ABSTRACT

Community-based heart health promotion is viewed as an effective means of reducing cardiovascular disease risk. Although public health agencies have a central role in the implementation and dissemination of heart health programmes, their effectiveness is being challenged by major structural changes to Provincial public health systems across Canada, although the impacts of the changes have received relatively little attention in the research literature. As part of the Canadian Heart Health Initiative – Ontario Project (CHHIOP), this study used a qualitative approach to address the perceived implications of these changes to Ontario's public health system for heart health promotion. Interviews (n=38) were conducted in eight public health units with staff most familiar with managing and/or delivering heart health activities. The results are mixed; that is, while many see the future of heart health promotion programming in Ontario as being at risk, others see recent changes as a step forward toward their institutionalization, particularly in light of recent funding decisions made by the Ministry of Health's Health Promotion Branch.

ABRÉGÉ

La promotion de la santé cardiaque en milieu communautaire est considérée comme un moyen efficace de réduire le risque de maladie cardiovasculaire. Bien que les organismes de santé publique jouent un rôle primordial dans la mise en oeuvre et la diffusion des programmes de santé cardiaque, l'efficacité de ceux-ci est remise en cause par d'importants changements d'ordre structurel effectués dans les systèmes de santé publique au Canada. Les divers documents fournis par la recherche n'ont toutefois pas encore vraiment prêté attention aux répercussions de ces changements. Effectuée dans le cadre de l'Initiative canadienne en santé cardiaque – Projet ontarien, cette étude a eu recours à une approche qualitative pour aborder les implications perçues quant aux changements apportés au système de santé publique ontarien pour promouvoir la santé cardiaque. Des entretiens (n = 38) ont été menés dans huit services de santé publique auprès de membres du personnel sachant gérer et/ou fournissant des activités liées à la santé cardiaque. Les résultats sont variables: d'un côté, beaucoup considèrent l'avenir de la programmation dans le domaine de la santé cardiaque en danger; de l'autre, certains estiment que les récents changements opérés constituent un pas vers leur institutionnalisation, tout particulièrement grâce aux récentes décisions financières prises par la Direction générale de la promotion de la santé au sein du ministère de la Santé.

Restructuring Public Health in Ontario: Implications for Heart Health Promotion

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Cardiovascular disease is the principal cause of death and disease in most western nations.¹ Community-based heart health promotion is viewed as an effective means of reducing cardiovascular disease risk. Although public health agencies have a central role in the implementation and dissemination of heart health programs,² their effectiveness is being challenged by major structural changes to provincial public health systems across Canada. While 9 of Canada's 10 provinces have undergone a devolution of health care decision making to the local level over the past decade or so,³ there has been little systematic analysis of the effects of this devolution on public health practice and/or the role of a population health perspective in addressing public health challenges.⁴ Ontario is the one exception to the apparent national trend toward regionalization of health care.³ The public health system in Ontario is currently being challenged, however, by major structural changes. The first of these involves the 'municipalization' of funding responsibilities. In January 1997, the Ontario government announced a change in funding from the previous cost-shared arrangement for boards of health to a requirement that boards be 100% municipally funded as of January 1, 1998. At the

same time, the province is seeking to retain control through the regulation of public health standards set out in the recently revised "Mandatory Health Programs and Services Guidelines."^{5,6} The major guideline change (potentially) affecting heart health staff was the reorientation of the three primary risk factor areas (i.e., nutrition, physical activity and tobacco use prevention) from a perspective of 'Healthy Lifestyles' to 'Chronic Disease Prevention'. At the time of this study in 1997, the second and penultimate draft had been circulated to each public health unit.

As part of the Canadian Heart Health Initiative - Ontario Project (CHHIOP), this study used a qualitative approach to address questions of the implications of these major structural changes to Ontario's public health system for heart health promotion. Detailed descriptions of CHHIOP have been published previously.⁷⁻¹⁰ The specific questions addressed in this paper are: 1) What are the perceptions of public health staff with respect to the changes in the mandatory guidelines and the implications of these changes for heart health promotion? and, 2) What is the future of public health in Ontario in light of the transfer of costs to municipalities? More specifically, what are the perceived implications for local heart health promotion and for population-health-based strategies?

METHODS

Interviews (n=38) were conducted in June 1997 in eight public health units with staff most familiar with managing and/or delivering heart health activities. Sites were selected to represent maximum variation on the basis of four criteria: regional repre-

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sentation; change in mean implementation score, 1994-1996; potential for longitudinal comparison (i.e., site included in 1995 qualitative study); and, whether or not the site had been a demonstration site.⁸ Respondents (n=38) were predominantly female (76%), of mid-career age (61% 36-55 yrs. old), and well educated (87% Bachelor's degree; 37% Master's degree). Professions represented included: director/supervisor/managerial (26%); public health nurse (18%); medical officers of health (18%); health promotion officers/educators (16%); dietitians (11%); and program (e.g., tobacco use prevention, school, heart health) coordinators (8%).

The checklist used to guide the interviews addressed a range of topics including: perceptions of predisposition (i.e., the motivation to undertake community-based heart health promotion activities), capacity (i.e., the skills and resources necessary to realize motivations), and implementation (i.e., the level of heart health activity); perceptions of (changes in) levels of predisposition, capacity, and implementation over time, and factors affecting (changes in) these levels; internal and external partnerships; the use and usefulness of resource centres and organizations; and the future of public health. This semi-structured approach – with minimal probing by the interviewers – provided valuable contextual information about factors which have influenced *changes* in heart health promotion from 1994 to 1996. This paper reports the results pertaining only to the perceptions of the future of public health.

Interviews, which lasted one hour on average, were conducted by two female researchers, and were taped and transcribed verbatim for subsequent thematic analysis assisted by *Ethnograph* qualitative software. Codes (N=270) were developed around the topics in the interview checklist as well as the themes emerging from the transcripts themselves. The coding protocol was tested for both inter-rater (68%) and test-retest (75%) reliability using the method proposed by Miles and Huberman.¹¹

In order to assess validity, the research results were fed back to those participating in the data collection process in the form of 'short reports' which summarized the findings for each unit. Member checking

of this nature is especially important in an interpretive context, where issues could possibly be misconstrued or taken out of context as a result of the deconstruction of interview transcripts by a theme code analysis. Along with the summary for their health unit, all interviewees received a fax-back sheet which contained one question: "Is the enclosed summary an accurate reflection of heart health promotion in your health unit?" Ten of the 38 returned a fax-back sheet and all responses were positive.

RESULTS

Mandatory guideline changes

Staff reactions to the revised mandatory guidelines were mixed. Positive responses entailed the view that the Public Health Branch had captured the essence of health promotion and by so doing had helped to ensure its implementation. Others were more critical, indicating they would rather focus on health (promotion) than disease (prevention). More positively, there was speculation that the integration of the three risk factors under the heading of chronic disease prevention would translate into a stronger, more cohesive message. As well, there was an expectation that it would facilitate increased collaboration among health unit staff.

A chronic disease prevention model was considered both effective and efficient given the overlap between the risk factors that contribute to cardiovascular disease and other health problems (e.g., cancer, diabetes). In this regard, the fact that heart health *per se* was not singled out as a program, but was integrated into risk factor programming was seen as a positive change.

Staff also commented on the shortcomings of the guidelines with respect to program gaps, particularly in the areas related to: seniors, mental health, substance abuse, and sexual health. A related concern was that teens would be hardest hit by the cut-backs in sexual health programs, which was an issue reinforced in some health units by concerned parents.

Concerns were also expressed over the actual content of the guidelines. Most apparent to staff was their highly prescrip-

tive nature, with minimum requirements and standards being set within the document. For example, the section on *Multi-Risk Factor Approaches to Chronic Disease Prevention* states:

The Board of Health shall provide information to the public to increase awareness and knowledge about the prevention of chronic diseases. This shall include as a minimum: (a) provision of, at least once a year, a community-wide media campaign which includes television, radio, pamphlets, Internet and presentations that address the prevention of chronic diseases through tobacco-free living, healthy eating, healthy weights, and regular physical activity; (b) provision and promotion of information services including a telephone advice line for the public on tobacco-free living, healthy eating, healthy weights, and regular physical activity and information on community and board of health programs; and, (c) participation in community-wide events at least twice a year to promote chronic disease prevention.^{12, page14}

However, there was acknowledgement that they understood the intention, in the context of the change to municipal-based funding, and the need for the province to establish some accountability.

Guideline changes were not expected to affect practice in those units already organized around healthy lifestyles and/or multi-risk-factor programming. While these organizational structures were viewed as supporting a chronic disease prevention model – including heart health promotion – others felt that those units not already organized in this manner would feel the greatest effects of the revised guidelines.

The importance of having adequate monitoring systems in place to ensure proper enforcement and therefore compliance with the guidelines was emphasized. Failure to have such regulation in place was predicted to result in program fragmentation and inequitable access to public health services across the province. In those communities with local tobacco lobbies, enforcement of the guidelines was seen as critical to ensuring the existence of tobacco use prevention initiatives. Although the province is seeking to retain control, many questioned what role the province *can* have under a system of 100% municipal fund-

ing. Proper enforcement of the guidelines was also viewed as difficult given the sheer number of health units across Ontario.

The future of public health

There was much speculation about what the potential effects of funding changes would mean for the future of public health in Ontario in general, and the future of heart health promotion in particular. Amidst all this speculation, however, one common theme emerged: downloading the costs of public health to municipalities will result in programming that is less driven by health statistics and more reflective of the priorities of local politicians.

There was consensus among staff that long-term health promotion programs were at greatest risk of being overlooked (or eliminated) by local politicians in favour of more immediate needs. Within this context, however, staff were divided in their opinion as to whether or not the priority of heart health – one of many long-term health promotion programs – would be maintained subsequent to downloading. On the one hand, staff expressed optimism regarding continued emphasis on heart health promotion given the pervasiveness of cardiovascular disease and the fact that it has impacted the lives of many, including politicians. Others speculated that in a financial pinch, more tangible public health programs such as mass immunization and restaurant inspections are likely to take priority over those designed to encourage healthy lifestyles and reduce future illness.

Linked to the opinion that it may be a difficult task, especially administratively, to convince municipal governments that heart health deserves the priority it currently receives, there was speculation that the future of heart health promotion will rest largely in the hands of the Health Promotion Branch of the Ontario Ministry of Health, through funding as part of the Ontario Heart Health Program.* Real concerns were expressed that public health might lose out when put in competition for funds over other municipal services.

* This is a five-year initiative under the Health Promotion Branch of the Ontario Ministry of Health to invest heart health promotion dollars in every health unit in the Province.

Even within health promotion programming, staff suggested that physical activity and nutrition programs may be easier to 'sell' to politicians than tobacco control programs given the ongoing controversy in some local areas around restricting smoking in public places.

There was an expectation by the majority of those interviewed that there will be a shift from a population-based health approach to a high-risk approach once public health comes under municipal jurisdiction. The primary reason: the concept of population health which encompasses broad determinants of health (e.g., social, economic) in addition to traditional medical care and biological factors is not well understood by politicians. Respondents reported that in some jurisdictions, the shift from a population-based health approach to a high-risk approach has already occurred at the provincial level, as evidenced in the latest draft of the mandatory guidelines which advocates a chronic disease prevention model. Education was viewed as the key to ensuring the survival of population-based health approaches and, more broadly speaking, public health programs.

CONCLUSIONS

This paper describes the views of public health unit staff regarding the future of public health in general, and heart health promotion in particular in light of the major structural changes currently being undertaken in Ontario public health. In summary, the prescriptive nature of the revised mandatory guidelines was a real concern for staff. Further, the future of heart health promotion was seen to be dubious, given the replacement in the Guidelines of 'health promotion' with 'disease prevention'. This future is further complicated by the (potential) competition between the needs of public health (e.g., health promotion resources) and other municipal services (e.g., roads, police), in light of the transfer of funding responsibilities to area municipalities from the Province. Perhaps these respondents are aware of the challenges facing their colleagues to the south, wherein the American Public Health Association issued a chal-

lenge to its membership in 1996 to 'remind policy makers and others why public health agencies are essential to the health of communities.'¹³, page 324 Even within public health, there is a perception that more traditional programming (i.e., mass immunizations) will 'win out' over long-term heart health promotion initiatives.

The findings suggest several challenges to public health in light of municipalization forces. At risk is the future of heart health promotion and the effects on long-term rates of CVD mortality and morbidity. For some participating in this study, there was optimism regarding continued emphasis on heart health promotion given the pervasiveness of cardiovascular disease and the fact that it has impacted the lives of many, including politicians. The seemingly negative views expressed here may reflect anticipatory anxiety on the part of those most greatly impacted by these major structural shifts to the delivery of public health programs in Ontario; indeed, it would be fruitful to follow-up with those interviewed to determine if the concerns raised are indeed realized and how public health has adapted to the changes.

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pratique interdisciplinaire en collaboration dans les soins primaires. Les étudiants en médecine intéressés à poursuivre une résidence en médecine de première ligne pourraient, grâce à ces stages, mesurer leur intérêt.

Les programmes de résidence en médecine familiale et les programmes des infirmiers praticiens de l'Ontario devraient examiner les éléments de contenu et de pratique qu'ils ont, et devraient enseigner, en commun. Ces programmes exigent une élaboration créative du curriculum en vue d'offrir des possibilités d'apprentissage et de pratique interdisciplinaires en collaboration. Les professeurs devraient être recrutés au sein des facultés de médecine et de sciences infirmières pour enseigner aux deux catégories d'étudiants ensemble et séparément, au besoin.

Ces initiatives exigent du soutien administratif et peut-être la nomination d'un directeur de l'éducation en soins primaires dans chacune des universités participantes. Ce directeur pourrait être recruté en médecine ou en sciences infirmières (ou les deux), mais il faudrait que cette personne ait le pouvoir de négocier des changements au programme pédagogique dans les deux facultés.

Au minimum, les facultés des sciences de la santé, de la médecine et des sciences infirmières devraient travailler à élaborer un nouveau modèle pour exposer le plus possible les étudiants à la collaboration

interdisciplinaire en milieux cliniques. Ce modèle permettrait l'enseignement des principes de la pratique interdisciplinaire en collaboration aux étudiants en sciences infirmières, aux aspirants infirmiers praticiens, aux étudiants en médecine et aux résidents en médecine familiale. Les étudiants dans ces disciplines devraient acquérir l'expérience de la théorie et de la pratique de modèles interdisciplinaires efficaces en collaboration dans les soins primaires. En retour, cette expérience devrait favoriser le développement d'une prestation harmonieuse des soins primaires.

CONCLUSION

Il faut accorder la priorité, dans l'ordre du jour provincial en matière de santé, à une réforme des soins de santé primaires qui met l'accent sur la pratique interdisciplinaire en collaboration. Les étudiants et étudiantes en sciences infirmières, les aspirants infirmiers praticiens, les étudiants en médecine et les résidents en médecine familiale devraient recevoir une formation en pratique interdisciplinaire en collaboration dans les soins primaires. Entre-temps, les directeurs de département de médecine familiale de l'Ontario et le Council of Ontario University Programs in Nursing ont amorcé l'identification des obstacles à une collaboration interdisciplinaire sur le plan de la formation et à chercher des approches visant à favoriser la collaboration et à créer une philosophie interdisciplinaire au niveau de l'éducation.

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