National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé

LEARNING TOGETHER:
A MODEL FOR INCREASING ORGANIZATIONAL CHANGE CAPACITY FOR HEALTH EQUITY

This document discusses organizational capacity for health equity change. It is best used alongside the companion NCCDH document *A practice framework for building organizational capacity for health equity*,[1] which explores essential aspects of organizational capacity for health equity.

ORGANIZATIONAL CAPACITY FOR HEALTH EQUITY ACTION INITIATIVE

The **Organizational Capacity for Health Equity Action Initiative** (OCI) fosters learning about frameworks, strategies and organizational conditions that can enable Canadian public health organizations to develop and sustain their capacity for health equity action. The participatory initiative uses a learning circle, reviews and discussion of the literature, and practice site implementation to explore these objectives.

The initiative is described fully in *Organizational Capacity for Health Equity Action Initiative: A brief description*.[2]

Visit **www.nccdh.ca** to learn more about the initiative.

A MODEL FOR ORGANIZATIONAL CHANGE

When the National Collaborating Centre for Determinants of Health (NCCDH) launched the Organizational Capacity for Health Equity Initiative (OCI) in 2018, we were interested in investigating how public health organizations could develop and implement initiatives designed to build and sustain health equity capacity.

Public health organizations embarking on health equity capacity-building efforts need a firm grasp of how to navigate change. To ground early discussions in the Initiative, we drew on a conceptual model by Klarner and colleagues[3,4] that describes what organizations must understand in order to implement successful change initiatives.

The conceptual model provides guidance to help organizations identify:

1. what they want to change (content);
2. how change will be enacted (process);
3. the internal and external conditions that influence change (context); and
4. and how emerging knowledge and opportunities will be built into the organization (learning).[3]

These four concepts contribute to an organization's capacity to undertake and sustain change. In order for organizations to manage and adapt to internal and external change, robust change capacity is essential.[2,4] Considered both independently and together, these four concepts can support or hinder efforts to develop organizational capacity for health equity and, consequently, can also significantly influence the success of change. As such, leaders, managers and health equity champions in public health can benefit from a stronger understanding of organizational change capacity.[5]

Using practitioner insight to illustrate the model

Below, we discuss each of the four dimensions of organizational change capacity (process, context, learning and content) in relation to health equity capacity-building. Considering each of these dimensions as health equity capacity-building initiatives are envisioned or planned provides an assessment of the organization's change capacity or readiness for change. This discussion is informed by the on-the-ground experiences of health equity champions shared during the OCI learning circle meetings held in May and June 2018.[6]

Organizational change capacity

As described by Klerner et al.:

"Organizational change capacity is defined as an organization's ability to develop and implement … appropriate organizational changes … to constantly adapt to environmental evolutions … and/or organizational evolutions … in either a reactive way … or by initiating it."[3(p14)]

Health equity as the content of change

The substance of change — that is, what an organization wants to change — is an important determinant of that change's eventual success over time.[3] Organizational capacity for health equity is multifaceted,[1,7-10] consisting of:

- organizational governance, leadership and accountability for health equity;
- organizational culture and values;
- investment in health equity and social determinants of health programs and policies;
- an equitable and inclusive human resource process and a skilled team;
- high-quality equity data and knowledge;
- strong intersectoral and community partnerships that support action on the social determinants of health;
- equitable physical and digital spaces; and
- awareness and ability to influence the external system.

As shown above, strengthening organizational capacity for health equity action necessitates attention to the strategic, structural and cultural changes that are needed to promote success in health organizations.[3,11,12] Bearing this in mind, health equity–oriented organizational change requires that organizations engage with complexity and change across multiple levels — individual, process and organizational. Furthermore, change should be informed by different types of wisdom and ways of knowing.

Organizations need an explicit strategic commitment to health equity, both formal and informal, to support organizational change.[6-8] Learning circle members recognized organizational policy as a useful tool alongside a clear plan for implementation and subsequent action.

The health equity change process

The manner in which health equity capacity-building is initiated and unfolds influences an organization's ability to develop and implement the change in question.[3]

Health equity champions are key to the success of organization-wide initiatives.

Transformational leadership, demonstrated by these champions supports the change process by generating support for change from those who hold organizational power, inspiring a shared vision and motivating staff to be part of the health equity-oriented change.[16-18] Linked closely is the extent to which proposed activities are seen as legitimate by those who have to inform or implement it.[3] Organizational leaders who model the desired changes demonstrate their commitment and support a culture shift towards more equitable practices.[6]

Decision-makers, or those in power, can have a vested interest to maintain the status quo within the conservative, hierarchical and colonial institutions in which they operate.[6] As such, these decision-makers can hinder the leadership of marginalized peoples, leadership which is critically needed to improve health equity.[19] These practices of limiting leadership can be a significant barrier to the success of any change initiatives. Further, changes in the leadership of organization and project team during the implementation of a change initiative can be a threat to success. Strategies to mitigate this risk include creating short-term milestones to demonstrate value early on and engaging new leadership quickly during periods of transition.[6]

Change can be initiated through a planned or emergent process. It can be immediate and radical or incremental.[5,20] Incremental steps may be more likely to support uptake and sustainability.[1] Organizations benefit from an implementation plan with clear steps that support staff to build skills while maintaining stability within the organization.

Building change collectively through dialogue and problem-solving ensures staff and partners can influence and contribute to the process. Transparency through open and ongoing communication engenders trust in the proposed change and ensures that everyone affected by the change stays engaged throughout the process.[3]

A common language is important when speaking with partners and when engaging in dialogue for health equity capacity–building activities. Partners and public health practitioners have to develop critical and reflexive capacities to engage in change. Building support for change is essential particularly to those who may be skeptical of or not invested in building capacity for health equity.

Clear communications can help generate support by stressing:

- the value of organizational change to ensure health equity remains a priority; and
- the risk of not acting to address health equity issues.

Health equity change initiatives also need sufficient resources for their development and implementation.[1,7,8]

The context of health equity change

Conditions of an organization's external and internal environment enable or hinder the change. Specific to the internal context, those planning health equity organizational change activities should consider the following:[3]

a. **Perceived value of the change** among staff that will influence the level of their support
b. **Flexibility** in the organizational structure will support problem-solving on change to improve health equity. Conversely, rigid structures detract from engagement and reduce opportunities for staff to reflect on and implement change.
c. **Cultural cohesion**, whereby a strong organizational culture increases the affinity and commitment staff have towards the organization and thus health equity–oriented change
d. **Degree of trust** between the person(s) leading change and others involved. Where there are strong relationships and a high degree of trust, the change is more likely to be successful.
e. **Collective problem-solving** based on consensus decision-making motivates participation and supports learning through the change process.
f. **Acquisition and application of new knowledge** by individuals in the organization.

Organizational learning for health equity capacity development

Organizational learning improves an organization's ability to adapt and change. Organizations that explore new opportunities and continuously improve their practices and processes are better positioned to develop and sustain equity-oriented change.[3]

A vibrant and dynamic learning environment includes the ability of an organization to:[3]

a. learn from past experience through reflection and application to new initiatives;
b. renew through experimentation, innovation and risk-taking;
c. draw on institutional experience and learning to resolve emerging challenges; and
d. transfer organizational knowledge through clear, consistent and efficient practices and processes.

DISCUSSION GUIDE

Public health organizations interested in their own health equity change initiative can begin to explore their readiness and plan by discussing the questions below.

CONTENT	NOTES
a. What area of health equity organizational capacity do you want to improve? See *A practice framework for building organizational capacity for health equity*[6] for a description of various elements of organizational capacity.	
b. What are the strategic, cultural and structural aspects of change you are looking to make?	
PROCESS	

c. How has the need for change been identified?
d. Is the change you propose supported by:
  • transformational leadership;
  • engagement and communication; and/or;
  • adequate resources.	

CONTEXT	
e. What are the current conditions **within** the organization that may support or hinder the desired change? Can you influence the identified barriers?	
f. What are the current conditions **outside** the organization that may support or hinder the desired change? Can you influence the identified barriers?	
LEARNING	
g. What experience does your organization have with health equity or health equity–oriented change?	
h. What can you learn from past experiences?	
i. How will you support learning throughout the change initiative?	

CONCLUSION

In this resource, we explore four broad concepts to support public health organizations as these organizations consider their capacity to engage in health equity change. After completing the discussion above, you will have identified priority areas to plan for your health equity capacity-building activities.

Need to support learning on health equity concepts? Use the NCCDH's **Let's Talk** series to build a shared understanding of health equity issues with your team. The series is available at http://nccdh.ca/resources/lets-talk.

Identifying the evidence

The evidence informing the learning circle discussion was identified through a strategic search of the literature, as well as staff experience in organizational change training and practice.

The evidence was initially narrowed down to three key documents: two from Klarner et al.[3,4] and one from Chen et al.[20] Additional literature was added following the learning circle meeting to inform the development of this resource.

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