Evaluation and Program Planning 36 (2013) 191–197

Contents lists available at SciVerse ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Defining principles for good practice: Using case studies to inform health systems action on health inequalities

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ARTICLE INFO

Article history:
Available online 14 March 2012

Keywords:
Case studies
Programme evaluation
Evaluators
Data
Health inequities
Social determinants of health
Health systems Action
Health policy

ABSTRACT

This paper presents work using case studies as a source of data to see if we could extrapolate from the specific to the general particularly with regard to understanding what constitutes effective practice in taking action on SDHI and as a way of enabling policy makers to make better use of knowledge within the case studies and as a way of better understanding what works, in what context and why. Case studies are important to evaluators in that they are relatively straightforward to undertake and because those involved in implementing an intervention are usually keen to profile the intervention. A checklist described in this paper will enable policy advisers and evaluators to quickly review a case study and right away see if it contains enough information to assist in the development of policy options for reducing socially determined health inequalities.

1. Introduction

Socially determined health inequalities (SDHI)[2] in the WHO European Region[3] have been increasing (Corsini, 2010; European Commission, 2009; WHO Regional Office for Europe, 2009) and will continue to do so without determined action to counter the social determinants causing the inequalities. The social determinants of health refer to the social conditions, in which people are born, grow, live, work and age, that shape their health and disease exposures, vulnerabilities and outcomes. These social factors may include: employment and working conditions, living environments, availability of and access to health and social protection services, education and social cohesion or connectedness. They also refer to the way in which social class, gender, age and ethnicity norms, values, and discrimination, relate with other determinants of health to increase the vulnerabilities and risks that lead to health inequities (*avoidable and unjust systematic differences in health status between different groups* in a given society) (WHO Regional Office for Europe, 2009). While there has been improvement in overall health status within the region, it is not equally shared across populations either within countries or between countries (Ministry of Health & Social Policy of Spain, 2010).

In 2007 one of the authors (SS) was tasked with identifying examples of "good" practice of health systems actions to tackle socially determined health inequalities from among WHO European countries (WHO Regional Office for Europe, 2011). This task was part of a wider joint action between the World Health Organization (WHO) Regional Office for Europe and the European Union (DG-SANCO) to improve knowledge and tools for policymakers and practitioners on health systems actions to improve health equity. "Good" practice was understood to mean activities that reduced health inequalities by action on one, some or several social determinants including the health system. However, assessing the quality of any practice – good, promising or best – implies being able to make some kind of an evaluative judgment. A best case scenario for the evaluator is where there are some internationally accredited standards against which to assess the practice. In the field of action on socially determined health inequalities we are not so fortunate, usually developing interventions and or assessing policy responses based on a set of principles largely derived from theory. This makes it a challenge to find specific and actionable knowledge for addressing health

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[1] The views expressed by the author do not necessarily represent the decisions or the stated policy of the World Health Organization.

[2] The term used here – socially determined health inequalities – is taken from the project brief and inequalities is the term used by the EU. We note that it refers to those "differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage (Whitehead, 1990)."

[3] The WHO European Region encompasses 53 countries or Member States including the 27 countries within the European Union. For more information about which countries this includes please see http://www.euro.who.int/en/where-we-work. Examples were to be drawn from both EU and non-EU Member States within the Region.

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doi:10.1016/j.evalprogplan.2012.03.007

inequalities – often we are left noting that "it depends" on the context. However this is beginning to change for the better.

There are many examples of initiatives to address the social determinants of health but few that have been systematically evaluated or documented against an agreed set of criteria that demonstrate the difference they make to health inequalities per se. Within the field of health inequalities and in the WHO European Region there is a strong emphasis on collecting examples of inequalities actions through case studies (e.g. DETERMINE project (European Portal for Action on Health Inequalities – Good Practice Database, 2010), HealthQuest (European Commission, 2008) and the case studies collected as part of the global Commission on Social Determinants of Health (WHO, 2011a)). There seems to be an assumption that case studies will *ipso facto* assist policy makers to take action. This paper presents work using case studies as a source of data to see if we could: extrapolate from the specific to the general particularly with regard to understanding what constitutes effective practice in taking action on SDHI; as a way of enabling policy makers to make better use of knowledge within the case studies; and as a way of better understanding what works, in what context and why. Case studies are important to evaluators in that they are relatively straightforward to undertake and because those involved in implementing an intervention are usually keen to profile the intervention. More importantly however case studies enable us to move beyond the numbers, particularly when an indicator or indicator(s) (e.g. differences in rates of physical activity between working age men with differing levels of education within a country) are seen has having an obvious cause and solution (e.g. to better target health education and information for men with lower levels of education).

2. Why is this knowledge important and needed?

When the joint action was conceptualised inequalities in the WHO European region were increasing and health systems within the region were undergoing significant change with potential gaps developing in universal access to health and basic health care services (WHO Regional Office for Europe, 2010a). At the same time, there had been growing awareness and recognition of the need to move beyond measuring and describing the problem of inequalities to looking at actions to better counter them (Millward, Kelly & Nutbeam, 2003). The establishment of the global Commission on Social Determinants of Health (CSDH) in 2005 with the aim to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it (CSDH, 2008) is a seminal example of this increased awareness and commitment to substantive action for change. The CSDH came on the crest of efforts by policy-makers, academics, practitioners and governments in the preceding 10–15 years to improve accuracy of knowledge about the nature and extent of inequalities as well as identifying and putting in place policies and programmes to remedy the social determinants of health inequalities (Acheson et al., 1998; Mackenbach & Stronks, 2002). This included different initiatives using evaluations of interventions to generate and or identify the most effective and evidence-informed options for acting. For example the second 6 year programme by the Dutch during the 1990s as well as the national evaluation of Health Action Zones in England (Bauld et al., 2005).

The 6 year programme by the Dutch was designed to gain systematic experience with policies and interventions to reduce health inequalities (Mackenbach & Stronks, 2002). As part of this 12 evaluation studies were commissioned of a range of interventions to tackle inequalities such as an anti-poverty intervention identifying (5 and 11 year old) children during the preventive health screen whose health could possibly be jeopardised due to the lack of money in the home situation, and providing them with a supplementary grant, to be spent on a specific activity or product. The evaluative approaches ranged from observational to quasi-experimental to experimental. Of the 12 evaluation studies seven gave positive results, i.e. there was an improvement in a health outcome and or intermediate outcome such as a lower percentage of pupils in the experimental group who received the anti-smoking intervention commencing smoking as compared with pupils in the control schools. Another example of other outcomes evaluated included decreased physical workload and absenteeism among bricklayers who received training in a new working method for bricklaying but no change in the prevalence of health problems (Stronks & Mackenbach, 2005). The overall 6 year programme was part of an evidence-informed approach with a view to developing a national response. The Committee that oversaw the work wanted to recommend policies and interventions that were known to reduce the exposure of low socioeconomic groups to the factors that are known to contribute to health inequalities. Despite this important investment in evaluation (including use of a range of evaluative approaches) to generate sound evidence for policy action, there were gaps in both the coverage of various policy options and the strengths of the interventions. As a result, the Committee recommended implementation of a combination of both "promising" interventions and continued evaluation efforts (Mackenbach & Stronks, 2002; Stronks & Mackenbach, 2005).

The global fiscal crisis has exacerbated existing inequalities in the region with more people moving into poverty and requiring assistance from aid agencies (International Federation of the Red Cross Red Crescent Societies, 2009) including the finding that the Europe and Central Asia (ECA) Region was hit harder than any other region in the world by the global financial and economic crisis and will be the slowest to recover (World Bank, 2011). Such developments have accelerated the need for this knowledge. It has potentially also changed the type of knowledge demanded – policy makers want increased specificity of knowledge about the outcome from potential interventions. As indicated previously this created an incentive to see if we could move beyond generating general knowledge to more specific and actionable knowledge about "what works and in what circumstances."

3. The challenges in defining "best" or "good" practice in order to identify it

Terminology such as "best" and "good" practice bring to mind concepts of benchmarking and standards around which there is consensus and which can be used to assess or evaluate the practice. There are many studies which provide theoretical and even practice based indicators of what "good" practice might look like (WHO, 2011b) and how it might be measured (Mackenbach, Judge, Navarro & Kunst, 2007), but there is no real consensus about this, nor an easy system for capturing it. This relates not to the issue of inequalities nor health per se but to complexity and that interventions to improve health equity are usually complex. In addition, because the effectiveness of an intervention is dependent on the context in which it is introduced, we know that what works in one context may not work in another – so it is also important to assess the context. More often we end up with the conclusion that "it depends". Furthermore in order to understand the factors that contribute to making an intervention work and to develop a real world perspective, operational information is needed about implementation. This information is not always available nor considered. However this is changing as evidenced by the recent Spanish Presidency of the EU which included as one of its key issues, monitoring of the social determinants of health and the reduction of health inequalities (Ministry of Health & Social Policy of Spain, 2010). There is a strong