“Playing on Shifting Sand”: Reflections on the Impact of Political Shifts on Community Action and Public Health

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This issue of the journal includes a report from the Community Action and Public Health Study (CAPHS).¹ The CAPHS provides an opportunity to reflect upon how politics at different levels of government can affect public health practice and research. Beginning as action research in 1991 and ending with qualitative case studies in 1998,²⁻⁴ the study was inextricably linked to the context of data collection⁵ which included political upheavals and changes to public health funding. In this commentary, we draw upon previously unpublished data to discuss links among politics, practice and research in public health.

The CAPHS was initiated because, while numerous policy documents underscore the potential contribution of community strategies on the determinants of health,⁶⁻¹⁰ few explicitly acknowledge the role of public health. Accordingly, there is little systematic analysis of community action in public health practice.

During the late 1980s and early 1990s, the spirit of collaboration and community development was expanding in public health units, other health, education and social services, and NGOs. In 1989 Ontario introduced the Mandatory Program and Services Guidelines (MPSG)¹¹ to help shape the core business, organization and practice of local health units. The Guidelines discouraged individual case management, accentuating the social determinants of health, working with local communities,¹¹ and accelerating discussions of community development and partnerships within public health. In addition, the left-leaning New Democratic Party formed the government from 1990 until 1995. During that time, community partnerships were strongly encouraged, most notably by the Premier's Councils,^{12,13} especially the Premier's Council on Health, Well-being, and Social Justice.^{14,15} Within this context, the CAPHS explored public health's role in community action, finding tensions around the “legitimacy” of such work;¹⁶⁻¹⁸ however, political events shifted the atmosphere within health units, such that broader questions of legitimacy emerged – questions about the core mandate of public health itself.

The provincial government had shifted to the right with the mid-1995 election of the Progressive Conservatives. The new government introduced a broad business-oriented, government-shrinking agenda which emphasized fiscal responsibility and accountability across health and social services.¹⁹ Following the election, the government's stance towards grassroots commu-

nity partnerships to achieve social equity in health shifted: Premier's Councils were disbanded, the provincial (and federal) Health Promotion offices lost their prominence, funding of public health was declared fully “downloaded” to local governments, and Ministry of Health officials sought research that informed questions that they posed directly.²⁰ In the wake of these changes, the CAPHS supporting organization – the North York Community Health Promotion Research Unit – lost its funding. The study itself, however, had secured NHRDP funding and in-kind support from the University of Toronto and the North York Public Health Department, enabling completion of data collection and maintenance of an advisory group of public health colleagues.

In addition, early in 1997 (midway through CAPHS data collection), the Ontario government announced that some health units would amalgamate, prompting research interview discussions of the implications of downloaded funding and amalgamation for community action and public health. Uncertainty and anxiety pervaded these issues; as one manager said, “These days everybody's playing on shifting sand... you keep trying to move forward but...people...don't know if they're going to have a job.” By late 1997, there was some sense of diminished legitimacy for community action work, translating into a diminished legitimacy for its related research – a sense that health promotion and community action had become “bygone” issues.

These events coloured, first, public health professionals' understandings of the role of public health and political support

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This research was funded by the National Health Research Development Program of Health Canada. It was also supported by the North York Community Health Promotion Research Unit, funded by the Health Systems Linked Research Grants program of the Ontario Ministry of Health, the North York Public Health Department, and the University of Toronto. The supporting organizations are not responsible for the content or opinions expressed in this article.

for community action, and second, the salience of the research.

Although a handful of public health interviewees predicted strong local political support for public health, the vast majority were pessimistic about the value local politicians would place on their work, especially in community action. A key problem was seen as the “invisibility” of impacts, especially where equitable partnerships are emphasized. Across sites, interviewees characterized local politicians as prioritizing tangible issues such as “roads and sewage”. Interviewees worried that community projects would lose resources, that their own experience and expertise would be devalued and wasted, and only “traditional” services (e.g., immunization) would remain publicly funded, with some services (e.g., inspections) becoming privatized.

Public health interviewees worried not only about local futures, but also about the survival of public health as an entity, the standards of public health practice, and the societal impact. Said one MOH,

“Public health funding going ...municipal... is pretty depressing...If you see programs’ or health units’ funding... cut here and there, we’re going to have such a [province-wide] patchwork of public health programs...the rich will get richer and the poor will get poorer and the gap between the bottom and the top will grow.”

Many public health professionals expressed strong commitment to community action, yet deep concern about the indifference of local municipalities, coupled with fear of central governing power. Many interviewees perceived that the provincial government’s health agenda is shaped by the philosophy and politics of the governing party. Thus the party’s agenda, as reflected in provincial policy, may shape public health practice locally. However, previously published CAPHS analysis of local policy implementation suggests that leeway is accorded individual staff members consistent with local management’s vision of public health’s appropriate relationship with its community.¹⁸

The CAPHS also highlights how research is susceptible to political forces. An iterative exchange often occurs between

theory, research and practice, especially within action research. This exchange was sharpened during the 1990s with the expansion both of collaborative research approaches and health promotion strategies that focussed on the social determinants of health, as exemplified by the CAPHS. The CAPHS advisory partners were interested in understanding their local practice. The collaboration began by designing and eventually implementing research that documented qualitative understandings of community action within a context of provincial political support for local community development. Several years later, in light of events and trends described above, several advisory partners had sharpened their interest in more formal assessments of the relative merits of community development, and related “best practices”. In other words, their motivation for participating had shifted over time from ‘what’ and ‘how’ to a skeptical ‘why’. In this sense, while the study did yield rich data on relationships among professionals and their communities, its salience for local partners was less compelling.

These events led to consideration of underlying issues and strategies for public health research and practice.

1. In the face of political non-support for community action, public health can revert to traditional activities (e.g., immunization, inspections) that require neither new research nor garnering ongoing public support. Such narrowly defined activities are also easily privatized, raising questions of accountability and mandate. Recent water quality crises in Ontario have been linked to privatization of inspections, renewing community and policy interest in public health’s role in environmental issues in the context of the political agenda of privatization.
2. Practitioners might adopt evidence-based practice to demonstrate value, i.e., reliance on positivist science to build “evidence” difficult for elected policy makers to deny as valuable (and worth funding). However, this assumes that policy is decided on rational arguments, rather than the converse process of developing rational arguments to justify and legitimize policy; evidence suggests the latter to be often the case.²¹

3. In order to secure local government support, CAPHS interviewees in several sites suggested that local health units may rely on the political leverage of grassroots groups, benefiting from good long-term community relationships. This approach, however, underscores a contradiction expressed by interviewees across sites: community action may be most successful when community ownership minimizes recognition of public health’s contribution.¹

4. In order to build a broader organizational base of support in the face of political opposition, alliances and collaboration with other health and social services may expand the profile of public health and the scope of practice. A current example might be the OPHA/Children’s Aid Society’s joint training initiative in the Ontario Better Babies, Better Children program.

5. From the research perspective, the inevitable time gap between research proposal and data analysis can be problematic for research that seeks to inform community action. While the intellectual process of peer review is essential, the tenuous nature of funding research through organizations that are themselves subject to political decision-making bears some examination.

These observations speak to challenges that reflect deeper philosophical differences between, on the one hand, a public health world view that stresses social justice predicated on community-based collective action addressing the broad determinants of health, and on the other hand, emphasis on economic competitiveness and trickle-down of social benefits consonant with the decline of the welfare state. These differences are unlikely to be bridged by strategies of “evidence” or “profile”. In light of political influences on public health, it is timely for public health professionals to consider political strategies to address such influences in the future.

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RESPONSE TO FISCHER & REHM COMMENTARY

Tobacco Industry Litigation and the Role of Government: A Public Health Perspective

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We welcome this opportunity to comment on issues raised by our colleagues on the role of government in tobacco industry litigation. Fischer and Rehm (pp. 7-8, January/February 2001 issue) argue that it is hypocritical and may be inappropriate for the state to initiate litigation against the tobacco industry. We propose a different 'tobacco logic': starting to smoke is rarely the rational act of informed adults, tobacco is not comparable to other consumer products, the government does not profit from tobacco, and litigation is a key component of a comprehensive tobacco control strategy.

Tobacco is a highly addictive drug, which most smokers begin to use as children or adolescents.¹ Most beginners believe they will not become addicted, yet many quickly do,^{2,3} and most who continue to smoke as adults are addicted. While we agree that the public is much better informed than it used to be about the dan-

gers of smoking, we do not believe that most beginners are well informed about their own susceptibility to addiction.

No other consumer product (including vehicles, and certainly skis) kills half its long-term users, when used exactly as intended by the manufacturer. Just as industrial polluters are held responsible for the environmental damage they cause, tobacco manufacturers should be held responsible for the societal damage they knowingly cause, as manifested by at least 34,000 deaths, 194,000 hospital admissions, and \$2.68 billion in health care costs annually in Canada.^{4,5}

The misperception persists that governments profit from tobacco. In fact, conservative estimates of health costs are at least double provincial government tax revenues for tobacco.⁶

Litigation can be viewed as one reinforcing component of a comprehensive strate-

gy to control tobacco use that could provide a number of benefits to public health.⁶ Successful litigation would likely lead to price increases by the industry to cover costs, ultimately resulting in reduced smoking and health care costs. Litigation is a public health measure that, like water treatment, is not generally practicable at the individual level.

Tobacco litigation also helps to denormalize the tobacco industry and its products, a key element (along with prevention, protection, and cessation) in Canada's National Tobacco Strategy. One of the major benefits of litigation in the United States has been the release of industry documents. Through the discovery process, we have learned about industry efforts to mislead the public, suppress research, and target youth and potential quitters.

Although the federal government and several provincial health ministries have made significant advances in tobacco control – including bans on advertising and promotion, protection from second-hand smoke, and graphic health warnings – we agree with Fischer and Rehm that other actions by government are not only warranted, but are urgently needed. The most critical of these, tax increases, can only be undertaken by government. The tax increases that were implemented in the 1980s resulted in a substantial decrease in the prevalence and level of smoking, particularly among youth. The illegal activities

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