hope the framework discussed here can be used by organizations such as Fraser Health to implement activities that motivate public health professionals to foster a dialogue with civil society around health equity, resulting in the elimination of health disparities in Canada.

3

2. Background

The purpose of this section is to describe my practicum and critically reflect on this experience to provide context and rationale for exploring the question of what is preventing health equity promotion. The questions that emerge from this reflection shape the remainder of this project where I explore guiding principles for promoting health equity in Canada and abroad, the state of health equity in Canada and why it is important for public health professionals to promote health equity.

2.1.   Practicum: Health Equity Messaging

The basis of my practicum at Fraser Health was to build on previous work exploring health equity messaging. As mentioned in the introduction, the purpose of this messaging work is to shift the cultural climate at Fraser Health towards health equity by increasing awareness and acceptance of health equity perspectives by Fraser Health staff, ultimately working towards achieving health equity in the Fraser Region. In 2011, a pilot study (Study #1) on health equity messaging was conducted at Fraser Health to test how health equity and SDoH related messages would be received by Fraser Health staff. Study #1 is based on work from the Robert Wood Johnson Foundation (RWJF) which explores better ways to communicate the SDoH, drawing on concepts of message framing; studies show framing messages and content has a positive impact on how information is received (RWJF, 2010). Message framing is defined as efforts to influence the persuasiveness of a message by phrasing it in particular ways that impact how individuals evaluate message content (Smith & Petty, 1996).

The purpose of my practicum was to delve deeper into the current cultural climate of Fraser Health; how can you change a culture if you do not know what the culture is in the first place? I worked closely with the HEWG, a group of like-minded equity-focused individuals from various departments within Fraser Health. In consultation with the HEWG, I developed a survey and focus groups to evaluate attitudes towards health equity and

attempted to establish common values among Fraser Health staff. The survey was crafted to measure baseline levels of health equity and SDoH awareness/attitudes and to capture values common among staff. Focus groups were designed to gauge how people feel about health inequity and capture values emerging during discussions about health equity.

Although I cannot go into detail[1], it is safe to say that are areas of common ground among Fraser Health staff and areas of divergence based on moderating variables (role, patient contact, program/service) of interest (see Appendix A); the results of the study show the moderating variables of interest did have an impact. This work is now being examined by a new practicum student and my preceptor and I are working on the report in hopes of having it published. Due to the sensitive nature of the results there may be some issues in publication and it may remain a private document within Fraser Health. If nothing else, we hope it will reach the eyes of upper management and have an impact on the likelihood of developing effective health equity messaging and perhaps more related programming in the future.

The change the HEWG wants to see at Fraser Health is ultimately health equity. The pathway for change is simple: first, explore current culture, attitudes, and awareness of health equity and the SDoH among Fraser Health staff. Second, use this information to create health equity messaging, framed in such a way to promote greater acceptance of health equity. Third, Fraser Health staff are receptive to messaging and become more aware of the importance of health equity. Fourth, Fraser Health staff adopt a health equity lens into the scope of their practice, resulting in more accessible, acceptable, and appropriate health services. Finally, it is hoped that more equitable health services will lead to health equity in the Fraser Region. This is a logical, evidence based approach and the best that can be done under the current climate at Fraser; health equity is on their radar but not central to planning and delivery of services. However, I wondered, can public health professionals working within Fraser Health do more? Considering the recommendations from the WHO (2008), these efforts by Fraser Health to promote health equity will have a limited impact if successful and will not address living conditions or inequitable distributions of power, money, and resources. Why not dream bigger?

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[1] Information about the content and results of the survey and focus groups will not be shared here due to data use agreements.

2.2.   Critical Reflection

A major part of my practicum learning has been to critically reflect on work both developing insight and fostering action at the scale of the health authority to more effectively champion health equity in policy and programs. Critical reflection is an important part of my learning as it has enabled me to engage in attentive consideration to challenge assumptions, assess knowledge, and understand held beliefs in varying contexts, all which facilitate the potential for change (Taylor, 2010). Other elements of critical reflection include an emphasis on the analysis of power relations and a concern for democracy (Vince, 2002). Critical reflection is also an inherently social endeavour where one takes the time to reflect on the meaning of one's work relative to others and examines what oneself and others have experiences while establishing a foundation for future action (Gorli, Nicolini, & Scaratti, 2015). Based on these above principles and the role of analysing power, reflexive practice is also useful for institutions to ensure that polices and programs are not creating inequities.

Working towards being an effective agent of change concerned with power relations and democracy are concepts central to my training as public health professional in the social inequities stream of the Master of Public Health (MPH) program at Simon Fraser University (SFU); those who study health inequities are ultimately most interested in pathways to change and how we can achieve health equity by addressing societal inequities. Critical reflection is an important tool to becoming a better agent of change; it is also a method for bridging the divide between theory and practice and finding ways to put theory into action (Taylor, 2010).

These potential barriers were very much on my mind after a series of conversations with individuals in local health units outside of Surrey Central offices where I was stationed. There was a general sentiment that those in the corporate setting were out of touch with what was happening on the ground and health equity was not a priority. This is certainly not representative of those working in the HEWG. Many staff I spoke with had strong feelings about health equity and were keenly aware of the impacts of the SDoH. However, even if the HEWG was successful and was able to fashion a health equity messaging campaign it is possible it would not be well received due to negative feelings

about Fraser Health as an organization. Overall, I felt the context of Fraser Health at the time was not very receptive to taking on meaningful equity work on an organizational level.

It is not easy for health equity advocates to stay the course alone and fight for health equity initiatives. Farrer et al. (2015) discuss the difficulties or reluctance of scientists and researchers to advocate for health equity. Advocating for health equity is associated with perceived attention seeking, a loss of credibility, and a blurring of boundaries between work and advocacy (Farrer, et al., 2015). The authors also suggest advocacy work may be too much of an added burden and is frowned upon by upper management and administrators (Farrer, et al., 2015). Public health professionals operate in a similar sphere to scientists, where evidence based practice is paramount and funding and job security is tied to the mandate of the organization, not individuals. Overall, barriers to promoting health equity are likely the source of difficulties for public health professionals to engage in advocacy efforts. Perhaps if we knew more about barriers to action it would be easier for public health professionals to promote equity in the workplace.

Based on my experiences at various workshops and conferences over the past four years, there are many individuals working within large health organizations who are doing similar work as the members of the Fraser Health HEWG. I recall Beth Jackson from the PHAC speaking at a *Center for the Study of Gender, Social Inequities and Mental Health* (CGSM, 2013) critical inquiries event about the challenges of trying to work on changing the system from the inside, how it is important work, but especially challenging. I admire people like Beth Jackson and members of the HEWG for sticking to their principles even though it may be complicated for them professionally.

I had several discussions with members of the HEWG about "windows of opportunity", where the sway of public opinion greatly influences liberties the equity-minded can take in their work. An example is hospital capacity, where staff at Royal Columbian Hospital (RCH) were forced to house emergency room patients in Tim Hortons in 2011 and in January of 2012, the lobby of the hospital was turned into an extended ward (McMahon, 2012). In 2012, a friend of mine spent a week in a hallway. The public outcry to overcrowding, lack of privacy, and proper care was substantial. Subsequently, in June of 2012, the Ministry of Health and Fraser Health (2012) announced there would be a redevelopment and expansion of RCH. Farrer et al. (2015) find strong reference in the

literature to "windows of opportunity" where those working within organizations not receptive to health equity have to be prepared to move quickly when opportunities for change present themselves. It seems these opportunities are largely driven by public opinion.

After finishing my practicum and reflecting on the experience I found myself filled with questions about health equity promotion. I wanted to know what was happening now in Canada relative to health inequities, why it is so important to address heath inequities, and how health equity is regarded at the international, federal and provincial level. I started looking into other health organizations to see what kind of equity work they were doing, wondering if there were other groups like the HEWG operating from the inside to promote equity. I wanted to know what is holding public health professionals back from engaging in this work on an organizational level and what strategies there were to overcome barriers and achieve health equity. Such is the purpose of this capstone, below I examine the state of health equity in Canada, examine how federal and provincial health organizations regard health equity, what barriers exist that prevent action, and what can be done to overcome these challenges and achieve health equity.

Reflecting on my practicum I felt I had more questions than answers about promoting health equity and eliminating health disparities in the Fraser Region. First, I wondered if all this work would pay off: do messaging campaigns like the one I was working on actually change attitudes? Second, I wondered if changing attitudes of Fraser Health staff would translate into action and if health equity would actually become more integrated into the scope of their practice? Finally, and most of all, I questioned why it is so hard to promote health equity? I wanted to know more about barriers to promoting health equity and strategies for circumventing them. The following section explores why it is important to promote health equity, what drives health inequities, barriers to promoting health equity, and potential strategies for overcoming barriers.

2.3.   Guiding Principles & Rationale

To answer the question of what is preventing health professionals from promoting health equity it is important to first find international and Canadian guiding principals that support health equity and why health equity is important. Since the introduction of the *Lalonde Report* (1974), the *Ottawa Charter* (WHO, 1986), and *Alma Ata* (WHO, 1978), health equity and the SDoH are once again become a priority for health organizations around the world. The roots of public health are social; early practioners like Virchow proclaimed ill health was the result of social inequality (Mackenbach, 2009).

In 2003, the WHO commissioned the report *The determinants of health: The solid facts* (Wilkinson & Marmot, 2003) that outlines the negative effects of poor social environments, frames health equity as a social justice issue, and calls for *healthy public policy* from governments to promote health equity. These documents highlight the importance of upstream approaches, social well-being, and health as a human right. More recently, the *WHO Commission on Social Determinants of Health* (2008) calls for global action, highlighting the need for governments, global organizations, and civil society to focus on social and economic policies instrumental in creating or addressing health inequities.

According to the WHO, the purpose of public health is "prevent disease, promote health, and prolong life among the population as a whole" (2015[1], para. 1) by working to create conditions where everyone is healthy. Health promotion is a central aspect of public health defined as efforts to enable people to improve and increase the amount of control they have over their health (WHO, 2015[2]). Health promotion also prioritizes increasing individual control over social and environmental determinants of health which strongly ties health promotion to health equity (WHO, 2015[2]). The path to change here is empowerment; health promotion efforts give license to individuals to take charge of their lives and health (Riddle, 2007, as cited in Rice 2011). The concept of empowerment is problematic because not all individuals are well positioned to gain control over the social and environmental factors influencing their health. Rice (2011) asserts structural approaches to health promotion are preferred over individual approaches and better

promote health equity due to the recognition of the broader social context and the differential status/abilities of individuals.

In Canada, two federal bodies set standards for health and have the power to address health inequities: Health Canada and the Public Health Agency of Canada (PHAC). Health Canada's goal is to have the healthiest people in the world, where prevention and health promotion are valued as important means to improve the quality of everyone's life (Health Canada, 2011). Objectives for Health Canada include elements of prevention, health promotion, and reducing health inequalities in Canada (Health Canada, 2011). It is the goal of the Public Health Agency of Canada (PHAC) to "*promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health*" and reduce health disparities (PHAC, 2015, para. 2). This mission is based upon five values that guide the actions of the PHAC: *respect for democracy, respect for people, integrity, stewardship*, and *excellence* (PHAC, 2015). The value of *respect for people* explicitly outlines the need to treat all people with respect, dignity, and fairness. Taken together, the objectives for both Health Canada and the PHAC prioritize health equity, health promotion and the fair treatment of all citizens.

A discussion paper released in 2004 for the PHAC by the *Health Disparities Task Group (HDTG)* lists four main reasons why it is important to address health inequities. First, the health sector mandates health inequities be addressed by both the First Ministers' Health Accords which call for national commitments to reduce health disparities and the Healthy Living Strategy, approved by the Minster of Health, which only has two goals: 1. improve overall health outcomes 2. reduce health disparities (HDTG, 2004). Second, health disparities create substantial burdens on individuals and groups, while reducing the ability to participate in their communities and fostering exclusion, stigma, and a loss of hope. Third, health disparities constitute a large drain on economic resources in the health sector, comprising roughly 20% of all health care spending. Finally, as mentioned above, health disparities in Canada are at odds with the values we hold as Canadians, where quality of life and societal cohesiveness are threatened and the economy is overburdened (HDTG, 2004).

2.4.   Health Equity in Canada

Those who experience health inequities often have low incomes, poor housing, food insecurity, poor or insecure employment conditions, and face discrimination based on race, immigrant status, sexual orientation, gender, Aboriginal status, disability, and/or age (Mikkonen & Raphael, 2010). The stressful conditions associated with marginal status lead to physiological and psychological stress, which in turn lead to poor physical and mental health (Mikkonen & Raphael, 2010). This is above and beyond issues these individual may experience in accessing acceptable and appropriate health services.

Achieving health equity in Canada is a top priority for public health professionals yet health inequities persist, evident in numerous examples of health disparities across the country. A study from the PHAC (2006) finds four significant areas of health disparities in Canada: income, Aboriginal status, geographic location, and gender. Income and Aboriginal status show the most significant impact, associated with reduced life expectancy, high infant mortality, higher rates of cardiovascular disease, injury, suicide, infectious disease, accidental death, and chronic illness (PHAC, 2006). Recent studies examining the state of health equity in Ontario find men and women from low income households are respectively 41% and 35% more likely to die before the age of 75 than those who are best-off (Mikkonen & Raphael, 2010). In British Columbia vulnerable populations such as children and families living in poverty, those with mental health or addiction issues, Aboriginal peoples, immigrants, and refugees experience higher prevalence rates of chronic disease (Provincial Health Services Authority of British Columbia [PHSA], 2011) and have disproportionally lower life expectancies, and increased rates of ischemic heart disease, and higher risk of injury (Raphael, Curry-Stevens, & Bryant, 2008).

Despite the goals outlined above to promote the health of all people in Canada and extensive discussions on the importance of health equity in Canada, a health equity perspective is largely absent in health care platforms and public policy (Raphael, 2012; McIntyre, Skyleyko, Nicholson, Beanlands, and McLaren 2013; Embrett & Randall, 2014). Raphael (2012) observes Canada is far behind other high-income countries (HIC) relative to the implementation of policy that strengthens SDoH – a fact demonstrated by the

nation's high incidence of poverty, large gaps between the health of the rich and poor, and a paucity of public health programming aimed at those most in need. McIntyre et al. (2013) cite the absence of health equity and SDoH in recent federal election campaigns and party health care platforms as evidence for limited action in health policy in Canada. In a systematic review of literature, Embrett and Randall (2014) explore the state of health equity and SDoH policy analysis research in Canada, finding few policies to improve health equity in government policy agendas and a lack of acceptable policy options.

Provincial and regional health organizations are well positioned to take up health equity efforts and have a central role in providing health services including acute care hospitals, community based residential care, home health, and mental health and public health services (Fraser Health, 2011). Some provincial and regional health organizations in Canada, such as the Fraser Health Authority[2], strive to address health inequities in their communities and we are starting to see health equity incorporated into some initiatives. The Toronto Central local health integration network (LHIN) is actively engaging in collecting demographic information from patients as part of the Toronto Public Health *Health Equity Data Collection Research Project* (Toronto Health Equity, n.d.). In Alberta, two teams within the provincial authority related to health promotion and surveillance have joined resources to produce an *Annotated Glossary* for health promotion with the aim to improve understandings of health equity presumably among staff[3] (Alberta Health Services, 2011). The PHSA (2015) has two ongoing projects addressing health equity: The *Equity Indicator Development* project and consultation efforts to develop a framework for promoting health equity. At Fraser Health there are committed individuals, such as the members of the HEWG, promoting programs and services across the region to address health equity, such as the development of resources and tools, education, and health communication work.

Given the mandates of Health Canada and the PHAC and provincial efforts to promote health equity, one wonders why it is so difficult to promote health equity on a national level and address the health disparities experienced by vulnerable populations in

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[2] The primary focus of this paper is work from Fraser Health as this was the site of my practicum and the context for this capstone.

[3] The document does not explicitly state it is for Alberta Health Services staff, but it appears to be an internal document designed for capacity building.

Canada. The PHAC discussion paper (HDTG, 2004) mentioned above states one of the main reasons health inequities should be addressed is that "*health disparities are inconsistent with Canadian values, challenge overall quality of life, including the cohesiveness of community and society, and place a burden on the economy*" (p.vii). If it is the mission of health professionals to protect, respect, and value all Canadians and it goes against our Canadian values to allow health disparities to persist, why is there not health equity in Canada? What are the barriers to action? The following sections build on the question of what is preventing health equity promotion by exploring the drivers of health inequities and flushing out the barriers that public health professionals face.

3. What is Driving Health Inequity?

According to the WHO (2008), health inequities are *avoidable*, a consequence of social inequities between various populations. By using the term *avoidable*, the WHO stresses that health inequities are not natural, driven by Darwinian notions of "survival of the fittest", but rather are a product of unfair processes in the social environment. The WHO (2008) positions health inequities as primarily the product of unequal distribution of social resources and power, operating across four dimensions: political, economic, social, and cultural forces. Within these contexts we see many populations who are excluded or included to varying degrees, resulting in health inequities.

The political, economic, social, and cultural conditions impacting health disparities are known as the SDoH. The PHAC lists twelve SDoH (Appendix B) that impact health: income and social status, social support networks, education and literacy, employment conditions, social environments, physical environments, personal health practices, healthy child development, biology and genetics, health services, gender, and culture (PHAC 2011). The *Commission on Social Determinants of Health* declares the negative effects of the SDoH are driven by structural forces such as inadequate social policies and programs, unfair economic practices, and "bad politics" (CSDH, 2008, p.1). Theorists posit the root causes of structural forces that create health inequities stem from local and global unequal distributions of power and resources (de Finney, Dean, Loiselle, & Saraceno, 2011).

The forces driving health inequities are complex, steeped in unequal power relations, and deeply embedded in the social fabric of our society, however, health organizations in Canada and abroad call for more action to address health inequities. As mentioned above, health organizations in Canada call for addressing health inequalities (Health Canada) and treating all citizens fairly (PHAC). Global organizations like the WHO have been calling for more focus on health inequities for years, providing detailed documents such as *The Commission on Social Determinants of Health (*CSDH, 2008*)* that outline evidence and strategies for change. It seems that health equity is gaining more traction in recent years, and yet, efforts to address health disparities are disappointing, which begs the question: what is stopping health professionals from promoting health equity?

4. Barriers to Achieving Health Inequity

As a future public health professional it will be my duty to work towards preventing disease, prolonging life, and advocating for conditions that promote health for all (WHO, 2015); to address health inequities and promote fair treatment for all. One of the purposes of writing this capstone is to identify a problem I will face as a future public health professional; in my opinion, the inability of health professionals to effectively advocate for health equity *the* problem of this moment. From what I have experienced and read, there are many barriers making it difficult for public health professional to advocate for health equity and enact change. Based on the evidence presented in this paper, relative to the absence of health equity or SDoH perspectives in public policy and practice, shifting to a health equity focus represents a considerable shift within public health and massive organizational change. Change is difficult, especially on an organizational level. Facilitating such a major shift towards promoting health equity requires a critical understanding of the barriers to change. Which leads me to ask the question driving this capstone: what prevents public health and other health professionals from promoting health equity? By exploring the barriers to promoting health equity I hope to gain an understanding of the challenges ahead and what might be done to address them.

Despite repeated calls from advocates for action to address health inequities in Canada such efforts are lacking, evident in the fact that Canada fails to address equity issues such as child poverty and missing and murdered Aboriginal women, and that health equity remains elusive. A Health Council of Canada (2010) report finds Canada has failed to implement public policy that address SDoH, citing difficulty garnering support for SDoH due to complexity of the issues and the sheer gravity of changes in organizational culture required. In Ontario, Brassolotto, Raphael, and Baldeo (2013) observe the SDoH are neglected by public health units that favour agentic health promotion approaches over structural approaches to address health inequities. The Inter-American Commission on Human Rights (IACHR, 2014) states that national systemic racism, violence against Aboriginal women, and the failure of the RCMP to protect these women are to blame for the thousands of missing and murdered Aboriginal women in Canada. Twenty-five years ago, the Canadian government vowed to end child poverty by the year 2000, but high rates of child poverty persist (Campaign 2000, 2014). The *United Nations Human Rights*

Committee (2015) report released this year also calls out the Canadian government for its failure to act on missing and murdered Aboriginal women, adding further failures to address violence against women, inhumane treatment of refugees, and persistent gender inequality.

Ultimately, any discussion regarding barriers to action is a discussion about power; a barrier exists only if it has the power to stop action. For theorists like Foucault, knowledge is power, manifest in the ability to impose ideas about what is right or true; power that often rests with an influential but small minority of society (Gaventa, 2003). According to Foucault, power is everywhere and ever changing; "*it is the name we give to a complex strategic situation in a particular society*" (Foucault, 1984, p.93, as cited in Gaventa, 2003). Situations change, ideas evolve, and values shift, as does the balance of power. Power is in essence strategies that embody ideas and create intentions above those of the actors who ideas are being embodied; people are products of power just as often as creators (Gaventa, 2003). The strategies that emerge to uphold ideas are characterized as almost having life of their own, where embodied ideas can have unintended consequences. An example is the fact that prison systems create better criminals even though they are created to deter crime; prison systems have the power to create better criminals even though no one wants them to (Gaventa, 2003). The same could be said for neoliberalism, meant to advance well-being with free markets, free trade, and robust private property rights (Thorsen & Lie, 2007) but often results in economic instability and the inability of governments to protect citizens due to restrictive trade agreements (Labonte & Shcrecker, 2007).

Foucault positions discourse as an essential mechanism of power, through which power is constituted and resisted (Gaventa, 2003). Discourse occurs when one communicates, debates, or speaks with authority on a topic (Gaventa, 2003) and has the potential to create or abrogate barriers to action. There are many barriers that control discourses around health equity and make it difficult for public health professionals to promote heath equity. Barriers can impede progress on an individual and organizational level and represent political, economical, epistemological, or ideological challenges (Raphael, 2007). Discourse and communication offer an interesting path to change; Could it be as simple as changing the conversation? Before discourse can be utilized to resist or

transform the power inherent to barriers to action, one must first understand what barriers exist.

4.1.   Political Economy

Political economy refers to the intersection of economics, and politics, and how various institutions create social and economic systems, such as capitalism, and is used as a lens to examine how public policy is formed and applied (Hooks & Cranston, 2013). Considerable power dwells within aspects of the political economy, controlling how markets are formed, the way governmental agencies communicate, and the formation of trade agreements. Barriers of the political economy variety represent key structures that prevent the promotion of health equity.

Neoliberalism. The most common barrier to advocating for health equity is contemporary neoliberal economic approaches favouring privatization, deregulation, neoliberal/market values, and prioritizes economic outcomes (Farrer, et al., 2015). Market forces are theorized to reflect the wants and needs of the public and interfere with the capacity of governments to regulate economies to prioritize health. Although some elements of neoliberalism may seem attractive and appear to promote more freedom and choice, the opposite is true. Critics of neoliberal policies point out that the market often fails, meaning market forces do not actually reflect the needs and wants of the people and result inequitable allocation of goods and services (Ruckert, Labonte, & Parker, 2015). Privatization and deregulation can lead to fragmentation of health systems, decreased access for low income populations, budget cutbacks, and reduces the potential for universal health care (Ruckert, et al., 2015).

Researchers state these above-mentioned elements of neoliberalism make it hard for policy-makers to create healthy public policy because it is not profitable and difficult to justify in this economic climate. Others posit neoliberal forces on a global level reduce the ability of governments to address health inequities because it makes them less

competitive in global markets, ironically creating situations where countries are unable to respond to protect their citizens, resulting in further health inequities (Farrer, et al., 2015). Contemporary economic policies are fueled by "rugged individualism", personal responsibility, and a lack of collective action and responsibility (Farrer et al., 2015), which further reduces societal acceptance of the role SDoH and creates barriers to addressing health inequities. By promoting individualistic perspectives, those who espouse contemporary economic approaches blame individuals for their own poor health outcomes while ignoring external causes (Farrer, et al., 2015).

Cross-sectoral cooperation. As we see in the WHO recommendations (CSDH*, 2008*) for addressing health inequities through improving living conditions and establishing equitable distribution of wealth, health outcomes are not only derived from issues within the health system. Farrer et al. (2015) find there is a lack of cooperation and communication between health and other sectors which limits efforts to eliminate health inequities. Selsky and Parker (2005) argue this lack of cross-sectoral cooperation is the result of tensions of power and control, that the political dimensions are largely under researched and unknown, and call for more attention to political and critical perspectives. This lack of coordination is attributed to the creation of policy silos, the inability or lack of capacity of various sectors to share knowledge, or efforts within health systems to dampen attempts to address health equity (Farrer, et al., 2015). A central element to addressing health equity is understanding that health is impacted by more factors than just those within health systems. Cross-sectoral cooperation is key to promoting health equity.

4.2.   Epistemology

Epistemological barriers to addressing health equity are especially difficult to overcome because they relate to conflicting worldviews associated with the nature and scope of knowledge. Raphael positions epistemological barriers as "*Foucaultian discourses which, since they involve issues of legitimating, power, and coercion, exert a … powerful influence upon research and practice*" (Brassolotto, et al., 2013, p. 2). Barriers

such as the primacy of biomedical perspectives and contemporary conceptualizations of the SDoH represent intellectual hurdles where practioners wishing to promote health equity must challenge the paradigmatic base of the health system.

4.2.1.   Biomedical Primacy

Researchers and public health advocates position the pervasiveness of biomedical perspectives by politicians, the health industry, and public opinion as a major barrier to achieving health equity (Farrer, et al., 2015). Biomedical perspectives position health as decontextualized, individualized, and depoliticized, and seek to address illness or disease by reducing risk, measurable only through mortality and morbidity rates (Brassolotto, et al., 2013). Practice, programming, and policy based only on biomedical perspectives treat structural factors such as gender, race, sexual minority status, age, etc., as unconnected to health and outside the scope of practice. Biomedical perspectives also represent a powerful lobby, controlling the majority of health care funds globally, with strong ties to pharmaceutical companies and political parties (Farrer, et al., 2015). Biological primacy in understanding and treating illness, devoid of social circumstance, is the norm, making it difficult to situate health socially (Farrer, et al., 2015). Biomedical, reactive health care is certainly the norm here in Canada; estimates of health care funding spent on public health is 5.3% whereas over 60% is allocated to hospitals, pharmaceuticals, and physicians (CIHI, 2013).

4.2.2.   Defining & Measuring Health Inequities

Conflicting ways in which health inequities are defined and measured make it challenging for public health professionals to identify the issues, gather evidence, and monitor progress. The National Collaborating Centre for Determinants of Health (NCCDH,

2011) observes conceptual issues among public health professionals relative to population health approaches which question whether this approach should include vulnerable populations. The NCCDH (2011) also states there is a lack of knowledge sharing among those doing work to reduce health inequities due to the lack of priority to publish findings and mechanisms to share and learn from others work. Finally, the NCCDH (2011) finds many public health professionals are unsure how to address health disparities due to the complex nature of SDoH that are often influenced by factors outside the health sector. For health professionals to take action they need a deeper understanding of the roots of health disparities and more resources to take action (NCCDH, 2011).

Sutcliffe, Snelling, & Laclé (2010) state that although there may be a desire to address health inequities, there is a lack of knowledge of evidence-based strategies to reduce health disparities among health professionals. Evidence based strategies are often a requirement for public health professionals. It is also critical to have the means to translate research knowledge into action and supports to implement such work; resources for knowledge translation and putting health equity initiatives into action are lacking (Sutcliffe, et al., 2010). Without an evidence base, knowledge translation activities, and the ability to implement health equity initiatives, the options for addressing health inequities are very limited.

There are considerable difficulties in monitoring the extent of health disparities. This is due to lack of sociodemographic data collection from participants reluctant to disclose information stemming from discomfort sharing such information and a lack of understanding of the importance of such data (Kirst, Shankardass, Bomze, Lofters, & Quiñonez, 2013). Here the release and subsequent collection of such data are inhibited by concerns of discrimination or reductions in access to health care (Kirst, et al., 2013). Kirst et al. (2013) posit concerns over release of personal information are also fueled by privacy concerns, lack of clarity on how data will be used, and limited trust in public use of information (Kirst, et al., 2013). Brassolotto et al. (2013) also explore epistemological barriers in Ontario, finding issues with conceptualizations of the SDoH, the role of public health professionals in addressing the SDoH, and confusion surrounding how to define evidence and outcomes for health inequities. Overall Brassolotto et al. (2013) find there is a discrepancy between the actions on the SDoH between various public health units and a lack of leadership in promoting health equity in public health in Ontario.

The First Nations Health Authority (FHNA) in B.C. recognizes the impact of data collection tools and methods on Aboriginal health. The *Transformative Change Accord: Tripartite First Nations Health Plan* includes action to improve the collection, use, and sharing of Aboriginal health data to increase involvement in decision making process, improve access to health information, and to facilitate and support FHNA principles of information governance (FHNA, 2015). The overall goal of FHNA data management principles is to improve the delivery and effectiveness of health and wellness programs and services for Aboriginal people in B.C (FHNA, 2015).

4.3. Ideology

Researchers such as Raphael et al. (2008) position barriers to forwarding a health equity agenda within ideologies concerning the sources of health and illness, namely professional and societal discourse. *Ideology* refers to a systematic set of ideas or beliefs that guide individuals, groups, organizations, and political parties (Merriam Webster, 2015). Professional and societal discourse is *how* we talk about health based on our ideas and beliefs, which affects the way we conceptualize and discuss health and illness ultimately impacting the uptake of health equity perspectives (Raphael, et al., 2008). Some aspects of this discourse are *how* health science issues are envisaged and implemented and the *tension* between individualistic perspectives and the acknowledgement of SDoH (Raphael, et al., 2008).

The first ideological issue that creates a barrier to health equity promotion is *how* health science issues are envisaged and implemented. Raphael, et al. (2008) state the focus and tools used in health sciences are problematic due to an overreliance on quantitative methods and measures, the view that sources of health and illness are the result of individual (in)action, the commitment to objective approaches to health, and process that de-politicize health. In essence, an overly positivist approach that is reductionist and ignores context (Raphael, et al., 2008). Positivist approaches are based the premise that cause and effect are determined by observable and predictable variables,

derived from an objective truth or reality (Raphael, et al., 2008). These positivist elements of contemporary health science approaches maintain health as an individual, de-politicized, and decontextualized and "*justify the retreat of governments around the world from investing in the collective health and well being of citizens*" (Raphael, et al., 2008, p.225).

The second ideological issue Raphael et al. (2008) raise is an overreliance on individual explanations for health and illness which eclipse the role of the SDoH. There is much resistance to the idea that health inequities are the result of external circumstances; public opinion is far more likely to favour perspectives that examine the hand those "less fortunate" have played in their own negative circumstances (Raphael, et al., 2008). Here, public issues are transformed into private matters, creating a strong bias against health equity perspectives (Raphael, et al., 2008). Individualistic perspectives ignore the role of the SDoH, revealing a strong desire to believe choices and behaviours are under the control of the individual, resulting in a plethora of interventions and policies that do little to improve the health of the vulnerable (Raphael, et al., 2008). Our ideas and beliefs about health matter and have far reaching impacts beyond how we merely conceptualize health. If individuals do not believe the SDoH play a role in their health then we will likely see a lack of interest and awareness, and negative perceptions of health equity that continue to mire public health efforts to promote equity.

4.3.1.   Awareness & Interest

Some attribute the lack of action to address health disparities to a lack of awareness or interest in the role of SDoH on health, stemming from ideological differences. In a discussion paper outlining issues surrounding chronic disease prevention and reducing health inequities, the PHSA (2011) says a lack of awareness within the health system of the role of SDoH on health outcomes and health inequities is a primary reason why programs have failed to address health disparities. At the time this paper was written, I could find no articles backing up this assertion from the PHSA. It is possible

health authorities are not tracking or measuring health equity or SDoH awareness among staff or that the work is being done, but not released to the public.

Awareness of health equity is lacking among the Canadian public as well. Raphael (2012) cites a lack of health equity and SDoH awareness by the Canadian public as instrumental in the lack of health public policy that stems from a paucity of media coverage and inconsistent efforts from public health units to raise the issue of health equity. Shankardass, Lofters, Kirst, and Quiñonez (2012) contacted over 2,000 participants in Ontario to measure public awareness of income-related inequities. The authors find that although over 73% of participants acknowledged the existence of health inequalities in Ontario, far fewer (53%-64%) knew there were disparities between high and low income individuals and even fewer realized the extent of health disparities for outcomes such as obesity (35%), diabetes (25%), and accidents (18%) (Shankardass, et al., 2012). The authors note a slight increase in acknowledgment of income related inequities from previous studies (up from 30%), which they attribute to increased media coverage of economic hardships among the lower income populations following the 2008 recession (Shankardass, et al., 2012).

Bryant, Raphael, Schrecker, and Labonte (2011) state there is a plethora of governmental documentation touting the importance of health equity. Rather than an institutional lack of awareness of health equity and the SDoH. Bryant et al. (2011) attribute barriers to health equity uptake to changes in the political economy of Canada that create more reliance on welfare state solutions and a lack of government interest in creating an equitable society. Here then perhaps it is not a lack of awareness but rather a lack of will or interest to act that is keeping health equity initiatives on the back burner. Raphael (2012) states this lack of political will to address health equity persists due to a lack of public awareness, for without pressure from civil society there is little impetus for governments to act. It is hard to imagine why, in the face of mounting evidence supporting the need for health equity promotion and acknowledgment of the SDoH, this lack of interest and awareness persists.

4.3.2. Negative Perceptions

Some researchers and organizations posit negative perceptions of health equity and the SDoH are a major barrier to these perspectives gaining traction. Reutter, Neufeld, and Harrison (1999) suggest negative personal opinions about health equity have an influential role in *how* or *if* social policies are instituted and play an important part in the observed lack of support. A report from Canadian Medical Association (CMA) (2013) cites barriers to health equity as stemming from negative attitudes from health workers and the general public, where a lack of interest hampers health equity efforts which are in turn fed by attitudes that blame individuals experiencing inequities for their situation. This lack of interest is also precipitated by perceived inabilities of the Canadian public to understand what drives health inequities and a lack of ability to empathize with those who are disadvantaged or recognize the role social structures play in limiting individual capacity to address health issues (CMA, 2013). This lack of interest from the public results in lack of action from politicians. Inaccurate beliefs about the sources of SDoH such as poverty also negative perception of health inequities (CMA, 2013).

Understanding barriers to action on health inequities is a critical step towards addressing challenges to forwarding the health equity agenda. The barriers discussed above are considerable, deep seated, and reflect conflicting view points on the nature of health and explanations for sources of behaviour and poor health. In exploring the guiding question of this capstone, what is preventing public health professionals from promoting health equity, I feel overwhelmed by the sheer weight of opposition. Working towards changing people's minds about the nature of health and role of societal influences felt manageable and I hoped to leave this capstone with a serious of recommendations to help public health professionals better advocate for health equity; to help myself as a future practioner and for others doing similar work. However, I do not see how public health professionals can fight against such entrenched and hegemonic forces such as capitalism and the primacy of biomedical perspectives with the help of civil society. Something needs to change. I need to look beyond merely affecting the scope of practice of public health professionals to be equity-minded and explore how to shift attitudes of society itself.

5. Taking Action

I had hopes that exploring barriers to promoting health equity would naturally lead to an examination of strategies that I as a public health profession could employ to overcome these challenges. After examining these barriers to action I feel a different approach is required to create space to effectively advocate for health equity. I argue public health professionals need more than strategies to overcome barriers; a societal shift in attitudes away from current political, economical, epistemological, and ideological perspectives is the best hope for achieving health equity.

5.1. A Framework for Change

As mentioned in the introduction, the WHO (CSDH, 2008) calls for the elimination of health inequities within a generation, recommending work be done to improve daily living conditions, address inequitable distributions of power, money, and resources, and better measure and understand how inequities arise while establishing ways to assess the impact of actions taken. Public health professionals are well positioned to address the last recommendation above, however, the first two are beyond the scope of practice for most public health professionals. How then can public health professionals better promote health equity in Canada considering the barriers discussed in the previous section?

Potential strategies for public health professionals being better able to promote health equity are based on shifting attitudes to be more accepting of health equity and breaking down the barriers that prevent action on health inequities. However, considering the numerous substantial barriers outlined above, this is no easy task. I argue it is currently beyond the scope of practice for public health professionals to stalwartly and consistently challenge biomedical perspectives, contemporary economic policies, measurement and evidentiary issues, lack of cross-sectoral cooperation, and conflicting ideologies around

health and illness that precipitate a lack of awareness or interest and negative perceptions of health equity; this is simply too much and we need help.

Raphael challenges public health professionals to take the lead in eliminating health inequities by focusing on galvanizing civil society to champion health equity and be the agents of change. Raphael (2012) outlines a very simple theory of change: Public health professionals use communication strategies (such as public service announcements [PSAs]) to educate the public to increase their awareness and acceptance of health equity perspectives. The public will in turn apply these perspectives to activities (e.g. pressure policy-makers to prioritize health equity or decrease support for activities that promote inequity), resulting in healthy public policy that reduces health inequities (Fig. 1). Farrer et al. (2015) also propose communication strategies to educate the public about the importance of the SDoH, calling for long-term sustained efforts in concert with more concerted training for public health professionals to advocate for health equity. Farrer et al. (2015) challenge public health professionals to become "long-term enablers of effective advocacy for health equity", charged with improving civil society's understanding and acceptance of health inequities; without this public awareness, public health advocacy efforts will be less effective.

There are two main types of public policies that strengthen the focus on the impact of the SDoH and will have a major impact on promoting health equity. The first type of public policy are those that improve health and quality of life, such as better delivery of benefits, supports, and services that strengthen the SDoH (Raphael, 2012). Such policies address early child education and care, skill development, social services, and community based health care (Raphael, 2012). The second type of public policies are already functioning in more wealthy and developed regions (relative to health equity) such as Scandinavia, and promote economic and social security. Such policies improve collective bargaining rights, employment security, and benefits and result in lower rates of child poverty, better housing and income, and increased economic security (Raphael, 2012).

The types of policies mentioned above are central to improving health and reducing inequities, but fall outside the purview of public health; this is why it is critical to involve the public in efforts to promote health equity. Focusing on improving policies that address living conditions and equitable distribution of wealth fulfill the recommendations

26

of the WHO (CSDH, 2008) to eliminate health inequities in a generation. If public health professionals take up efforts to promote health equity within health systems and monitor progress of such actions and civil society pressures governmental bodies to address living conditions and equitable distributions of wealth, we just might achieve health equity.

The only problem with Raphael's idea to have public health professionals begin educating the public about health equity is this: How do we get public health professionals in Canada to actively promote health equity to the public? According to evidence presented in section 2 there is a major gap in health equity promotion among public health professionals, so why would they start now? Negative perceptions about health equity and the SDoH and a lack of interest and awareness are not restricted to civil society only. If we want public health professionals to take up health equity promotion efforts, then we need to them to care very deeply about health equity. If en masse public health professionals in Canada cared very deeply about health equity, we would see more efforts to reduce health disparities. This is why the work at Fraser Health to create a cultural shift towards health equity is so important.

The factors that drive health inequities are not only the result of elements of the health system. Evidence presented in this paper shows that health inequities arise from far larger structures such as federal immigration policies, systemic race, sex, gender, income, sexual orientation-based discrimination, neoliberal policies, capitalism, and ideological arguments that position health as a perk rather than a human right. If we combine health equity messaging work with Raphael's theory of change, where the focal point is public health professionals educating citizens, there is so much more Fraser Health could do to enact change. By broadening Fraser Health's ultimate objective to enact a shift in the cultural climate of the region, not just the health authority, we could start to see massive changes. The work by Fraser Health is a critical first step to getting an educated and sympathetic civil society that will advocate for the rights of everyone.

By combining health equity messaging work with Raphael's call for health equity advocacy, we create a powerful framework (Fig. 1) for change that addresses all three of the WHO (CSDH, 2008) recommendations for addressing health inequities. Such work is the epitome of structural health promotion, where public health professionals galvanize civil society to take control and promote health equity. Health equity advocacy efforts will

27

result in the public better recognizing the role of the broader social context and differential status and abilities of individuals, demanding better from decision and policy makers. The only question left is: Will any of this work?

5.2.   Possibilities for Success

It is exciting to imagine a world without health inequities and the role people like myself can play in promoting health equity. However, I wonder how public health professionals can make the public care about health equity? There will be barriers there as well, such as negative perceptions, lack of interest or understanding which are powerful hurdles to gaining acceptance of the SDoH and health equity. Work to create education campaigns for civil society will have to be crafted in similar ways to health equity messaging work at Fraser Health. There must be efforts to gauge existing attitudes and awareness and careful consideration of how to present messages about the SDoH. It is also important to consider whether education campaigns actually shift attitudes and if these shifts translate into action.

There is good evidence that using communication strategies to educate the public and professionals about health equity has a positive impact. The CMA (2013) report cites several factors that can facilitate better uptake of health equity perspectives. The most powerful facilitator among physicians is education, such as more integration of SDoH perspectives into medical school curriculums and more attention given to medical students receiving more experience with vulnerable populations and working in communities. Ongoing education for physicians is also a factor that can facilitate better understandings of SDoH, especially relative to understanding the role SDoH play in health outcomes and interventions. This is relevant to my own experience in the MPH program at SFU where there is a lack of integrated health equity perspectives in coursework and tensions between students who study inequities and those who do not.

Work from the RWJF (2010) shows educating the public using communication strategies had a positive impact on attitudes towards the SDoH. This work began by interviewing voters and trying to establish what kinds of messages would resonate with both Republicans and Democrats. They find the majority of participants, for all types of voters, appreciate the significance of SDoH after seeing messaging, resulting in a 31% increase in support for external factors that impact health (RWJF, 2010). Here the implication is participants did not automatically situate health socially but respond to messages that highlight the role of SDoH (RWJF, 2010).

There are few studies evaluating whether attitudinal shifts translate into action. Garnett et al. (2014) investigate the effectiveness of social marketing campaigns aimed at decreasing negative self-talk related to body size and weight. Garnett et al. (2014) employ the Elaboration Likelihood Model (ELM) of persuasion to develop social media campaign, a model based on the idea that messaging is more effective if it is personally relevant. Personal relevance and salience of the message is attributed to greater motivation, through increased attention and comprehension, leading to changes in attitudes and behaviour (Garnett, et al., 2014). Garnett et al. (2014) tested college students before and after viewing social media campaigns to see if the campaign had any impact on negative self-talk and find the number of participants who engaged in this behaviour dropped from 50% to 34% (Garnett, et al., 2014). The positive results are attributed to the salience of the campaign, which resulted in higher motivation to shift attitudes and behaviours. The authors also posit the campaign impacted social norms, making it less socially acceptable to engage in fat talk behaviours.

Arbuthnott (2009) states that if we want to translate attitudinal change into action, far more must be done than merely creating campaigns to change opinions; behaviour change is ultimately tied to attitude change, but navigating this relationship is complex. Research shows that relative to environmental issues, changing attitudes can translate into behavioural change when the public is aware of the impact of individual action and the consequences of doing nothing (Arbuthnott, 2009). Arbuthnott (2009) recommends specific strategies to influence attitudes to affect behavioural change such as highlighting particular behaviour targets and modelling potential action.

Corrigan (2012) questions whether messaging in the form of public service announcements (PSAs) impacts mental health stigma. Corrigan observes a paucity of studies evaluating of PSAs and difficulties in assessing the degree of impact (2012). Impact is often measured in terms of length of time spent on a website or whether participants remembered the PSA, without attention to changes in discriminatory attitudes or beliefs about mental illness (Corrigan, 2012). Corrigan makes three recommendations to address the effectives of PSAs. First, evaluation must be built into any PSA development program to assess impact. Second, PSAs should target internet formats as there are less people accessing media from television, radio, and print. Finally, PSAs should be targeted, not addressed to entire populations. By targeting those in power and instrumental in discriminatory attitudes, such as employers and landlords, there may be more of an impact on mental health stigma (Corrigan, 2012).

The purpose of this capstone is to explore the barriers to public health professionals advocating for heath equity. From this discussion a framework for change has emerged, where the efforts of Fraser Health to achieve a cultural shift towards health equity are combined with calls for public health professionals to educate civil society about health equity. This combination presents a mechanism for health equity advocates to shift the balance of power and change the conversation. If civil society begins to champion health equity and is able to see how powerful forces such as capitalism and biomedical primacy impact health disparities, then we will achieve health equity. There is good evidence that education and communication strategies can be successful in changing attitudes, but whether attitudinal change translates into action is unclear. Any efforts to create messaging for the public will need to be carefully crafted and monitored for success.

6. Discussion

The WHO (CSDH, 2008) calls for health inequities to disappear in a generation, no small feat considering the barriers thwarting public health professionals from promoting health equity. The purpose of this capstone is to engage with the main question that emerged from my practicum: <u>what are the barriers to promoting health equity</u>? To answer this question, I examine international and national guiding principles for acting on health equity, explore the state of health equity in Canada, investigate drivers of health inequities and barriers to action, and develop a framework for change. The ultimate goal is to design a framework for change to be used by organizations such as Fraser Health to implement activities that motivate public health professionals to foster a dialogue with civil society around health equity, resulting in the elimination of health disparities in Canada.

My practicum experience caused me to reflect on many aspects of health equity work, primarily barriers to action. I have met several public health professionals working in large organizations who also face obstacles to action, namely, a lack of leadership on health inequities from management. Where is the leadership that the PHSA (2015) and other organizations profess? It is frustrating to consider that the guiding principles of the health organizations referred to above all espouse support for health equity, yet health equity is mostly absent from planning and policy. If an organization itself is disconnected from movements that prioritize health equity efforts to address health inequities will likely be watered-down, tokenistic and perpetuate norms of deservingness and undeservingness (Spade, 2011). At the moment, movement on health inequities is largely dependant on the will of the public. Public outcry can have a significant impact on the health system, evident in the response to expand RCH after overcrowding made headlines (Fraser Health, 2012), drawing the ire of the public. Hence the need for increasing the public's understanding and awareness of health equity.

Reflecting on my time in the MPH program I feel the Faculty of Health Science (FHS) also needs more connection to movements that prioritize health equity. The core competencies of the MPH program include acquiring "*knowledge about the health status of populations, inequities in health, the determinants of health and illness*" to "*improve the health of the of the entire population and to reduce health inequities among population*

groups" (FHS, n.d., para. 3 & para. 5). However, in my experience, there was a paucity of integrated health equity perspectives in my core courses and a perpetual rift between students in the social inequities stream (SIH) and other students. Several core courses I took during my degree made no mention of health equity or the SDoH; courses such as *Epidemiology* and *Biostatistics* are prime examples of core courses in need of an equity lens, where measuring and tracking inequities should be a primary concern. I met with the new group of SIH students last fall and my main advice to them was that part of their role as SIH students was to be advocates of health equity in the classroom because students in the other streams will not be getting the same information, nor will health equity be included in all courses. I continue to find this very frustrating and wonder if a recent letter presented to faculty from SIH students about these very issues will have any impact on the program; if public health students are not learning to be "long-term enablers of effective advocacy for health equity" in programs like the MPH at SFU as suggested by Farrer et al. (2015), how will they become health equity promoters in the scope of their practice?

This capstone identifies many powerful barriers that make it difficult for public health professionals to promote health equity. Some barriers are the result of the political economy in Canada, where neoliberal policies and a lack of cross-sectoral cooperation create inequities and prevent cooperative efforts to combat them. Epistemological barriers such as biomedical primacy and a lack of consensus on measuring and defining inequities maintain focus on individual factors and make it difficult to address health inequities. Finally, ideological barriers constituting positivist and individualized approaches to health lead to a lack of awareness and interest and negative perceptions about health inequities, all which impede action. Understanding these barriers is a critical step towards addressing health inequities, but public health professionals are not well positioned to address these barriers consistently and a different approach is required to achieve health equity.

For the most part, the barriers and forces driving health inequities and recommendations for change fall outside the purview of public health. As a future public health professional I want to work towards eliminating health inequities, but if I try to enact change from inside the health system only, the inequities I aim to eliminate will be continually perpetuated by forces beyond my reach. By focusing my efforts on educating civil society to be more accepting of health equity and the SDoH, I can broaden the reach of my work and do more to promote health equity. It is troubling that despite the apparent prioritization

of health equity by Health Canada, the PHAC, and tenets of public heath, that health inequities persist. By not addressing the factors that drive health inequities and prevent action we as a society permit inequities to continue. The fact that heath disparities persist is indicative of hegemonic attitudes that normalize inequities, public policy that perpetuate inequities, and is a violation of human rights.

Theories of power formulated by Foucault position power as amenable to change through discourse. By combining the work at Fraser Health to change the conversation around SDoH and increase acceptance of health equity among staff with efforts to educate civil society we see a powerful framework for change emerge. A framework that not only addresses the barriers to action, but presents an opportunity for real social change and to shift the balance of power by shifting the conversation around health inequities. By increasing acceptance of health equity among health professionals and challenging them to focus efforts on educating the public about equity, there will be a shift in the way society views health equity. This shift will swing perspectives away from individualistic interventions and towards structural health promotion in the form of healthy public policy. Only then will there be improved living conditions, equitable distribution of wealth, better understanding of inequities and mechanisms for change and monitoring, and ultimately, health equity. Health equity is a consequence of an evolved, democratic, and equitable society where every person has the same value. Human beings are capable of great kindness and most foster strong feelings of fairness, and I believe we are capable of creating a society where are all equal.

6.1.   Limitations

There is good evidence that using communication strategies to educate civil society and health professionals about health equity can have a positive impact on attitudes. However, the utility of these strategies is limited by an inadvertent re-entrenching of inequities and watering down of equity messages. Relative to work from the RWJF, there are interesting lessons for producing effective equity messaging such as using plain

language, action oriented ideas, and limited facts per message. However, from a health equity perspective, some of these lessons are alarming. Here, the message is to pander to perspectives that favour personal responsibility, use existing beliefs as common ground even if they clash with SDoH concepts, reduce the visibility of those most affected by disparate health outcomes, and never say the words *social determinants of health*. The RWJF (2010) report also indulges conservative views that reject health equity by suggesting equity messaging avoid words and phrases such as *equality*, *creating balance*, *injustice*, *immoral*, *outrage*, and *unconscionable* (RWJF, 2010).

It is also unclear if using communication strategies will result in action and behaviour change. Evaluations of the effectiveness of education campaigns are sparse, likely due to difficulties associated with attributing actions to attitudinal change. Work that has been done on attitudinal shifts and behaviour change shows that individual shifts in attitudes towards health equity are not enough to impact behaviour; change lies in impacting social norms, modelling action, and targeting messaging towards those in power (Arbuthnott, 2009; Corrigan, 2012; Garnett, 2014).

It is not lost on me that this capstone presents a largely individual approach to bring about structural change. However, structures do not make change, people do. Structures do hold considerable power, but when we consider Foucault's vision of power, the nature of power is dependent on beliefs and who is allowed to control the conversation. Structures only have power because people give it to them; people create the structures and people can tear them down and build better ones. To bring about structural change there needs to be motivated people to bring about that change. Civil society is capable of bringing about system change by challenging hegemonic belief systems that perpetuate inequities such as neoliberalism, biomedical primacy, and individualism. Hegemonic beliefs are challenged when civil society turns to perspectives such as socialism, equity, holistic views to health, and alternatives to positivism. The first step to getting people to address the structural problems plaguing our society is to increase acceptance and understanding of health equity.

6.2. Recommendations for Policy and Practice

The primary recommendation of this capstone is for public health professionals to prioritize efforts to educate civil society about the importance of health equity. The factors that drive inequities and present barriers to action are myriad and largely beyond the scope of public health practitioners. By taking up efforts to educate the public, health equity perspectives will seed themselves into all corners of policy, practice, and society, resulting in a more equitable society and healthy populous.

The fact that health disparities are not clear-cut problems with easy answers also creates the need for clear and persuasive health equity messaging. Health communication campaigns often aim to change attitudes and behaviours by altering social norms at a population level (Garnett, 2014). Arbuthnott (2009) recommends specific strategies to influence attitudes to affect behavioural change such as highlighting particular behaviour targets and modelling potential action. By targeting those in power and instrumental in discriminatory attitudes, such as employers and landlords, there may be more of an impact (Corrigan, 2012).

There is the risk any new structures that emerge post-health equity to also recreate inequities in society, leading back to health inequities. However, if structures and organizations are built up on an equity focused foundation that is reflexive and designed to adapt to unintended discriminatory or unfair practices, then the risk for recreating inequities is reduced. Selsky and Parker (2005) suggest the creation of a societal sector platform, where integrative approaches to incorporating health equity are promoted across organizational and sectoral boundaries. Incorporating health equity into all policy and program development from governmental institutions is also recommended, where the intention is to create environments that enable everyone to lead a healthy life (Raphael, 2012).

There is much that can be done to educate health professionals about health equity before they enter practice. The CMA (2013) recommends integrating SDoH perspectives into medical school curriculums, providing medical students with more exposure to vulnerable populations within their communities, and ongoing professional

development relative to health equity. Public health programs, such as the MPH, should build all course work upon a health equity base, where health equity is a primary goal of all public health efforts. If all medical and public health programs integrate health equity perspectives and put more focus on the guiding principles of the WHO, Health Canada, and the PHAC that promote health equity, then the practioners of the future will be better prepared and motivated to champion health equity to civil society.

Eliminating health inequities should be a central aspect of <u>all</u> public health efforts. I believe it is possible to achieve the WHO (CSDH, 2008) call for an end to health inequities within a generation by using strategies that promote better living conditions, equitable distribution of power, money, and resources, and strong mechanism to prevent inequities in health systems and monitor progress. Health inequities are a profoundly disturbing symptom of deep seated social inequality in our societies. Public health professionals have an opportunity to be agents of change and advocate for a better more equitable planet. By engaging the questions that emerged out of my practicum I feel better prepared to move forward as a public health professional charged with eliminating health inequities. Understanding the barriers health professionals face in health equity advocacy will make me a better practioner and advocate, lying in wait for my window of opportunity to open.

7. Conclusion

Eliminating health inequities in Canada is a lofty, but attainable goal. The WHO (CSDH, 2008), recommends three areas of action to eliminate health inequities - fostering better living conditions and equitable distributions of power, money, and resources, and creating strong mechanisms to prevent inequities in health systems and monitor progress. The mission of public health officials is to prevent disease, promote health, and prolong life among the population as a whole (WHO, 2015). Here in Canada, although we have a paucity of healthy public policy, the primary health organizations all acknowledge the importance of promoting health for all; the objectives for Health Canada and the PAC prioritize health equity, health promotion and the fair treatment of all citizens (Health Canada, 2011; PHAC, 2015).

My practicum at Fraser Health involved a project working to create health equity messaging for staff and leaders. Here, efforts focus on infusing the scope and practice for Fraser Health staff with health equity to achieve more accessible, acceptable, and appropriate health services. From this practicum arose many questions for me surrounding the success and reach of this work and why it is so challenging to promote health equity. The purpose of this capstone is to describe and reflect on my practicum at Fraser Health, while critically exploring barriers to promoting health equity and possibilities for expanding this work. The problem at the center of this capstone is how difficult it is to promote health equity perspectives.

There are several forces driving health inequities and many barriers that make it difficult for public health officials to promote health equity including primacy of biomedical perspectives, contemporary economic policies, measurement and evidentiary issues, lack of cross-sectoral cooperation, and conflicting ideologies around health and illness that produce negative perceptions, lack of awareness, or interest in health inequities. The forces driving inequity and preventing action are substantial and beyond the scope of practice for most public health professionals. By focusing efforts on educating the public about health equity and the SDoH public health professionals can broaden the reach of their work and do more to promote health equity.

First steps are being undertaken at health authorities such as Fraser Health where efforts to produce health equity messaging for staff and leaders aimed at shifting the cultural climate towards health equity. Once there are legions of health professionals in the Canada, all charged with advocating for health equity, we will see health inequities start disappearing. What is required here is a massive shift in the way civil society appreciates the impacts of the SDoH on health and action from the public to demand public policies that improve living conditions and equitable distributions of wealth for everyone.

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Figure 1: A Framework for Change
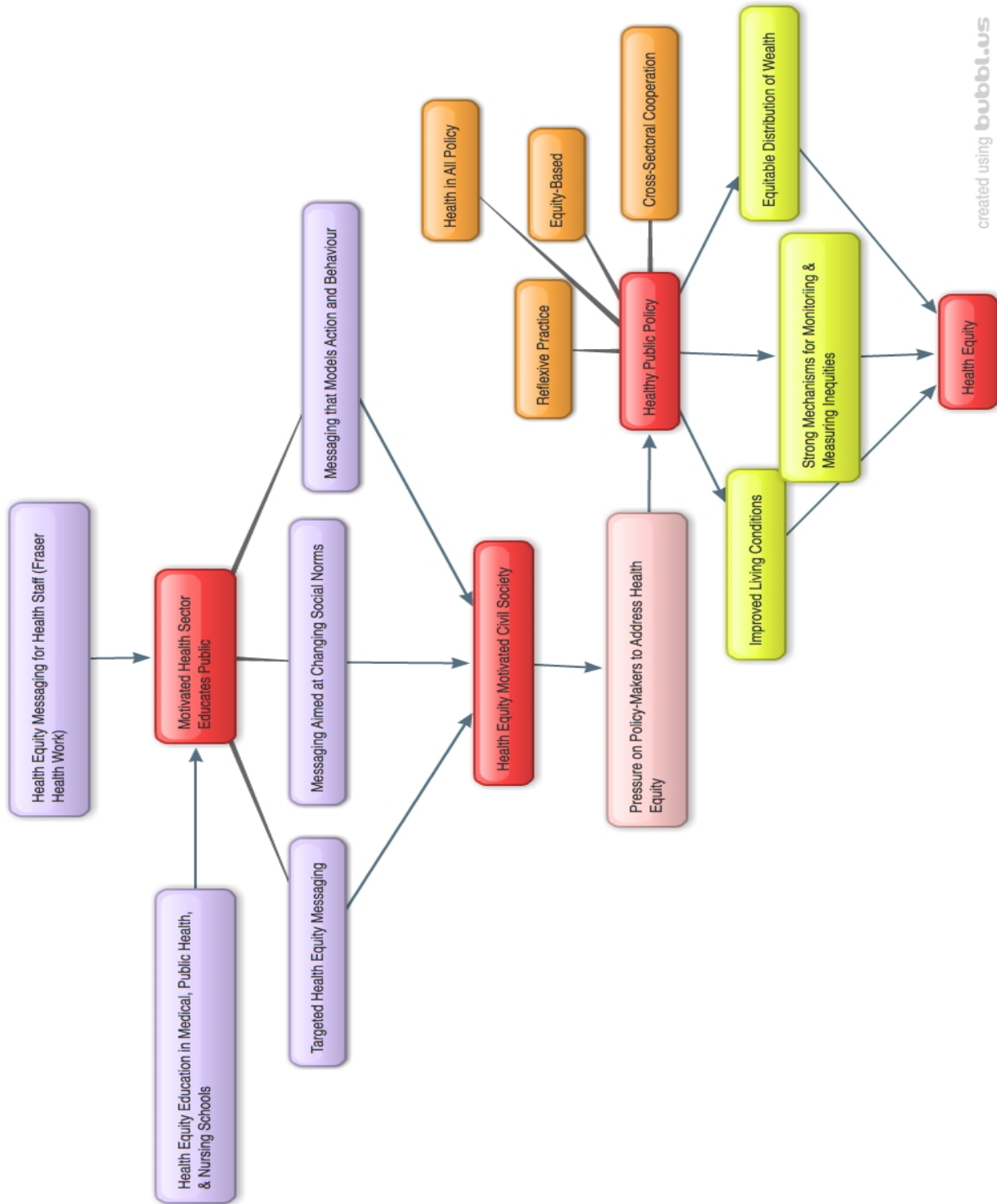
Appendix A.

Fraser Health Practicum Description

The basis of my practicum at Fraser Health was to build on previous work exploring health equity messaging. In 2011, a pilot study (Study #1) on health equity messaging was conducted at Fraser Health to test how health equity and SDoH related messages would be received by Fraser Health staff. The purpose of this study was to determine which messages best resonated with FH staff and could be used to motivate and empower staff to address health inequities within their scope of practice (Practicum Report: Lammersten, 2012). Study #1 consisted of a short survey administered to a large group of FH staff and smaller focus groups, which explored reactions to health equity messages.

The first study drew on concepts of message framing. Studies show framing messages and content/ intent has a positive impact on how information is received (Robert Wood Johnson Foundation (RWJF), 2010). In 2010, the RWJF conducted a U.S. study to explore better ways to communicate SDoH by exploring SDoH opinions/values and then creating messages for the purpose of changing opinions (RWJF, 2010). Values are defined as clear statements about what is important to us; our values influence attitudes, decisions and actions that are, in turn, based on beliefs about what is true in the world and what is important. One of the main findings show messaging connecting with existing participant values (e.g. ideas surrounding personal responsibility for health) with SDoH values and health equity (e.g. entitlement to health care) is more successful than merely presenting SDoH messages.

The messages created in Study #1 were based on results from the RWJF study. In Study #1, some aspects of the RWJF study results were successful (e.g. using practical examples and plain language). However, other aspects of the RWJF study results either did not translate in the Canadian context (e.g. nationalistic identity) or aspects of the messages did not connect with the personal values held by FH staff. The results of Study #1 show that some assumptions from the RWJF study (i.e. patriotism as common ground) did not translate in the Canadian context, (Practicum Report [Internal document]: Lammersten, 2012), which begs the question: what else is being assumed about the culture of Fraser Health? Thus, the objective of my practicum was to explore the current

culture and attitudes regarding health equity and SDoH among Fraser health staff. The idea being that once we have a better understanding of the culture of Fraser Health and commonly shared values, we can craft health equity messages that resonate with Fraser Health decision-makers and health practitioners so they: i) understand the importance of health equity and determinants of health; and ii) are motivated to address health equity in their program planning and service delivery. I began researching strategies to explore the cultural climate and attitudes of Fraser Health staff. We chose to create a survey to measure baseline levels of health equity and SDoH awareness/attitudes, to capture what values are common amongst staff, and attitudes towards SDoH. Focus groups were also conducted to gauge how people feel about health inequity and observe what values emerge during the course of health equity discussions. A literature review was conducted to examine potential mitigating factors, strategies for developing the survey and focus groups, and data collection.

Survey

The survey was developed according to Fraser Health guidelines where a privacy impact assessment was submitted to ensure compliance with privacy standards. Before the survey was finalized, all potential survey questions, values, and variables went through several rounds of consultation with the Department of Evaluation and Research Services, members of the Fraser Health health equity working group (HEWG), and Fraser Health Ethics and Diversity Services. To build the content of the survey, a literature search was conducted to gather information on measuring values and to identify variables of interest. The databases Medline, Science Direct, and the SFU Library database were consulted, using the search terms "*measuring values*", "*measuring culture*", "*values survey*", and "*attitudes* AND *SDoH* OR *health equity*." The term "*Canada*" was included to find research conducted in a Canadian context.

The literature review revealed several variables moderating how health equity and SDoH views differ. Ruiz-Casares et al. (2013) examined attitudes of health care professionals, primarily, attitudes concerning care for undocumented migrants. The authors find health care professionals with more contact with clients are more inclined to believe everyone has the right to health care (RTHC), a concept central to health equity. Thus, Study #2 explores Fraser Health staff roles in the workplace and their degree of

patient contact. The survey also collected information about participant program and regions within Fraser Health to see if there were any differences in ratings of SDoH and values. The survey included ten variables: *gender*, *patient contact, program/service type*, *region*, *role*, and baseline measure of *awareness of health equity* and *SDoH*. To make the survey as inclusive as possible, demographic information obtained pertaining to *gender* included the options: *female*, *male*, *transvariant* or *transgender*, *prefer not to answer*, or *I identify as _____*.

To evaluate what values may be common among Fraser Health staff, work on basic human values by Schwartz (2001) was used to craft survey questions. Schwartz (2012) defines values as concepts that characterize various groups, crucial to understanding personal organization and change, explaining what motivates attitudes and behaviour. There were several additional values we felt were important to add. Through discussions with the HEWG we decided to explore values related to concepts of health equity such as Fraser Health organizational values, *individualism*, *pluralism*, *RTHC*, and *social equality*. Fraser Health is guided by three core values: *caring*, *respect*, and *trust* (Fraser Health, 2011).

Focus Groups

A literature search was conducted to find information relative to conducting focus groups and eliciting attitudes about SDoH, health equity, and values. Research shows how you ask questions matters. Fisher and Katz (2000) explore the idea that the social desirability bias (the desire to answer questions to reflect social norms) impacts the way people respond to questions measuring personal values, values that may not be socially acceptable. The authors find those who score high on measures of social desirability do not always present their true feelings when asked directly about values that may conflict with their own. Based on these findings, questions aimed to elicit values and attitudes about SDoH and health equity indirectly, rather than using direct questions. Three main questions guided the sessions, designed to elicit attitudes and values surrounding factors affecting the health of the public and participants. By asking about factors impacting health, we were indirectly probing to see if social determinants would arise as possible explanations or if individualistic ideas would prevail.

Results

Although I cannot go into detail, it is safe to say that are many areas of common ground among Fraser Health staff and areas of divergence based on the moderating variables of interest. The results of the study show the moderating variables of interest did have an impact (role, patient contact, program/service) and there were differences between the awareness of health equity compared to SDoH. There were also differences between the way participants rated the value individualism and the SDoH of personal health practices which is interesting as these two factors are essentially getting at the same concept, but were asked about in different ways. This work is now being looked at by a new practicum student and my preceptor and I are working on the report in hopes of having it published.

Appendix B.

Key Determinants of Health (PHAC, 2011)

1. Income and Social Status: Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies that are prosperous and have an equitable distribution of wealth.

2. **Social Support Networks**: Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.

3. **Education and Literacy**: Health status improves with level of education. Education is closely tied to socioeconomic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.

4. **Employment/Working Conditions**: Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

5. **Social Environments**: The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others.

The array of values and norms of a society influence in varying ways the health and well being of individuals and populations.

6. **Physical Environments**: The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

7. **Personal Health Practices and Coping Skills:** Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health. Definitions of lifestyle include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play.

8. **Healthy Child Development**: New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.

9. **Biology and Genetic Endowment**: The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain

individuals to particular diseases or health problems.

10. **Health Services**: Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention.

11. Gender: *Gender* refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "*Gender*ed" norms influence the health system's practices and priorities. Many health issues are a function of *gender*-based social status or roles.

12. **Culture**: Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.