

BUILDING CAPACITY FOR HEALTH PROMOTION
IN MANITOBA'S REGIONAL HEALTH AUTHORITIES

BY

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A Thesis Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the degree of

DOCTOR OF PHILOSOPHY

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Winnipeg, Manitoba

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ABSTRACT

TITLE: "BUILDING CAPACITY FOR HEALTH PROMOTION IN MANITOBA'S REGIONAL HEALTH AUTHORITIES"

In the late 1990s, Manitoba implemented a 'Health Reform' initiative that involved (a) the devolution of decision-making for the planning and delivery of health services to Regional Health Authorities (RHAs), and (b) the adoption of a 'population health' approach to health planning and action. Manitoba Health proposed that a change in thinking was required, in order to shift from a health care system that is focused on health services and short-term action dealing with sick individuals to a health care system that would focus on health and the determinants of health, and on long-term investment in health promotion (HP) aimed at groups and populations. This raised the following fundamental question, which motivated this doctoral research study: What is the *capacity* of RHAs to transform this broad vision for population health promotion in Manitoba into reality? An exploratory, descriptive study design was developed to explore the discourse, both in the literature and in Manitoba RHAs, regarding (i) the concept of 'population health' and its integration into program planning and action; (ii) the nature of HP policy/practice within the Public Health sector; and (iv) the impact of health system regionalization on capacity for HP in the Public Health sector. A key finding of the study was the gap between the vision of 'population health' and health promotion found in the theoretical and policy literature and the discourse on 'population health' and health promotion in the RHAs. In particular, multiple barriers to health promotion action were identified in all regions. The characteristics of an RHA that is rich in capacity for health promotion are identified, a conceptual model for understanding capacity for health promotion is presented, and recommendations for building health promotion capacity in the Public Health sector in Manitoba are discussed.

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CHAPTER ONE: INTRODUCTION AND METHODOLOGY

PART I - BACKGROUND

1.1 - Motivation for the Study

The 1990s was a decade characterized by significant changes in the organization and delivery of health services throughout Canada. In the province of Manitoba, health system restructuring— or ‘Health Reform,’ as it is commonly referred to— included the devolution of decision-making authority for the full continuum of health services (excluding physician and pharmaceutical services) to Regional Health Authorities (RHAs). In its *Action Plan* (Manitoba Health, 1992), the Manitoba government outlined a number of goals for Health Reform, including: reduction of inequalities in population health status; establishment of public policy that promotes health; and fostering of environments that promote health. In a later Manitoba Health document (Manitoba Health, 1997), these goals were reiterated, and a framework was outlined which emphasizes the need to incorporate a ‘population health’ approach into health planning and action at the regional level— an approach which focuses on the economic, social, and environmental factors that enhance the health and well-being of groups or populations. The document identified inter-sectoral collaboration and advocacy for healthy public policies as key strategies required to promote population health and well-being.

It is interesting to note that the stated goals and objectives of Manitoba’s Health Reform initiative coincide with the strategies for health promotion outlined in the

Canadian Public Health Association's (CPHA) *Action Statement for Health Promotion* (Canadian Public Health Association, 1996a). That document was the product of a two-year consultation process involving more than 1000 people from a variety of sectors—including, health, social services, education, recreation, environment, and law enforcement—who work (and volunteer) to promote health in their communities across Canada. The purpose of the *Action Statement* was to provide strategic direction to those involved in health promotion, and it identifies several priority areas for action. Two of these priority areas—advocacy for 'healthy public policy' and strengthening community capacity for health—focus directly on strategies for acting on the determinants of population health at various levels of government, including the RHA. The third priority area for action—reforming the health system—includes the need to develop and maintain appropriate infrastructure support for health promotion within the health system and to assign dedicated resources to the promotion of health. The *Action Statement* puts forth the following challenge:

Governments at all levels, non-governmental and voluntary organizations, private sector organizations, community groups and individuals all have key roles in transforming this statement from words into action...*It is essential that each and all of the key players take a leadership or partnership role in the particular actions that best fit with their mandate, interest, ability, obligations and sphere of influence* (p.3, emphasis added).

Clearly, Manitoba's RHAs are 'key players' with a potential role to play in the promotion of population health, but what should that role be exactly? What are the particular actions that best fit with their mandate, interest, ability, obligations and sphere of influence? Perhaps most important of all, what is the *capacity* of the health system for

the task of population health promotion itself. If 'Health Reform' in Manitoba is to be successful in achieving the goals outlined above, and to create a health system that is truly focused on the *health* of the population, then we need to start by examining the capacity for change now— at the outset of the process— and then building that capacity wherever possible.

1.2 - Research Objectives

In the broadest sense, the objective of this research was to investigate the issue of organizational capacity for health promotion in the Public Health sector in Manitoba, particularly within the context of a regionalized health system based on a population health approach to planning and action. The study was *not* intended to be a cross-sectional *evaluation* of health promotion capacity in the RHAs, but rather, it was intended to document the *discourse* on organizational capacity for health promotion— both in the literature and among key stakeholders within the RHAs during the data collection period. It was hoped that, by identifying the dimensions of organizational capacity for health promotion, it might be possible eventually to develop process indicators that RHAs could use to assess their health promotion capacity over time. More specifically, I wanted to explore these three questions:

1. What is the discourse on 'population health' (in the literature and in the RHAs), and how are Manitoba RHAs incorporating population health principles into health system planning and action?
2. What is the discourse on the nature of health promotion policy and practice in the Public Health sector (in the literature and in the RHAs)— including any barriers to

HP capacity that the RHAs might be experiencing, and any tools that they might be using to build health promotion capacity?

3. What is the discourse (in the literature and in the RHAs)– on the process of regionalization and how it impacts on organizational capacity for health promotion in the Public Health sector?

1.3 - Clarification of Concepts

One of the first challenges that one faces when attempting to explore this subject is the wide variety of interpretations of its central concepts, such as ‘public health,’ ‘population health,’ and ‘health promotion.’ A brief discussion of how these concepts will be used throughout the dissertation follows.

1.3.1 - ‘Public Health’ and ‘Population Health’

It is quite common to see these two terms used interchangeably in the literature as a generic reference to ‘the health of the public or population.’ However, this can cause some confusion, since both of these terms are also used in other ways. For example, it has been noted that, aside from the generic use of the term referred to above, ‘public health’ is also used to refer more specifically to (a) a system and social enterprise, (b) a profession, (c) research methods and techniques, and (d) those activities/services ascribed to government-funded rather than privately- funded health services agencies (Turnock, 2001). In this dissertation the term, ‘Public Health,’ will be used in its broadest sense to signify a system and a social enterprise. The Public Health system, or sector, incorporates (i) a comprehensive approach encompassing health promotion, disease prevention, health

protection, and healthy public policy; (ii) a range of services, programs, and strategies¹, (iii) the skills and knowledge of a multidisciplinary group of practitioners², and (iv) links with individuals, communities, the broader health system, and other health-determining sectors (Canadian Public Health Association, 1996b). The social enterprise of Public Health relates to its mission of “fulfilling society’s interest in assuring the conditions in which people can be healthy” (Institute of Medicine, 1988, p.7). When used in either or those two contexts the term, ‘Public Health,’ will be capitalized in order to distinguish it from the more generic (‘health of the public’) meaning.

In a similar manner, while ‘population health’ is often used in the generic sense (‘health of the population’), this term has also become associated with a specific conceptual framework and approach to health system research, planning, and delivery of

¹According to the Canadian Public Health Association (1996b), the range of services, programs and strategies provided by Public Health includes: administration and planning, advocacy, addiction services, child health, communicable disease control, community hygiene, community mental health, community organization and mobilization, dental health, epidemiological and social analysis and research, evaluation, family planning, food protection, health education, health inspection, health standards, home care, laboratory services (public health), medical care, nutritional advice, occupational health and safety, poison control, preventive field services, primary care, program development, therapies and rehabilitation.

²According to the Canadian Public Health Association (1996b), Public Health incorporates the skills and knowledge of a multidisciplinary group of practitioners including: addiction counsellors, child care workers, community developers, community health representatives, dental health practitioners, economists, epidemiologists, health educators, health promoters, health service administrators, home care workers, mental health practitioners, microbiologists, midwives, nurses (public/ community), nutritionists, occupational health and safety practitioners, ophthalmologists, optometrists, pharmacists, physicians (family, infectious diseases, medical officers of health, etc.), planners, public health inspectors, rehabilitation and therapy (occupational, speech, physical) practitioners, social and medical researchers, social marketers, volunteer coordinators, and others.

services (which will be discussed in more detail in Chapter Three). When referring to a specific framework or approach the term will be capitalized. When referring to a more general population health perspective or the health of the population, capitals will not be used.

1.3.2 - Health Promotion: 'New' vs. 'Old' Paradigms

A discussion of the concept of 'health promotion' (HP) could form the basis of an entire dissertation. Suffice it to say here that use of the term is problematic because it has so many different interpretations. Just as in the case of 'public health,' HP is subject to both generic and more specific usages. Indeed, Maben & MacLeod Clark (1995) identify six different ways in which the concept of 'health promotion' is referred to in the literature: (i) health promotion as an umbrella term for any activity designed to foster health; (ii) health promotion used synonymously and interchangeably with health education; (iii) health promotion as lifestyle behaviour change; (iv) health promotion as the marketing or selling of health; (v) health promotion as 'health education plus' (the 'plus' referring to measures that create social and environmental change; and (vi) health promotion as an approach which encompasses a set of values. The authors suggest that the first four attributes of the concept examined in the literature are in line with the 'traditional' approach to the concept of HP, whereas the latter two attributes are more in line with the 'new paradigm' approach to HP. A brief overview of the 'old' or 'traditional' versus 'new paradigm' approaches to HP may be helpful.

Until the end of the 1970s, the main non-medical strategy for the promotion of health was health education. The concept of 'health promotion' was developed when it

became apparent that health education in isolation from other measures would not necessarily result in the radical changes required to achieve a new era of improved health (Parish, 1995). The 'new paradigm' approach to HP– which is also referred to as the 'new health promotion' and the 'new Public Health'– was articulated in the World Health Organization's (WHO) document, *Health Promotion: A Discussion Document on the Concept and Principles* (World Health Organization, 1984). This document outlined five basic principles of 'health promotion' which distinguished it from earlier conceptions of promoting health:

1. Health promotion involves the population as a whole and the context of their everyday life, rather than focusing on people at risk for specific diseases.
2. Health promotion is directed towards action on the determinants or causes of health.
3. Health promotion combines diverse, but complimentary, methods or approaches.
4. Health promotion aims particularly at effective and concrete public participation.
5. Health professionals, particularly in primary health care, have an important role in nurturing and enabling health promotion (p.3) .

The 'new paradigm' conceptualization of 'health promotion' was further developed and articulated in the *Ottawa Charter for Health Promotion* (World Health Organization, 1986). In this document, 'health promotion' was defined as "the process of enabling people to increase control over, and to improve, their health" (p.5). In other words, health promotion is not viewed as a set of activities or programs to be delivered; rather, it is viewed as a process of empowerment. The *Ottawa Charter* identifies a number of pre-requisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity– i.e., social and environmental

determinants of health, rather than behavioural ones. In fact, a central feature of the *Ottawa Charter* perspective is that the primary focus of health promotion is on achieving equity in health. Five key health promotion action strategies were outlined in the *Ottawa Charter*: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and re-orienting health services. Clearly, from this perspective, health promotion goes beyond education for individual behaviour change to include measures for social and environmental change, plus it is an approach that is *not* value-neutral.

More than fifteen years have passed since the 'new' health promotion, or 'new Public Health,' paradigm was first articulated and it seems inappropriate to be using the term 'new' after this amount of time has elapsed. In the early 1990s, Labonte (1993) provided a useful alternative when he outlined a 'socioenvironmental' approach to health enhancement— an approach which clearly is based on the 'new paradigm' perspective outlined in the *Ottawa Charter*. From a socioenvironmental perspective, psychosocial risk factors and socioenvironmental risk conditions are the main determinants of health (as opposed to behavioural or lifestyle factors), health promotion strategies involve a continuum of empowerment strategies ranging from a focus on individual empowerment to political action, and the goal of socioeconomic and political equity, or 'social justice,' is considered to be at the heart of health promotion activity. In this dissertation, the conceptualization of HP used in the analysis most closely fits the 'new paradigm' and 'socioenvironmental' approaches to HP described above. However, it is not clear that this conceptualization of HP is shared by those within the formal health system (at either

the national, provincial, or regional levels). This is a question that will be explored further in this study.

The description above of the key elements of a socioenvironmental perspective on population health enhancement suggests that it is a mammoth enterprise that needs to take place at various levels within, and across, multiple government and non-governmental sectors of society. It is beyond the scope of this study to explore the issue of building capacity for HP within society as a whole. In this dissertation, the focus will be on the task of building capacity for HP within the formal government-subsidized Public Health sector specifically.

1.3.3 - Health Promotion vs. Population Health Promotion

It has been noted that two of the central distinguishing characteristics of the socioenvironmental approach to health enhancement are its focus on populations within the context of their everyday lives rather than individuals at risk for disease, and its direction towards action on the broad determinants of population health rather than focussing solely on changing individual behaviours. As a result, it would probably be more accurate to use the term, 'population health promotion (PHP),' in order to distinguish this approach from the more traditional forms of health promotion. However, as mentioned above, it is not clear to what extent this conceptualization of health promotion is shared by individuals within the formal Public Health sector and so, in general, the term health promotion is utilized throughout the dissertation. In this dissertation, the term, 'population health promotion,' is used most frequently in the generic sense to refer to promotion of population health. It is also used to refer to a

specific framework, the Population Health Promotion Model (PHPM) (see Chapter Three for further discussion).

1.3.4 - Health Promotion vs. Disease Prevention

Since the late 1980s, there has been some debate about the relationship between the concepts of 'health promotion' and 'prevention of illness.' The dominant perspective within the health promotion movement, articulated most clearly by Stachtchenko & Jenicek (1990), is that these two concepts are mutually exclusive. This perspective is an understandable response to the traditional (and still prevalent) narrow view of 'health' as the absence of disease and 'health promotion' as synonymous with educating individuals to change their behaviours in order to reduce the risks of disease. However, it is not necessarily the most useful perspective. While it is true that 'health' may have nothing to do with the absence of disease or disability— e.g., a person diagnosed with cancer can still feel 'healthy' because she is surrounded by the people and things that make her happy— it is also true that the absence of disease or disability may be an essential factor in the sense of well-being of an individual or a community (think about Walkerton, Ontario³). Rather than viewing the two concepts as mutually exclusive, it is suggested that prevention of disease and disability be viewed as simply one element of the broader initiative of health promotion. While it might initially appear that this is inconsistent with a socioenvironmental perspective of HP, it is argued that this is not at all the case. The important point is that, from a socioenvironmental perspective, the focus of disease

³Walkerton is a small town northwest of Toronto, Ontario where contamination of the town's drinking water with E.Coli 0157:H7 in May of 2000 killed seven people and made hundreds ill.

prevention is not solely on changing individual risk behaviours or lifestyle; rather, it is on changing the broader social and environmental conditions that contribute to disease/disability in the first place.

PART II - METHODOLOGY

Qualitative methods are appropriate when the research questions pertain to understanding or describing a particular phenomenon about which little is known from the emic perspective— i.e., from the point of view of those who are experiencing the phenomenon (Field & Morse, 1985). Qualitative studies may be exploratory, descriptive, explanatory, or predictive in nature, depending on the research questions that are being asked (Marshall & Rossman, 1989). The purpose of exploratory studies is to investigate little understood phenomena, to identify/discover important variables, and to generate hypotheses for further research, while the purpose of descriptive studies is to document the phenomenon of interest. Therefore, in keeping with the intention of documenting the perceptions of key players regarding a process about which little is known— i.e., the process of building capacity for health promotion in Manitoba's regional health authorities— a descriptive, exploratory study design was used. Within this design, three major research strategies were utilized: (i) a review of the literature; (ii) field work involving key informant interviews and document analysis; and (iii) a focussed group consultation, referred to as a 'Think Tank.' Although the first two processes often occurred simultaneously, they will be discussed separately here.

1.4 - The Literature as Data

In the traditional approach to scientific inquiry the literature is reviewed prior to

data collection in order to determine what is already known about the particular topic under investigation, including preexisting theoretical explanations for the phenomenon. The research design is then based on testing or verifying the preestablished theory. In contrast, there are forms of inquiry that are aimed at generating theory, rather than testing pre-existing theory. For example, grounded theory is a qualitative approach based on a 'discovery model' of theory development and one of its unique features is that the literature is used to assist with the discovery process— that is to say, the literature review is an ongoing process that is conducted to fulfill the needs of the analysis, and the literature itself is conceived of as data in the form of written documents (Chenitz, 1986). Although this study is not based on a classic grounded theory model— that is, it's main purpose is exploratory, not to generate new theory— it does adopt the grounded theory approach to the literature.

Prior to initiating the field work phase of the study, an initial review of the literature was done in the following areas: (i) the process of health system restructuring in Canada and its implications for health promotion in the Public Health system; (ii) building capacity for population health promotion; and (iii) the role of Public Health practitioners in population health promotion. This initial review guided the development of the field work phase of the study. During the analysis of data gathered during the field work phase of the study, the above-mentioned literature was revisited and re-analyzed, and the review of the literature was expanded to explore issues that were raised during the field work. Several subsequent chapters of the dissertation consist of a comparison of what was found in the literature with the information that was obtained from interviews

with key informants and an analysis of key documents (both of which are described below).

1.5 - Field Work

The field work component of the research design consisted of two distinct data collection and analysis phases. Each one will be described separately.

1.5.1 - Phase One: Field Work in RHAs

The first phase focused on the experience of three RHAs in Manitoba. These RHAs were chosen to reflect the diversity of the province's regions (excluding Winnipeg⁴), both geographically and demographically (i.e., northern, primarily resource-based region vs. southern, primarily agricultural region; urban vs. rural; sizeable aboriginal population versus primarily non-aboriginal population). Another reason for selecting three distinct RHAs was to determine which factors influencing capacity for HP were shared by all three regions (in spite of their very different contexts), and which factors were unique to each area. The study design is discussed in more detail in the following sections.

1.5.1.1 - Pre-Data Collection Phase: Informal Feasibility Study

The process of accessing study sites was initiated through an informal feasibility study. Letters were sent to the Chief Executive Officers (CEOs) of the selected RHAs,

⁴ At the time that data collection was initiated, the City of Winnipeg had adopted a different health system regionalization model than the rest of Manitoba's RHAs— i.e., Winnipeg had separate Health Authorities for Hospital and Community services, as opposed to the integrated model that had been adopted by the rest of Manitoba RHAs. During the data collection phase, the separate Health Authorities were integrated into one Winnipeg Regional Health Authority.

outlining the proposed research, and requesting their feedback regarding the value of the research and their interest in participation in the study. The letters were followed up by a telephone call to the CEOs (or other designated authorities), at which time various aspects of the tentative plan for the research project were discussed. All three of the officials in the selected RHAs indicated that they were interested in the proposed project and tentatively agreed to participate. They asked to see a more formal proposal once it was approved by the dissertation committee, at which time they confirmed their participation.

1.5.1.2 - Data Collection Method - I: Interviews

According to Patton (1990), the purpose of interviewing is to allow us to enter into another person's perspective—the assumption being that this perspective is meaningful, knowable, and able to be made explicit. One of the ways to increase the likelihood that these perspectives are indeed meaningful, knowable, and able to be made explicit is to focus the interview on those individuals who are most likely to have specific knowledge of the phenomenon under study—often referred to as 'key informants' (Polit & Hungler, 1991). The selection of key informants was carried out using a 'purposive' or 'selective' sampling strategy, which involves sampling those people (or documents or events) who will provide "the *greatest opportunity* to gather the *most relevant data* about the phenomenon under investigation" (Strauss & Corbin, 1990, p.181, original emphasis). This type of sampling involves a calculated decision to sample a specific locale or type of interviewee according to a preconceived initial set of dimensions (Strauss, 1987). Representation of similar experiences or knowledge, rather than representation of a demographic sampling of the general population, is the primary

consideration of participant recruitment (Morse, 1994). In this study, the following groups of key informants were identified in each of the RHAs as being the most likely to provide relevant information regarding thinking, policies, structures, and practices related to population health promotion — (i) Senior Administrators (CEOs, Vice-Presidents of Community Health Services or other relevant individuals); (ii) Managers of Public Health/Community Health Programs; (iii) Community/Public Health Nurses; (iv) at least one representative of the RHA Board of Directors and each of the District Health Advisory Committees (where established); and (v) other Public Health practitioners (e.g., Health Promoter/Educator, Community Nutritionist).

A standardized open-ended interview approach was selected. This type of interview consists of a set of questions carefully worded and arranged with the intention of taking each respondent through the same sequence and asking each respondent the same questions with essentially the same words. Any clarifications, elaborations, or probing questions are written into the interview itself (Patton, 1990). Advantages of using standardized open-ended interviews include: (i) the ability to minimize the potential interviewer effects of asking questions on a single topic in different ways with different people, including the problem of obtaining more comprehensive data from certain persons while getting less systematic information from others; and (ii) the facilitation of data analysis because of the ability to compare answers to specific questions among various respondents. Disadvantages of the standardized open-ended interview include: (i) that, in theory, it does not permit the interviewer to pursue topics or issues that were not anticipated when the interview guide was written, and (ii) that constraints are placed on

the use of different lines of questioning with different people based on their unique experiences (Patton, 1990). However, Patton argues that it *is* possible to use this approach and still retain some flexibility:

Thus, a number of basic questions may be worded precisely in a predetermined fashion, while permitting the interviewer more flexibility in probing and more decision-making flexibility in determining when it is appropriate to explore certain subjects in greater depth....It is even possible to adopt a standardized open-ended interview format in the early part of an interview and then leave the interviewer free to pursue any subjects of interest during the latter parts of the interview (p.204).

Patton's flexible approach to standardized open-ended interviewing was utilized in this study. The interview guides contained predetermined questions (including possible probing questions), but the interviewer retained the flexibility to explore certain subjects in greater depth where the situation arose at the end of the interview. In order to deal with the constraints placed on the use of different lines of questioning with different people based on their unique experiences— one of the main disadvantages of a standardized approach— separate interview guides were developed for each different *type* of key informant (e.g., administrators and board members versus Public Health program managers versus frontline practitioners). This allowed for some variation in questions among different types of key informants that better reflect the experience of each of these groups, but maintained some consistency of questioning within each of these categories (see Appendices B-H for copies of the different interview guides).

Some research suggests that if respondents are contacted by letter prior to a formal interview, more complete information can usually be obtained (Rogers, 1989). A letter was sent to potential participants in each RHA, inviting their participation and including a

list of topics for discussion. By obtaining the interview topics in advance, potential participants had some time to think about the complex issues involved, which maximized the quality of information obtained at the time of the interview. It was felt that this advantage outweighed any disadvantages of such a procedure (e.g., participants talking with each other about the topics before the interview). Before commencing the interview, participants were asked if they agreed to the terms of participation in the study that are outlined in the disclaimer form (see Appendix A), which was sent ahead of time to individuals who agreed to participate in an interview. With the participants' permission, all interviews were tape-recorded.

The specific access protocol for each group of participants is described below.

(i) Interviews with Public Health/Community Health Program Managers

While these positions vary from region to region, each RHA has the equivalent to an overall Director of Community Programs, and then one or more managers of specific programs (e.g., Public Health Nursing, Mental Health). These individuals were specifically chosen in order to obtain the perspective of those persons in positions of decision-making authority in matters related to Public/Community Health program funding, planning, and/or service delivery. A list of the names of the individuals in these positions was obtained through the regional office. A letter of invitation was sent directly to these individuals, indicating that they would be contacted by telephone within seven days in order to determine their interest in participating in an interview.

The interview for these key informants was structured as follows (see Appendix B): First, key informants were asked some general questions about a 'population health

perspective,' including their interpretation of the term. Next, for each of the priority areas for HP action identified in the CPHA's (1996a) *Action Statement*, key informants were asked (i) to indicate whether there had been discussion within the RHA about this particular issue, or to discuss the potential role of the RHA in engaging in such a strategy; (ii) to identify the factors that may be hindering the RHA's capacity to take action in this area of HP; and (iii) to identify the three most influential factors that could facilitate action in this area of HP.

To assist participants in identification of factors that were influencing the process, they were asked to think about the potential factors in terms of the following two categories: (i) Factors that are *external to the RHA* at the levels of (a) the community or municipality; (b) the province; (c) the federal government; and (ii) Factors that are *internal to the RHA* at the levels of (a) the organization, and (b) the individual employees. They were also asked for their opinions regarding the short-term and long-term implications of health system regionalization and integration for the organization and delivery of Public Health programs.

(ii) Interviews with Community/Public Health Nurses (C/PHNs)⁵

Community health nurses— especially Public health nurses – are the largest group of front-line practitioners and have been identified as being strategically poised to play an important role in population-based health promotion efforts (Halbert et al., 1993).

⁵The majority of community health nurses working in the RHAs function within the public health nursing (PHN) role. In one of the RHAs, there was a separate group of nurses working out of a community health centre. These nurses were referred to as Community Health Nurses (CHNs). The term, C/PHN is used to refer to community health nurses as a group.

Participants were recruited in each of the selected RHAs through a mailed letter of invitation, which was distributed to C/PHNs at their workplaces (with permission from the employer). The letter invited participation in a face-to-face interview and outlined some of the topics for discussion in the interview. It included a detachable form that the potential interviewee was asked to fill out, detach, and return in an enclosed, self-addressed, stamped envelope within seven working days (indicating interest in participation and best time to reach him/her). A follow-up letter was sent out to all potential interviewees fifteen working days after the first mail-out, reminding those who had not returned their form to do so (and asking those who had already done so to disregard this notice). In the interview (see Appendix C), C/PHNs are also asked to discuss the concept of a 'population health perspective,' but the questions are more detailed than those for the other key informants and they focus on the implications of such a perspective on nursing practice. C/PHNs are asked questions about the use of various HP strategies in nursing practice, whether or not there is a need for staff education around these strategies, and if there are any specific tools or strategies currently being utilized or that might be considered in the future for increasing HP capacity. A separate interview guide was used for C/PHNs in supervisory positions (see Appendix D), with only minor differences in wording of questions.

(iii) Interviews with Other Public Health Professionals

While C/PHNs may be the largest group of Public Health practitioners, there are others who may provide a unique perspective on the subject— e.g., the Health Promotion/Education consultant, Community Nutritionist, recreation worker, etc.

Keeping in mind that not every RHA has these positions filled, letters of invitation were sent to these individuals where appropriate. The access protocol and interview guide were the same as for the Program Managers.

(iv) Interviews with Board members, District Health Advisory Committee members

The Chief Executive Officers (CEOs) were the gatekeepers to the RHAs. Interviews began with the CEOs, who then suggested other appropriate senior administrators. Due to the difficulty in arranging interviews with these senior administrators, and the limited time that they had available, the interview guides were shortened to focus on discussion about the concepts of 'population health' and the 'determinants of health' within the RHA, perceived barriers to increasing capacity for health promotion, and perceived advantages/disadvantages of health system regionalization (see Appendix E).

It was also important to obtain the perspective of citizens who are involved in governance and advisory positions in relation to the RHA. At least one representative from the Board of Directors, most likely the Chairperson, and one representative from each of the District Advisory Committees (DACs) in the region (where applicable) were invited to participate in the study. The same interview guide that was used for the Senior Administrators was used for Board members. The interview guide for the DAC representative(s) was more limited, focusing primarily on their understanding of population health concepts and their attitudes regarding health promotion and illness prevention (see Appendix F).

Summary of interviews completed in Phase One

From September, 1999, until February, 2000, a total of sixty face-to-face interviews and one telephone interview were conducted in the three study sites. The breakdown in each region was as follows:

TYPE OF INFORMANT	REG. 'A'	REG. 'B'	REG. 'C'	TOTAL
Senior Administrator (e.g., CEO, V-P)	3	2	2	7
DHAC Member ¹	3	---	---	3
Board Member	1	1	2	4
Public/Community Health Program Manager ²	4	2	5	11
C/PHN ³	7	5	8 (PHN) 4 (CHN)	24
Non-Nursing Public Health Service Providers	2	5	5	12
TOTAL⁴	20	15	26	61

¹Region B did not have a DHAC. Region C did have several DHACs established, at least officially, but only one of them was active at the time of the interviews. Unfortunately, lack of time and other resources prevented the researcher from being able to include a DHAC member in this area.

²Medical Officers of Health (MOH) from two of the three regions were interviewed. Although these individuals could be considered in the category of 'non-nursing Public Health service providers,' it was decided that, due to their active involvement in program planning, it was more appropriate for them to be included as Public Health Program Managers.

³In Region C, a Community Health Centre was operated by the RHA, although it was part of a provincially funded pilot project. The nurses working in this Centre had a different role than the PHNs in the RHA, and so they are distinguished from each other.

⁴This refers to the total number of interviews conducted. Fifty-nine of these interviews involved one key informant. Two interviews involved discussion with two key informants at the same time.

1.5.1.3 - Data Collection Method - II: Document Analysis

In addition to interviews, a variety of documents were analyzed in order to provide supporting information. Before interviews began, the Community Health Needs Assessment and most recent Annual Report of each participating RHA was reviewed, in order to become familiar with the context that key informants were operating within.

Permission was obtained in all three RHAs to review minutes from RHA Board meetings for any discussion of issues related to health promotion or illness prevention, as well as annual reports, organizational plans and other relevant documentation.

1.5.1.4 - Analysis of Data Collected in Phase One

In qualitative studies, data collection and analysis go hand in hand (Marshall & Rossman, 1989). Even before the transcription of interviews was completed, notes were made regarding major recurring themes that arose during interviews and areas where there were data gaps so that this information could be explored further, or substantiated, in subsequent interviews and analysis of documents. The interviews were then fully transcribed and read, in order to identify specific categories of information that could be used as a coding scheme for further analysis. Next, the transcript files were entered into *ATLAS*, a qualitative data management software program. The purpose of using such a software program was to facilitate the management of the huge volume of research material that resulted from the large number of interviews— specifically, to facilitate the coding and selecting process. Once all of the transcripts had been coded using the *ATLAS* program, they were then analyzed primarily through the use of question analysis.

Question analysis is similar to content analysis, which involves applying an objective coding scheme to interview data, except that— due to the fact that each group of participants in each phase of the study were asked the same questions— the initial sorting of the interview data into coding categories is by question number (Berg, 1998). For example, in the key informant interviews, all of the Question 1s were sorted into one category, Question 2s into another category, and so on. The investigator then read all of

the responses from each question category and conducted a content analysis of that data.

For questions exploring participants' interpretation of concepts, the analysis focused on identifying key elements or dimensions of the concept— e.g., the elements of a *population health* perspective. In addition, data was analyzed for the degree of consensus regarding interpretation of concepts among key informants *within* each RHA and among specific groups of key informants *across* RHAs. For example, do all key informants within a particular RHA have the same interpretation of the concept of a *population health* perspective? Do particular types of key informants, such as C/PHNs, in various RHAs share the same interpretation?

In those questions exploring factors that would hinder or facilitate capacity for HP, the data was sorted into pre-identified categories— i.e., factors that are external to the RHA at the levels of the community/municipality, the province, and the nation, and factors that are internal to the RHA at the levels of the organization and the individual. Data was then analyzed for identification of HP capacity domains (e.g., knowledge/skills, funding, etc.) which might serve as capacity indicators for HP. Data was also analyzed for the degree of consensus among key informants *within* each RHA and among specific groups of key informants *across* RHAs regarding factors that would facilitate/hinder capacity for HP. Participants were asked to rank the top three factors that they saw as either facilitating or hindering capacity for HP. However, the majority of interviewees were unable to rank these factors beyond identifying the most important barrier/facilitator, then identifying any others that were important. The final analysis was adjusted to reflect this phenomenon.

1.5.2 - Phase Two: Perspective of Current/Former Manitoba Health Employees

Preliminary analysis of interviews and documents in the RHAs suggested that one of the key factors influencing capacity-building for HP in the regions was the relationship between the RHAs and the provincial health department— especially the changes in dynamics in that relationship following the devolution of authority for health services to the regions. As a result, it was decided that a second phase of interviews would focus on the perspective of current and former individuals employed with Manitoba Health who might have insights into capacity- building for HP in the RHAs. Unfortunately, some of the key individuals who had been part of decision-making related to HP prior to and during the regionalization process had left the province as a result of the downsizing of the provincial health department following regionalization, while several other current employees declined to be interviewed. In the end, a small selective sample of seven individuals agreed to participate in an interview— two were current employees of Manitoba Health, three were former employees of Manitoba Health, and two were current employees of Healthy Child Manitoba (the latter two individuals were interviewed together). A modified version of the interview guide was utilized for the current/former Manitoba Health employees (see Appendices G,H). The focus was on these key informants' interpretation of concepts, the degree to which these concepts were being/had been integrated into Manitoba Health programs, and their perceptions regarding barriers to capacity- building for health promotion in the province. The employees of Healthy Child Manitoba were asked specifically to describe the history of their program and how it integrated the concepts of population health and the determinants of health. The

purpose of this interview was to clarify the relationship between this provincial government department and the provincial health department. Analysis of these six interviews followed the same process as in Phase One.

1.5.3 - Phase III: 'Think Tank'

The first round of interviews in the RHAs were conducted during the 'transition phase' to regionalized health systems when the focus of activity was on establishing the administrative infrastructure for the new RHAs. Preliminary analysis of the interview and document data collected in Phase One indicated that discussion about the RHAs' vision for building health promotion capacity was only in its very early stages at that time. As a result, it was decided to carry out a third and final phase of data collection. This phase took the form of a one-day consultation—referred to as a 'Think Tank.' The 'Think Tank' was based on a model developed by the Saskatchewan Heart Health Program, which incorporates elements of focus group methodology and the participatory processes used in community development and group facilitation.

The focus group interview as a methodology originated within the field of marketing, but it has now become widely used in the social sciences (Morgan, 2002). The focus group interview has been defined broadly as "a research technique that collects data through group interaction on a topic determined by the researcher" (Morgan, p.141). The key word here is *interaction*. Rather than being used simply as a cost-effective technique for interviewing several people at once, the distinguishing feature of the focus group interview is the explicit use of interaction between participants to produce data and insights that would be less accessible without the interaction found in a group (Morgan,

1988). Such interaction has a number of advantages: it highlights the respondents' attitudes, priorities, language and framework of understanding; it encourages a great variety of communication from participants— tapping into a wide range and form of understanding; it helps to identify group norms; and it provides insight into the operation of group/social processes in the articulation of knowledge (e.g., through the examination of what information is censored or muted within the group) (Kitzinger, 1994).

Traditionally, focus group interviews have the following characteristics: (i) they are highly structured, using a non-judgmental but empathetic moderator to direct discussion of a predetermined set of questions (often funnelling from the general to the specific); (ii) the typical length is one to three hours, with specific amounts of time allotted per question; (iii) the ideal group size is 6-10 participants; (iv) through a process of theoretical or purposive sampling, participants are selected for their ability to provide the most meaningful information on the subject under study; (v) participants are often strangers to each other; and (vii) the group composition is relatively homogenous in terms of age, gender, culture, social class conditions or power associations (Morgan, 1998). Further to the latter characteristic, the usual practice is that a number of focus groups will be held around a specific topic, with each group based on a specific *break characteristic*. Break characteristics describe different subsets of the population with potentially different experiences and viewpoints concerning the topic— e.g., rural versus urban, elderly versus young, male versus female, managers versus staff employees, etc. (Knodel, cited in Morgan, 1993). *Control characteristics*, on the other hand, are those elements that will be held in common for all focus groups of the study— e.g., all participants may be residents

of Manitoba (Knodel, cited Morgan, 1993).

Having described some of the typical characteristics of a focus group interview, it is important to note that there are a number of variations of the traditional structure and function of focus group interviews. For example, Morgan (2002) proposes a less structured approach and he encourages such innovation. Moreover, two of the common features of traditional focus group composition— homogeneity and participant strangers— have been challenged. Regarding the first characteristic, Morgan (1988) argues that the goal is homogeneity of background and experience, not of attitudes, and that homogeneity based on one or more characteristics may or may not be influential in terms of inhibiting willingness to discuss a particular topic. He notes that, in a study of widowhood, the researchers found that the phenomenon of widowhood itself overcame social class differences. Morgan (1993) also challenges the common assumption that participants should be strangers, suggesting that strangers often have a harder time generating a discussion. He also points out that the reality of many social science settings, where the research involves a small community or an organization, means that it is inevitable that acquaintances will be present. It has even been suggested that pre-existing groups can actually provide a more natural social context within which a person's ideas are formulated (Kitzinger, 1994).

Kitzinger (1994) states that the role of the researcher in a focus group interview is to maximize the interaction between the group participants. The responsibility for achieving maximum participation has traditionally fallen to the moderator of the focus group interview, who must walk the fine line between “understanding empathy” and

“disciplined detachment” (Morgan, 1988). Two of the decisions that need to be made are (i) whether or not the principle investigator will act as the moderator of the focus group, and (ii) the degree of moderator involvement in the proceedings. In the field of marketing research, focus group interviews have been characterized by the use of professional moderators (Morgan, 1988). In the social sciences, there is more of a tendency for researchers to moderate focus group interviews themselves (Morgan, 2002). It has been suggested that moderator bias may be introduced if the moderator of the focus group is too involved with the topic or is perceived to have particular viewpoints or beliefs about the topic (Krueger, 1994). However, moderator bias can be introduced to a focus group in other ways, no matter who acts as the moderator. For example, a moderator’s demographic (or other break) characteristics— whether actual or perceived— can influence group participation, therefore it is suggested that the moderator be compatible with the group (Stewart & Shamdasani, cited in Martens, 1995).

As far as the level of moderator involvement in the focus group is concerned, Stewart and Shamdasani (cited in Martens, 1995) suggest that the highly involved moderator can be useful in a situation where there is a strong externally generated agenda, where the researcher has specific needs, or where groups are to be compared. The advantages of a high degree of moderator involvement include the ability to cut off unproductive discussion, to probe for more information, to cover a wide range of topics, to include the quieter members in discussion, and to allow for adjustment in the direction of discussion. Disadvantages of a highly moderated focus group include the potential to reproduce the presuppositions of the researchers, and the potential for participants to end

up discussing what is important to the researcher rather than what is important to themselves (Stewart and Shamdasani, 1995). Morgan (2002) prefers a less structured approach with minimal moderator involvement, in order to ensure that participants' interests are dominant and to explore participants' thinking, however he does acknowledge that this unstructured approach would not be appropriate in all situations.

A number of characteristics of an effective moderator have been identified in the literature, including: a genuine interest in hearing others' thoughts and feelings; a sense of humour; insightfulness about people and group dynamics; flexibility; knowledgeable, but not all-knowing; a good listener; a friendly leader; a keen memory (in order to recall previous statements and redirect conversation by introducing comments made at different times in the focus group interview); and the ability to generate an overall picture and summarize the discussion concisely (Martens, 1995). It may well be that the possession of these characteristics is more important than whether or not the researcher acts as the group moderator. It has been suggested that a person directly involved in the research project may do a better job of steering the discussion in useful directions, rather than an uninvolved professional moderator (Martens, 1995). However, the researcher can still control both the content of the focus group interview and the group dynamics, using a moderator, through careful planning of questions and the process by which the focus group is conducted. This is where some of the participatory methods of group facilitation popularized in the community development field become important. The goal is to create participatory groups that are characterized by four core values— full participation, mutual understanding, inclusive solutions, and shared responsibility— and this is accomplished

through the use of techniques for honouring all points of view, supporting a free-flowing exchange of ideas, and varying participation formats to build group momentum (Kaner, 1996). For example, creating visible documentation of group deliberation or brainstorming by recording ideas on 5 x 8 cards and placing them on the wall— sometimes referred to as ‘cardstorming’— is a method that enables authentic dialogue with the data, keeps the focus on the data and not on particular personalities, allows the group to get a sense of the clusters of data under consideration and gives the facilitator the flexibility to organize ideas later in order to see the connections (Williams, 1993). ‘Structured go-arounds,’ small group work and debriefing of structured activities are other techniques for achieving a participatory group process (Kaner, 1996).

1.5.3.1 - Objectives of the ‘Think Tank’

There were four main objectives for carrying out this third phase of data collection: (i) to bring together the exemplars or ‘champions’ of health promotion in Manitoba’s RHAs for a day of focussed, facilitated consultation and discussion related to building capacity for health promotion, and to provide the opportunity for these exemplars to share ideas with each other, and to identify common issues/ concerns; (ii) to share and discuss some of the findings from the first two phases of the study— specifically, barriers to HP capacity— beyond the original three RHAs; (iii) to begin the first step in the development of a set of indicators for HP capacity-building— i.e., the identification of characteristics of a region that is rich in capacity for HP— as well as identifying possible strategies/tools for capacity-building; and (iv) to stimulate on-going interest in building capacity for HP in Manitoba’s RHAs.

1.5.3.2 - Composition of the 'Think Tank'

The 'Think Tank' was a full-day event, rather than a one- to three-hour discussion (as in a traditional focus group or group interview). As mentioned earlier, in qualitative research such as focus groups the sample is determined according to the needs of the study, and representation of similar experience or knowledge is the primary consideration of participant recruitment rather than representation of demographic sampling of the general population (Morse, 1994). Participants were selected who were considered to be 'exemplars' or 'champions' of health promotion— i.e., individuals who have exhibited a strong commitment to/passion for HP (this was the control characteristic). Some individuals were identified as 'exemplars' by their peers during Phase I and II interviews, while others were recommended by their peers prior to the Think Tank. Although the purpose of the 'Think Tank' was that it be representative of the 'exemplars of health promotion' in Manitoba, rather than representative of the RHAs per se, an effort was made to identify individuals from each of the Manitoba RHAs— this time including the Winnipeg region⁶, but excluding the Churchill RHA (for the same reason mentioned earlier). An effort was also made to identify exemplars from different levels of the RHA organizations— e.g., management and frontline staff. At least 10 invited participants were unable to attend the event due to prior commitments. In the end, there were 22 participants from eight of the ten Manitoba RHAs and three participants from Manitoba Health at the 'Think Tank.' The following categories of exemplars from the RHAs were

⁶ In early 2000, following the initial round of Phase I interviews, the two separate Health Authorities in Winnipeg were integrated into one Winnipeg Regional Health Authority (WRHA). For this reason, the WRHA was included in this phase of the study.

represented: board member; senior administrator; public health program manager; medical officer of health; public health nurse; health promoter/educator. The fact that many of the participants knew each other was not considered to be a detriment in this case, as they were all highly vocal individuals who were not likely to be inhibited by the presence of colleagues. In fact, it was anticipated that this familiarity and the opportunity to share common experiences would enhance discussion (which proved to be the case). All participants were provided with a formal 'Disclaimer Form' (see Appendix I) prior to the Think Tank, outlining the purpose of the project and the manner in which results would be reported.

1.5.3.3 - Organization of the Think Tank

Two decisions were made regarding the organization of the Think Tank. First, it was decided that, in order to maintain autonomy from the provincial Health Department, financial and administrative support for the event would be sought from the federal government. Second, it was decided that, in order to minimize the introduction of researcher bias into the proceedings, an independent facilitator would be utilized. The Population Health Section of Health Canada's Population and Public Health Branch- Manitoba Region- agreed to provide financial and administrative support for the Think Tank, including a facilitator for the event. The latter individual was an experienced facilitator who was recommended as someone with many of the characteristics of an effective moderator listed above. She was very familiar with both the subject matter and participatory methods of group facilitation, and the fact that she had no formal connection with the provincial Health Department meant that she would be acceptable to participants

from the RHAs.

After the facilitator introduced the day's proceedings, the primary investigator provided some background to the event, then gave a brief overview of concepts related to HP, addressing the questions: "What is health promotion?"; "How does health promotion work?"; and "Why build capacity for HP?" The purpose of the concept overview was to ensure that all participants were using the same language during the day's discussions and to avoid having to interrupt discussions throughout the day in order to clarify concepts. It was felt that the benefits of this approach outweighed the risks of introducing researcher bias into the proceedings, especially since participants were not provided with the primary investigator's own interpretation of concepts but rather, with the various interpretations that are commonly expressed in the field of health care and health promotion.

The remainder of the day was organized around discussion of four main questions (outlined below). These questions were posed using a variety of group facilitation techniques, which were designed to ensure maximum participation and interest from participants.

Participants were asked to introduce themselves and to answer the following question: "*What excites you about current health promotion activities in your region/workplace?*" Next, participants were asked to consider the question: "*What is your vision of what a regional health authority would look like if it had the highest possible capacity for health promotion— i.e., what would the characteristics of the RHA be?*" Each individual was asked to write down three to five ideas, each idea on a separate

half sheet of paper. Ideas were then posted and clustered into rough categories (which were then further refined by the author during the data analysis phase). Since this was a brainstorming exercise, there was no discussion about the relative benefits/limitations of individual ideas. Later in the morning, the author presented a summary of barriers to health promotion capacity that had been identified during Phase I of the study.

Participants were then divided into small groups, organized on the basis of geography (i.e., northern, central, southern rural/urban, WRHA), and asked: *“Which of these challenges or barriers to building capacity for HP are you currently experiencing in your regions?”* *“Are any of these not relevant to your regions?”* *“Are there others that you are experiencing that aren’t mentioned here?”* Each of the small groups then reported back to the large group and there was further discussion. The last set of questions was: *“What are the opportunities for overcoming some of these barriers and for building capacity (in all of its dimensions) for health promotion in your organization/region?”* *“Realistically, what can your peer group do in order to build health promotion capacity over the next 3 years?”* Participants were once again divided into small groups to discuss these questions, but this time they were divided according to peer group— i.e., frontline practitioners, community/public health program managers, and senior administrators/Board members. As before, each of the small groups then reported back to the large group and there was further discussion. Lastly, there was a closing round where participants were asked for any insights, inspirations, or ideas from the discussions that they would take back to their work.

1.5.3.4 - Analysis of data from Think Tank

Two methods were utilized to record information– (i) flipcharts, overheads, or cards; and (ii) tape recording of all small- and large- group discussions. Following the Think Tank, all written information was transcribed by a research assistant. The author then analyzed, categorized, and summarized the transcribed information after listening to the tapes, which helped to clarify written notes and to add contextual details that had not been recorded in written form. Unfortunately, the tape recorder in one of the breakout rooms malfunctioned, and the recording of two of the small group discussions that were held in that room were unintelligible. The tapes were sent to a laboratory where they were re-dubbed. This made some parts of the tape clear enough to listen to. However, there were still segments of the two small-group discussions that were not discernible and a number of points in written form where the context/meaning wasn't clear. In those cases, participants were sent a list of points that required clarification. If, after receiving their feedback, there were any statements that were still unclear, and could not be clarified, then they were left out of the final analysis.

1.6 - Managing Ethical Concerns

Formal approval for this study was obtained from the Ethics Committee of the Faculty of Medicine, University of Manitoba– including an extension to the original approval in order to conduct the third phase of the project (which had not been anticipated in the original proposal). While there is no risk of physical harm to participants in a study such as this one, the issue of anonymity is an important one– especially since current and former employees of both the RHAs and Manitoba Health

were being asked to express their opinions about organizational change and/or issues related to their current/former work. As a result, every effort was made to protect the anonymity and security of individuals participating in the study. For example, RHA administrators were aware of the various groups of employees who were *eligible* to participate in an interview, but they will not be able to identify which individuals actually *did* participate. Interviewees were given the option of being interviewed at a location of their choice— i.e., away from the workplace. In addition, all comments are reported here in a manner that protects individual identity. Since we are dealing with a relatively small number of individuals who are functioning in very specific public positions, protection of individual identity means more than simply not using names. It involves using statements such as the ones listed below:

“Public health nurses in all RHAs frequently stated that...”

“One program manager [RHA will not be identified] expressed the opinion that...”

“A public health practitioner in one RHA suggested that...”

“In the northern RHA, the issue of...was raised by [a number of, one of] the interviewees”

In addition to protection of individual anonymity, the participating RHAs are not identified and are referred to using a neutral term (e.g., RHA ‘A’, ‘B’, ‘C’). However, it is acknowledged that contextual information and comments made by participants will likely make the identification of the RHAs possible by individuals who are familiar with Manitoba.

1.7 - Limitations of the Study

The limitations that were specific to each phase of the study will be discussed separately.

1.7.1 - Limitations of Phase I

First, it was hoped that a pilot study to test the validity of the interview guides could be conducted, but circumstances prevented this from happening. Until very close to the commencement of data collection, it was not clear which of the RHAs would be participating in the study (in fact, one of the originally selected sites had to be dropped at the last minute when it was discovered that another research team was doing a study that might have interfered with this one); as a result, it wasn't clear which RHA could be used as a pilot study site. By the time that the three study sites were finalized, there was not enough time to do a full-fledged pilot study. In the end, the interview guide for C/PHNs and Public Health Managers was tested prior to data collection in the study sites, using two C/PHNs from Winnipeg.

A second limitation relates to the issue of generalizability of results. Although the three study sites were selected to represent the diversity of Manitoba's RHAs, geographically and demographically (excluding Winnipeg and Churchill), it is acknowledged that any commonality found between these three sites— in terms of barriers/facilitators for HP— cannot be assumed to exist in all of Manitoba's RHAs.

A third limitation is that interviews of key informants in all study sites were limited to (i) those individuals within the RHA organization who had either direct or indirect responsibility for community health services, and (ii) those individuals in

governance or advisory positions related to the RHA organization. It is acknowledged that it would have been ideal to contrast the views of these individuals with others— e.g., RHA employees in the acute care sector, health care and non-health care professionals outside of the RHA, etc.— but this was not possible due to financial, time, and human resource constraints. Finally, the original intention was that examples of specific strategies or tools that were being used by RHAs to strengthen capacity for HP would be described, and key components of these initiatives would be identified. As it turned out, this objective was somewhat premature. There were very few examples of capacity-building strategies or tools being used at the time of the first phase of data collection, largely due to the fact that the RHAs were still in a transitional phase of the regionalization process that was focussed on the development of new administrative structures.

1.7.2 - Limitations of Phase II

It was very difficult to obtain the participation of both current and former Manitoba Health employees. Out of a total of eight current Manitoba Health employees who were identified as potential key informants, only two agreed to be interviewed. Several of the former Manitoba Health employees who were identified as potential key informants had left the province and could not be reached. Two former Manitoba Health employees who were contacted stated that they preferred not to be interviewed. Others simply did not respond to requests for an interview. As a result, the sample of key informants is much smaller than anticipated and cannot be considered representative of the views of all Manitoba Health employees. However, their perspective is included and

identified as such, where appropriate.

1.7.3 - Limitations of Phase III

The intention in this phase of the study was to capture the perspective of individuals who were considered to be 'exemplars' or 'champions' of health promotion – with particular emphasis on their vision for the future of HP capacity in Manitoba's RHAs. Although every effort was made to obtain the participation of these 'exemplars,' there were several cases where an individual was not able to attend, and a last-minute substitution was made (i.e., someone selected by the invitee to take his/her place). In addition; it was the intention to have greater representation by frontline C/PHNs, but staffing levels prevented several nurses from receiving permission to attend the Think Tank. As a result, the final group of participants was not as perfectly balanced, in terms of a balance between the various types of 'exemplars' and representation of various regions, as originally desired. In addition, the break characteristic used to form small groups for discussion about opportunities for capacity-building was based on the type of participant– i.e., frontline practitioners versus program managers versus administrators/board members. Ideally, it was hoped to have enough C/PHNs to form a separate group, but the relatively small number of C/PHNs necessitated their integration with the other non-nurse frontline practitioners (health promoters/educators). As a result, it is possible that the C/PHNs' unique perspective may not have been captured in this discussion. Lastly, the break characteristic used to form small groups for discussion about barriers to capacity-building was based on type of region– i.e., large urban versus northern versus small urban/rural. This means that the small groups potentially consisted

of participants who were in positions of authority/ subservience to each other in their respective regions. Normally, the inclusion of participants with unequal power relationships in a focus group is discouraged in order to maximize the uninhibited participation of all group members in the discussion. It is acknowledged that frontline practitioners and program managers may not have expressed concerns about their employers' role in inhibiting capacity-building for HP if one of their Board members or senior administrators was present. However, the decision was made that, due to the fact that these individuals were all considered to be 'exemplars' for HP in their regions, the risk of inhibition by some group members regarding discussion of certain perceived barriers to HP capacity-building was likely outweighed by the benefit of giving 'exemplars' from different levels within one or more RHAs with similar demographic/geographic contexts the opportunity to share their perceptions with each other— an opportunity that would not arise very often.⁷

PART III - ORGANIZATION OF DISSERTATION

The remainder of this dissertation will be organized as follows: Chapter Two will focus on a review of the literature in order to answer the question: *What do we know about building capacity for health promotion?* The next two chapters will explore contextual influences on HP capacity-building in Manitoba. Chapter Three focuses on the discourse on 'population health,' and implications for health promotion. In Chapter Four the phenomenon of health system restructuring and implications for health

⁷In fact, several participants mentioned how much they appreciated this opportunity in the written evaluations of the Think Tank.

promotion will be discussed. Both of these chapters will begin with a review of the literature on the subject, followed by a report of key informants' views about the subject. Chapter Five examines the discussion in the literature regarding the role of health promotion in Public Health practice at both the theoretical level (including values, principles and core functions of Public Health), and at the level of Public Health practitioners. The current role of health promotion in the Canadian Public Health system will also be described. The next two chapters will focus on presenting and analyzing key informants' perspectives on health promotion within the RHAs. Chapter Six reports on key informants' views about health promotion in the RHAs, including perceived barriers and facilitators to HP and Public Health practitioners' descriptions of their HP practice. In Chapter Seven, we will focus on the perspective of health promotion 'champions' in Manitoba regarding their vision of a RHA that is 'rich' in capacity for health promotion, barriers to achieving that vision, and opportunities for building health promotion. Finally, Chapter Eight will summarize the lessons learned from this study and outline a number of recommendations for health promotion policy initiatives that can support health promotion capacity in the future.

CHAPTER TWO: WHAT DO WE KNOW ABOUT CAPACITY FOR HEALTH PROMOTION IN PUBLIC HEALTH?: A REVIEW OF THE LITERATURE

What do we mean when we talk about ‘*capacity*’ for HP? It has been noted that definitions of capacity tend to centre around capacity as abilities or skills to effect action (Jackson, Burman, Edwards, Poland, & Robertson, 1999). However, capacity is more complex than simply possessing the tools to effect action. According to the Canadian Oxford Dictionary (Barber, 1998), ‘capacity’ refers to “the power of containing, receiving, experiencing, or producing”(p.210). The key word here is ‘power.’ Turning to the dictionary again, ‘power’ refers to “the ability to do or act” and “government, influence, or authority” (p.1136). Therefore, one might view ‘capacity’ for HP as ‘having the ability, influence, and authority to take action on HP.’ Of course, one of the questions that immediately comes to mind is, what are the factors that contribute to, or create, capacity for HP? The other is, does capacity for HP necessarily include the *commitment* or *will* to take action? A review of the literature⁸ was conducted with these questions in mind and it revealed several interesting characteristics.

2.1 - Health Promotion Capacity: For Whom and For What Purpose?

In their critical analysis of capacity building in health promotion, Labonte & Laverack (2001) set out to answer the question: capacity building for whom and for what purpose? The relevance of this question becomes clear after an initial review of the

⁸The literature review was conducted using the *CINAHL* and *PubMed* databases, as well as texts on health promotion, Public Health, and relevant provincial and federal government health department documents. Unfortunately, the search was limited to English language literature. It is acknowledged that, by excluding literature in French, some key perspectives from French-Canadian sources may have been omitted.

literature, which reveals that there are two distinct lenses through which the phenomenon of HP capacity is explored. One of these lenses focuses on capacity for HP as an end in itself, while the other focuses on capacity for HP as a means to an end.

Regarding the first perspective, a substantial amount of the discussion on capacity for HP takes place within the context of strengthening *community capacity* for health, which refers to the capacity or potential of community groups, alone or in partnerships, to effectively address the determinants of health affecting their members (Labonte & Laverack, 2001). Several groups of researchers have attempted to define the dimensions or domains of 'community capacity' for health (Bopp, GermAnn, Bopp, Baugh Littlejohns, & Smith, 2000; Goodman et al., 1998; Labonte & Laverack, 2001). Work has also been done on searching for relevant theories and principles to guide practice for those who seek to strengthen community capacity for health (Freudenberg et al., 1995), developing indicators and tools for assessing and evaluating community capacity for health (Bopp et al, 2000; Jackson et al, 1999;), and identifying key features that are required to assure sustainability of community capacity building efforts at the neighbourhood level (Social Planning Council of Winnipeg, 2000). Thompson, Baugh Littlejohns, & Smith (1998) suggest that community agencies have a central role to play in the development of community capacity:

We defined community capacity as the degree to which a community *and its agency partners* can develop, implement, and sustain actions for strengthening community health....Both agency and community play a significant role in contributing to community capacity and it is through their joint efforts that community capacity is built (p.12, emphasis added).

While the literature that we have just described focuses on building *community capacity* for health, the second lens in the literature focuses on building *organizational capacity* for HP. This body of literature is characterized by several prominent features. First, the conceptualization of 'health promotion' varies. Second, 'organizational capacity' for HP is also conceptualized in different ways. Third, the focus in the literature (especially in Canada) has been on building capacity for HP related to one specific health problem. Fourth, there is a paucity of information about efforts to build capacity for HP in Canada's regionalized health system. Lastly, the potential challenges that may be faced by organizations attempting to build capacity for HP has received only marginal consideration in the literature. Let's look at each of these in more detail.

2.2 - The Concept of Health Promotion: Narrow vs. Broad Interpretation

For the purposes of this study, we have defined HP as a broad approach to health promotion which encompasses a specific set of principles and strategies— strategies which go far beyond education for individual or even population-level behaviour change. It must be noted, however, that the conceptualization of HP utilized in the literature does not necessarily fit this broad HP perspective. For example, a recent book on reorienting health care organizations to be 'health-promoting' organizations (Skinner, 2002) begins by acknowledging that HP in health organizations must address relevant aspects of all five of the Ottawa Charter actions for HP— not just lifestyle or personal behaviour change. Nevertheless, the author proceeds to focus almost exclusively on organizational changes required to more effectively influence individual and population level behaviour change. Other examples of this phenomenon can be found in Guldan (1996), who states that the

goal of HP in the community is changing individual and community health attitudes and behaviours, and in some of the heart health promotion literature and literature from Australia on building capacity for HP (which will be discussed in more detail below). These examples fit with Labonte's (1993) observation that state Public Health agencies tend to work from a behavioural rather than a socioenvironmental perspective.

In contrast to this more narrow interpretation of HP, some discussions of building organizational capacity for HP clearly conceptualize 'health promotion' in the broader socioenvironmental sense outlined earlier. One of the most significant examples (and most relevant to the Manitoba context) of a broader HP conceptualization can be found in a position paper from the Centre for Health Promotion (CHP) in Canada on creating a health promoting integrated health system (Birse, 1998). Noting that most existing health organizations claim to promote health, the CHP paper argues that most do so only within the narrow definition of health as 'the absence of disease,' and few take a broader approach that tries to influence all the individual and social factors that affect health. It is also suggested that organizations charged with the task of meeting the health needs of their populations must balance their responsibility to treat illness and provide rehabilitative services with their responsibility to provide preventive services and to develop individual and social initiatives that help encourage healthier people, communities, and environments (e.g., ensuring that people have access to housing, food, education, income, a stable ecosystem, and social justice and equity).

2.3 - Defining 'Organizational Capacity' for Health Promotion

There are not many examples in the literature where the concept of 'organizational capacity' for HP is clearly defined. The main sources in the literature where the topic is addressed include: (a) the various reports associated with the international heart health promotion initiative; (b) the work being done in Australia on capacity-building for HP; (c) reports that come out of World Health Organization (WHO) discussions about reorienting health systems; and (d) the Canadian initiative exploring the idea of a 'health promoting' integrated health system mentioned above.

Beginning with the heart health promotion literature; in a document produced by the Advisory Board to the Third International Heart Health Conference (Pearson et al., 1998)– commonly referred to as the *Singapore Declaration*– organizational capacity for HP is conceptualized as the capability of an organization to promote health formed by two essential components. The first is an appropriate *infrastructure*, which includes policies, scientific and technical knowledge, physical and organizational capabilities, and economic or financial resources. The second essential component of capacity for HP is the *will* to develop, use, and sustain the infrastructure. Variations on this definition can be found throughout the literature on heart health promotion. For example, infrastructure and will are embedded conceptually, if not stated explicitly, in the Saskatchewan Heart Health Program's definition, where capacity for health promotion is described as "a set of knowledge, skills, commitment and resources required by individuals and organizations to conduct effective health promotion" (Ebbesen et al., 2001, p.35). A slightly different variation of the 'infrastructure + will' conceptualization of capacity for HP is presented

by the Ontario Heart Health Initiative (OHHI) (Taylor, Elliott, Robinson, & Taylor, 1998), which emphasizes the predisposition (i.e., the collective motivation to engage in) and organizational capacity (the infrastructure required to implement) community-based heart health promotion. In the Alberta Heart Health project, 'leadership' is added to infrastructure and will as an essential component of capacity for HP (Smith et al., 2001). The Alberta project also identifies the crucial role of 'champions' of health promotion under the *leadership* dimension of capacity.

The common theme and major contribution of these definitions of capacity is the notion that infrastructure on its own is not sufficient for HP capacity. In fact, in the *Singapore Declaration* (Pearson et al, 1998), it was pointed out that infrastructures without the will to use them "are like stranded whales, perhaps magnificent in appearance, but unable to function" (p.192). However, it must also be noted that one of the key features of the discussions about capacity for HP in the 'heart health' literature is that the conceptualization of HP is more behavioural in nature than socioenvironmental. In fact, one of the criticisms of heart HP initiatives is that there has been very little attention paid to reducing inequalities in the distribution of cardiovascular disease within the population that results from socioeconomic inequalities (Raphael, 2001).

Unlike the heart HP literature, which was motivated by concerns about one specific disease, the Australian HP capacity building literature appears to be the result of a broad government initiative at both the national and state levels to reorient the health system to focus on health promotion. For example, in the state of Victoria, work has been done on identification of the key elements required to build the infrastructure

capacity for HP at state and local levels (State of Victoria, 1998; 1999; 2000). This emphasis on infrastructure means that the focus is on the processes and support mechanisms for HP, including: resources and planning processes; policies and communication strategies; administrative systems; agency mandate and culture; and practitioners' skill for HP (State of Victoria, 1998). From this infrastructure capacity perspective, the key HP capacity-building tasks of an organization are (a) workforce development (advancing the HP skills and knowledge of both management and practitioners), (b) organizational development (strengthening organizational support and opportunity for HP), and (c) resource development (ensuring and/or developing resources for HP and allocating them strategically) (State of Victoria, 1998; 1999). An important point made in this literature is the cautionary message that a focus on workforce development alone is an insufficient strategy for building HP capacity; rather, it is necessary to address all three components of capacity building in order to create an effective, health promoting organization. A limitation of this infrastructure approach is that the concept of *commitment or will* to take action on HP appears to be taken for granted.

In New South Wales (NSW), Australia, a framework for building capacity to improve health at the state and local levels has been developed which expands the conceptualization of HP capacity beyond a focus on infrastructure (NSW Health, 2000). For example, capacity-building for HP is defined as "an approach to the development of sustainable skills, organisational structures, resources and *commitment* to health improvement in health and other sectors, to prolong and multiply health gains many times

over” (Hawe, cited in NSW Health, 2000), p.3, emphasis added). The NSW framework for building HP capacity also adds *leadership* and *partnerships* to infrastructure as key components of HP capacity. From this perspective, the goal of HP capacity-building goes beyond *health infrastructure or service development* (i.e., the capacity to deliver particular program responses to particular health problems) to include *program maintenance and sustainability* (the capacity to continue to deliver a particular program through a network of agencies, in addition to, or instead of, the agency which initiated the program) and the development of *problem-solving capability* of organizations and communities (the capacity of a more generic kind to identify health issues and develop appropriate mechanisms to address them). Several of the current Canadian Heart Health Initiative projects focus on this *sustainability* aspect of HP capacity building (Harvey, Hook, McKay, Capanec, & Gelskey, 2001; Holmes, Neville, Donovan, & MacDonald, 2001).

An important contribution of the Australian literature as a whole is the attempt to develop comprehensive frameworks and specific indicators of capacity for HP that can be applied by health systems at the local level to any activity that addresses national HP priorities. It is part of a national initiative to reorient the health system to focus on HP. The limitation is that the HP priorities that have been identified are still very much limited to disease-prevention. For example, the five national health priority areas are: cancer, cardiovascular disease, injury prevention, mental health, and diabetes (State of Victoria, 1999). The State of Victoria has expanded the priority areas to include physical activity, healthy nutrition, no smoking, responsible drinking, reproductive and sexual HP,

and oral health (State of Victoria, 1999). However, the focus remains on risk reduction and behaviour change. There is no discussion of reducing inequalities in health due to social, economic, or environmental factors.

A third body of literature that explores the concept of organizational capacity for HP comes out of World Health Organization (WHO) discussions about reorienting health systems to promote health— especially those discussions that occurred within the context of the WHO's Fifth International Conference on Health Promotion in Mexico City in 2000. In this case, unlike the previous two examples, the conceptualization of capacity for HP is not explicitly defined, but is embedded within the discussion of the required elements of a health system oriented towards HP. One of the five major strategies for HP identified in the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) was the need for governments to reorient health services, including a move of the health sector in a HP direction, beyond clinical and curative services. A decade later, one of the challenges identified in the Jakarta Declaration on Health Promotion into the 21st Century (World Health Organization, 1997b) was the need for governments to secure an infrastructure for health promotion. However, it has been noted that, since 1986, much of the literature and debate on reorienting health services has remained either at the level of values and principles, or as isolated components of categorical disease prevention and management interventions, while little progress has been made in defining an explicit, detailed and commonly agreed upon framework for implementing changes in a systematic fashion (Lopez-Acuna, Pittman, Gomez, Machado de Souza, & Lopez Fernandez, 2000). In preparation for the Fifth International Conference on Health Promotion in Mexico

City, a group of researchers developed such a framework (Lopez-Acuna et al, 2000). The advantage of this framework is that it provides specific objectives and strategies for reorientation of the health system beyond the clinical and curative services. Some of the noteworthy objectives include: the need to induce financing and resource allocation practices that give priority to the development of Public Health infrastructure and to the lines of action aimed at reorienting health care delivery with HP criteria; and the need to incorporate advocacy of five guiding health promotion principles (equity, social participation, financial sustainability, efficiency, effectiveness & quality) into health service management models. However, the conceptualization of 'organizational capacity' for HP that is imbedded in this work is very much restricted to infrastructure development. The notion of *will or commitment* to implement these actions appears to be taken for granted.

Another background paper prepared for the WHO's Fifth International Conference on Health Promotion (Moodie, Pisani, & de Castellarnau, 2000) also focuses on infrastructure for promoting health, which they discuss within the context of eight essential elements of HP: workforce development; community capacity; healthy public policy; research, monitoring and evaluation; dissemination and communication; working through sectors other than health; and reorienting illness services to promote health (referring to the creation of health-promoting hospitals). Although the authors don't specifically refer to the concept of *commitment* or *will* as an element of capacity for HP, they infer it by arguing that dedicated HP infrastructures are needed to catalyze national, provincial and local HP action, to stimulate non-health sectors, to avoid random

intervention, and to provide long-term vision. Potential 'dedicated' institutions discussed in the paper include: a directorate for HP in the health ministry; a Public Health research council; intersectoral organizations for HP; a commissioner for Public Health; independent HP institutions (publicly and privately funded); issues-based HP organizations; and associations and networks of HP professionals.

A third report (Ziglio, Hagar, McMahon, Harvey, & Levin, 2000) prepared for the WHO's Fifth International Conference on Health Promotion outlines the 'investment for health' (IFH) approach for HP, which is described as "a deliberate attempt to address the main "causes" of health in a credible, effective, and ethical manner that engages other sectors of society as well as the health care sector" (p.5). The IFH approach develops policies and programs that are based on, and address, key determinants of health, which are viewed as being mainly linked to economic and social factors. Once again, 'capacity' for HP is only indirectly inferred. However, it clearly involves more than appropriate infrastructures. Ziglio et al (2000) identify a number of contextual factors that are essential requirements for the successful implementation of an IFH approach, including: political priority given to health; accountability for health improvement across policy sectors and departments; public understanding of and commitment to investments that promote population health; recognition of the trade-offs between health, economic and social development outcomes; skills for intersectoral action; incentives for different sectors to cooperate in an IFH approach; appropriate infrastructures; IFH indicators that include measures relating to the determinants of, and assets for, health; and a willingness to learn about how to make IFH work. The positive contribution of the previous two

examples from the literature lies in their conceptualization of health promotion in its broadest socioenvironmental sense and their recognition of the multiple contextual factors, in addition to appropriate infrastructures, that are required to effectively promote population health.

There is one example from the Canadian literature that addresses the issue of building organizational capacity for HP. It is found in the work of the Centre for Health Promotion (CHP) at the University of Toronto, which has explored the role of health promotion within an integrated health system, or IHS (Birse, 1998). An IHS refers to a network of organizations that provide or arrange to provide a co-ordinated continuum of services to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served. This model, with its notions of a rostered population (where membership is defined by consumer choice rather than geography and competition exists among systems for consumers) and risk-adjusted capitated funding (with financial incentives to providers for good performance), may first appear to fit more easily in an American system of health care delivery. However, there are many ideas in this document that are highly relevant to the health system in Canada, and so it is worth examining them in some detail.

The main argument put forward by the CHP is that simply restructuring traditional health care delivery organizations into a more integrated system— i.e., doing the same things in a different way— may be an effective way to maintain the quality and reduce the costs of health care delivery, but it will not improve population health or health outcomes. To achieve that goal it is proposed that health systems must do different things in a

different way. In particular, the health system must be reoriented to promote health. Noting that most health organizations claim that they are in the health promotion business, the authors suggest that they do so only in the most narrow sense of health as ‘the absence of disease,’ instead of using a broader approach that includes taking action on the broad social and environmental determinants of population health. In most cases, they maintain, HP is an afterthought or an add-on activity, rather than being an integral part of a health organization’s mission.

The key point to be made here regarding organizational capacity for HP is that, from the CHP perspective, the most important element is a clear understanding of the health organization’s role in HP and a *commitment* to promote health in its broadest sense. The authors propose that truly health-promoting organizations do not just happen, they have to be carefully created and nurtured, and they proceed to outline the following nine steps that are required to achieve that goal: (i) developing a mission based on HP values; (ii) developing a governance structure that reflects HP values; (iii) allocating a minimum percentage of the budget for HP; (iv) developing a health promoting service culture, roles, and responsibilities; (v) taking a health-promoting, client-focused approach to services; (vi) developing a work environment that promotes health; (vii) identifying and supporting partnerships in HP; (viii) setting targets and standards for HP; and (ix) adopting strategies that promote health.

While all of these steps are viewed as necessary components of organizational capacity for HP, the CHP clearly suggests that the first step— developing a mission based on HP values— is the most important, mainly because “*the foundation for any system is*

not a question of structure or the function of governance, but the mission and culture of that system" (Birse, p.44, emphasis added). Significantly, it is proposed that, in order to ensure that HP is an intrinsic part of what IHSs are, what they do, and how they work, the provincial government should set the standards for IHSs and include in their legislated mandate the following five core HP values: *empowerment* of individuals and communities; *public participation* in processes and activities that will help them define, analyze and take action on factors that affect their lives and living conditions; taking steps to *influence socioeconomic and other conditions* that affect people, communities, and the world; recognizing that social inequities and injustice can have a detrimental effect on health, and working to promote *equity and social justice* to ensure that every person, family, and community can benefit from living, learning, and working in a health-supporting environment; and encouraging *intersectoral collaboration* in activities that promote individual and community health. The IHS, in turn, should ensure that these core values are incorporated into its mission and vision statements, and they should guide all the IHS's operations, including the way it designs its management structure, and its funding and accountability mechanisms. Although the current regionalized health delivery system in Manitoba does not fit all of the characteristics of the IHS model described by the CHP, the ideas outlined here clearly are applicable to any health system. In particular, the focus on commitment to HP values as a key dimension of organizational capacity for HP is an important message to take away from this discussion.

2.4 - Focus on Heart Health Promotion Capacity in the Canadian Literature

We have already touched on the third feature of the literature on capacity building for HP— the fact that a significant proportion of the discussion, especially in Canada, relates to building capacity for heart health promotion (HPP), as opposed to HP in general. Nevertheless, there are some important lessons that have been learned from various Canadian Heart Health Initiative (CHHI) projects that may be applicable to broader HP efforts. Perhaps the most important contribution of the CHHI is the emphasis on the importance of combining a will to act with infrastructure development to create the capacity for implementing HHP. For example, the CHHI-Ontario project made a significant contribution by developing definitions and measures of predisposition (motivation), capacity (organizational infrastructure), and implementation (Riley, Elliott, Taylor, Cameron, & Walker, 2001; Taylor, Elliott, & Riley, 1998). Using a combination of quantitative and qualitative methods, the CHHI-Ontario study team found consistently high levels of predisposition for HHP, medium levels of organizational capacity, and low levels of implementation of HHP initiatives by Public Health units across Ontario. Significantly, they concluded that predisposition is *not* a sufficient condition for implementation to occur in the absence of a well-developed organizational capacity (infrastructure) to implement heart health activities.

Another contribution made by the CHHI is the use of a socio-ecological approach to HHP. This perspective maintains that improvements in the health of populations depend largely on changing environments in ways that promote, extend, and sustain healthy behaviours among individuals. While a limitation of this perspective is that the

ultimate goal is still behaviour change (as opposed to social change), it does recognize the critical influence of social, economic, political, and ecological environments on the choices that individuals have available to them. Changing organizational and community environments to enable the creation and sustainability of capacity for HHP is an underlying theme, if not an explicit objective, of each of the CHHI projects (O'Loughlin et al., 2001). The CHHI-Ontario researchers, guided by a socio-ecological perspective, propose that organizational predisposition and capacity are influenced by a variety of factors related to the internal organization as well as the external system (Riley, Taylor, & Elliott, 2001). Among the internal organizational factors that they identify as influencing organizational predisposition and capacity for HHP, appropriate human and financial resources are key, but structures and processes that encourage a focus on HHP and facilitate multidisciplinary activities, collaborative planning with community agencies and coordination of individual programs related to heart health are also essential, as is the presence of strong administrative support and leadership for HHP. With respect to the external system factors that influence organizational predisposition and capacity for HHP, strong inter-organizational partnerships are identified as particularly relevant. However, many other contextual characteristics at different levels (local/regional, provincial, federal) may also influence HHP capacity of Public Health agencies, including: social/physical characteristics of communities, community priorities, and trends in the health and social policy environment (Robinson & Elliott, 2000).

Another noteworthy contribution of the CHHI is the development of conceptual frameworks to guide our thinking regarding capacity building for HHP. For example, the

conceptual model developed in Nova Scotia (MacLean et al., 2001) captures the internal and external factors influencing the practices and activities of organizations involved in HHP. The conceptual model developed in Alberta (Smith et al., 2001) captures the three key dimensions (will, infrastructure, leadership) of capacity building for HHP within the context of the learning organization. In Saskatchewan, Ebbesen et al.'s (2001) complex conceptual model illustrates that individual capacity of HHP practitioners is embedded within and influenced by the Health District which is, in turn, embedded within and influenced by the larger provincial and national contexts. While these conceptual frameworks were originally developed in the context of building capacity for HHP, it is easy to see their applicability to the broader enterprise of building capacity for HP.

2.5 - Current Health Promotion Capacity of Canadian Health Systems: Lack of Empirical Data

As was mentioned in the previous section, most of the discussion about HP capacity-building in Canada has taken place within the context of heart health promotion. It appears that the task of building capacity for broad-based HP in Canadian health systems has only begun to be addressed in the literature. There is only one example in the literature of a community-based research initiative which specifically addresses the challenge of building HP capacity within the context of a regionalized provincial health system. In Saskatchewan, a five year project, *Building Capacity for Health Promotion* (Ebbesen et al, 2001), is underway to help Saskatchewan health districts increase their capacity to plan, implement and evaluate health promotion activities and to increase their understanding of the capacity-building process. Several key findings to date from this

project are worth mentioning here. First, the research team has found that the provincial context for capacity development is characterized by a collaborative spirit, interest in health promotion effectiveness, and political support for population health promotion and intersectoral action. Second, a vision of both a district that is rich in capacity for HP and an individual (referring to an employee working in a HP role) who is rich in capacity for HP was elicited from study participants. Characteristics of a capacity-rich district include: resources (human and financial) shifted from institutional care to HP; stronger and greater number of internal and external partnerships; enhanced inter-sectoral work; a seamless flow of information, greater and more consistent public and professional understanding of HP; incorporating HP explicitly into the mission and actions in a meaningful way; and seeking support and active participation in HP from across the district. Characteristics of a capacity-rich individual include someone who articulates clearly their HP values and principles, enhances the skills of self and others, is computer literate, partners within and across districts and sectors, records and shares experiences, steps out of 'comfort zones,' engages in reflective practice, and learns continuously. A baseline survey revealed that districts in Saskatchewan were at different levels of HP capacity development. Factors shaping organizational capacity included: the role of key individuals; changes in leadership; Board understanding; the creation of designated HP positions, and the act of 'pulling together' in times of downsizing. In addition to an annual survey and annual interviews with key informants, an interesting methodological feature of the Saskatchewan project was the use of several one-day 'Think Tanks,' or consultations, with representatives of various levels of different health districts who were

considered to be 'champions' of health promotion (including Board members, Chief Executive Officers, Medical Health Officers, and designated HP staff), in order to identify the realities of building HP capacity and to explore potential implications for action.

In Manitoba to date, the literature suggests that capacity building for HP has centred around heart health promotion initiatives (Harvey et al, 2001). Capacity for HP in Manitoba's RHAs has not been documented in the literature.

2.6 - What are the Barriers to Health Promotion Capacity?

A fourth significant feature of the literature is that there is very little discussion regarding the barriers or challenges to building capacity for HP within health systems. One exception is the work done by Moodie et al.(2000), who identify the macro-level political, social, economic and cultural obstacles which block progress toward HP. Using a broad socioenvironmental conceptualization of HP with its emphasis on a more equitable distribution of resources, they note that HP challenges the vested interests of the political, business, medical and academic establishments (regarding the latter group, Moodie et al. claim that academia has not provided the leadership that they could in promoting population health). They also point out that there are still glaring cultural barriers to HP, including discrimination against women with regard to schooling and participation in other activities outside of the household, and beliefs/attitudes towards sexual and reproductive health which make HP work in these areas very difficult. Finally, Moodie et al suggest that one of the major barriers to HP is the lack of appropriate skills of those charged with the promotion of public health. In general, they

argue, “we lack the political experience and the advocacy skills to push public health into the ‘main game’ and to have health valued by political leaders and decision makers, not to mention the skills and culture to plan, organise and implement effectively” (p.7). A striking aspect of their paper is their deliberate omission of financial resources as a main obstacle to HP– their central argument being that many untapped resources are already within reach.

In her discussion of why health promotion does not yet enjoy the popularity of curative medicine, Reilly (2000) identifies the following barriers to capacity for HP: (i) inertia within the health professions in accepting a shift in thinking; (ii) inherent confusion over the use of the term ‘health promotion’ as both a goal of public health and a description of health promotional practices; (iii) consumer capitalism’s emphasis on individual consumption and wants, not the collective needs of communities for healthy living; (iv) politicians lacking either the insight or the political will to realign limited resources in favour of health promotion, because it rarely provides a “quick fix”; (v) difficulty in providing proof for the efficacy of health promotion initiatives because results take longer to produce and more often present themselves in less demonstrable qualitative terms; and (vi) the challenges of coordination and mobilization of multisectoral and multidisciplinary partners, which requires time and dedicated, qualified staff. Robinson & Hill (1995) suggest that the wider social context of the current health care system supports a narrowly focussed biomedical view of health, which makes a health promotion perspective difficult to realize in practice.

Intersectoral collaboration, cooperation, or action for health (one sees all of these

terms in the literature), is consistently advocated as a central building block for effective population health promotion— one that is essential in order to successfully address the major social, economic, and environmental determinants of health (Nutbeam, 1994; World Health Organization, 1997a). However, there is debate regarding the degree to which local organizations representing different sectors can work together. The more optimistic argument is that local organizations are more able to interact with each other and are closer and more responsive to community concerns, whereas the pessimists argue that there are limits on the changes to government policy which can be effected at the local level and that different conceptual frameworks, decision-making processes, and levels of autonomy make collaboration problematic (Delaney, 1994).

Most of the discussion about barriers to capacity for HP in the Canadian literature takes place within the context of the Canadian Heart Health Initiative (CHHI). In one of the CHHI's Ontario projects (Taylor et al, 1998), a number of barriers to predisposition and capacity for HHP program implementation in Public Health units in Ontario were identified. Barriers to predisposition included: lack of community interest (low on their list of priorities); lack of support from administrative leadership; and lack of priority of heart health within the health unit. Barriers to infrastructure capacity included: lack of financial and material resources; lack of staff positions dedicated to heart health; and difficulty in deciding how to evaluate the success of the initiative (i.e., focus on short-term process or long-term outcomes?). Additional barriers to capacity for HHP that have been identified include: difficulty recruiting volunteers from a small volunteer pool and difficulty retaining participation of staff and volunteers who have developed high levels

of skills and knowledge (White et al., 2001); and provincial health reform and restructuring (MacLean et al., 2001). Regarding the latter barrier, MacLean et al. (2001) report that an unstable environment for capacity building was created in Nova Scotia by the 1996 Health Reform, which emphasized health promotion, and its subsequent abolition in 2000 by a new government. The initial Health Reform occurred at the same time as major cuts were made to the acute care system and became equated with deficit reduction, which dampened community support for HP initiatives. Moreover, the authors report, the subsequent freeze on the creation of structures, restrictions on resources, and lack of a clear direction made it difficult for partner organizations to move forward. Similarly, in Ontario, a political shift towards less government intervention, and major structural changes within the Public Health system are seen as major threats to securing the necessary resources for HHP in Ontario (Riley et al., 2001). While all of the above-mentioned barriers are discussed within the context of heart HP, it seems safe to conclude that many of them would be applicable to broader HP initiatives as well.

There is only one example in the literature which looks at barriers to capacity for HP in general within the context of a regionalized health system in Canada. It was mentioned earlier that the Saskatchewan Heart Health Program (SHHP) has expanded its scope beyond heart HP to explore capacity building for HP in general. A SHHP report on a five-year collaborative initiative to help health districts in Saskatchewan increase their capacity to plan, implement and evaluate HP activities identifies several barriers to HP capacity building at both the district level and the level of individual HP practitioners (Saskatchewan Heart Health Program, 1999). At the district level, barriers included: lack

of resources (financial and staffing); conflicting priorities; public apathy; lack of understanding of health promotion; territoriality among different professionals working in the district; large geographic distances separating communities; lack of political commitment or clear policies; and various organizational issues. At the level of individual practitioners, barriers included: the 'fuzzy role' of HP practitioners; the range of skills required in HP practice; practitioners' reluctance to work outside of their 'comfort zones,' so that they focus on lifestyle work instead of attempting more challenging approaches; difficulty in meeting closure and accomplishment needs of practitioners due to long time frame implicit in HP; lack of a shared understanding of HP among staff within the district; and lack of time to juggle conflicting responsibilities, to network with other sectors, to invest in community development work. The similarity between the Saskatchewan and Manitoba contexts raises the question of whether or not comparable barriers would be present in Manitoba's RHAs. It should be noted that the HP practitioners who took part in the SHHP study were designated as HP specialists in each district. It would be interesting to know how other practitioners who are involved in HP perceived the barriers to capacity building.

2.7 - Summary

If one had to choose the features of the literature on capacity for health promotion that stand out, they would be as follows. The first and perhaps most important observation is that the concept of 'building capacity for health promotion' may mean different things to different people. For example, the evidence suggests that 'health promotion' is still interpreted fairly narrowly as the prevention of disease or disability

through individual- or community-level interventions which are designed to influence behaviour change. Building capacity for health promotion within this context is a very different task than building capacity for health promotion when it is viewed from the socioenvironmental perspective, when increased socioeconomic and political equity and social justice are viewed as equally or even more important goals than behaviour change. The manner in which health promotion is conceptualized at regional, provincial, and national levels and the degree to which there is consensus regarding this perspective may be a key factor in building capacity for health promotion at each of these levels.

Similarly, the idea of 'organizational capacity' for health promotion can also be interpreted in several ways. A narrow interpretation would focus primarily on infrastructure capacity such as adequate human and financial resources, and knowledge/skills. A more wholistic interpretation views appropriate infrastructure as a necessary, but insufficient, condition for organizational capacity. From this perspective, the will or commitment to take action on health promotion is an equally important dimension of capacity. As in the case of infrastructure capacity, this dimension of capacity must exist at both the organizational level and at provincial, national, and even international levels. The presence of this dimension of HP capacity, and the way in which it is manifested at all levels, will be an interesting issue to explore. Perhaps most importantly, the evidence suggests that neither infrastructure nor commitment on their own are sufficient elements of organizational capacity for HP.

Another enduring impression after reviewing the literature is the notion that organizational capacity for HP can only be understood within its social, political, and

economic context. Clearly, there are a variety of contextual factors which may act to facilitate or block capacity for HP at both the practitioner level and the organizational level, and these must be identified. Lastly, although information about building capacity for heart HP is beginning to emerge in the literature, there is very little discussion about the process of capacity building for broad-based HP in the Canadian health system.

Therefore, any contribution to our understanding of this phenomenon— particularly within the context of regionalized health systems in Manitoba— should be useful.

In the next chapter, we will begin to explore the contextual factors influencing capacity for HP in Manitoba.

CHAPTER THREE: THE DISCOURSE ON POPULATION HEALTH: IMPLICATIONS FOR HEALTH PROMOTION

Sutcliffe, Deber, & Pasut (1997) suggest that two of the most influential trends in the field of Public Health in Canada during the past decade have been health sector 'reform' or restructuring (which will be discussed in more detail in the next chapter), and the discourse on 'population health.' While the latter phenomenon has most likely gone unnoticed by the average citizen, it has been the subject of much discussion among academics in the health field, health policy makers both within and outside of government, and certain frontline practitioners. As we noted earlier, Manitoba Health has adopted a population health approach as the basis for its Health Reform initiative. Yet, in spite of the substantial body of literature on the subject, and the numerous policy papers promoting the concept, if one were to put five people around a table and ask each of them for their definition of a 'population health perspective,' one might very well get five different interpretations of the concept. As Dunn & Hayes (1999) have noted, confusion permeates the discourse on 'population health.' In an attempt to clarify some of the confusion about this concept, those authors have suggested that it may be useful to distinguish between a population health *perspective* (which they use as an umbrella term to refer to the population health discourse in its most general sense), population health *research*, a population health *approach* (the application of knowledge gained through research to public policy), and a population health *framework* or model (the latter three terms being more specific components of the general perspective). An effort will be made to use this proposed lexicon here.

There are two broad goals for this chapter. In Part One, we will review the discussion of the 'population health' perspective in the literature. Given the focus of this study, the purpose of this literature review is not to summarize everything ever written about population health, but to explore the following question: "What is the relationship between the population health perspective and health promotion?" Or, to put it another way: "How does health promotion fit in to the population health perspective?" When we speak of a population health approach, is that synonymous with a socioenvironmental approach to health enhancement? In Part Two, we will examine how this perspective is being interpreted and incorporated into program planning within the RHAs.

PART I - WHAT THE LITERATURE TELLS US

3.1 - Origins of the Population Health Perspective: The Search for Health Determinants

It is not clear who first coined the term 'population health.' It is safe to say, however, that the term was popularized through the work of the Canadian Institute of Advanced Research (CIAR). In the mid-1980s, the interdisciplinary group of researchers in the CIAR's Population Health program began to pull together the vast quantity of epidemiological and other scientific studies which explored the relationship between various social, economic, political, and cultural factors and health outcomes. Their work culminated in the development of a conceptual framework that has become well known, and is often referred to as the 'Population Health' or CIAR framework (Evans, Barer, & Marmor, 1994).

The CIAR framework builds upon the 'Health Fields' concept promoted in the

Canadian government's 1974 policy paper, better known as the 'Lalonde Report' (Lalonde, 1974). The 'Health Fields' framework proposed that there were four main classes of factors, commonly referred to as 'determinants,' that influence the health of populations: biology, lifestyle, physical/social environment, and health services. Leaving some of the criticisms of the Health Field framework aside for the time being, the radical (at least, in 1974) aspect of this framework was the notion that access to health services was only one of several key determinants of population health— and not necessarily the most important one at that.

The CIAR framework distinguishes itself from the earlier Health Field concept by creating a more complex model, which clearly identifies social and economic factors as the most important set of determinants of population health, and the availability of and access to medical care as the least important determinant of population health. The CIAR analysis also goes further, noting that there are profound socioeconomic gradients in health status in all nations that have been studied, and arguing that significant improvement in overall population health status requires the shifting of fiscal resources away from the health care sector, which (the analysis argues) does not contribute to population health, to the more 'wealth producing' sectors of the economy— thus, increasing population health by increasing overall wealth (Mustard & Frank, 1991).

Since the publication of the CIAR framework there have been other attempts to model the complex set of relationships between the broad determinants of health and both population-level and individual-level health status. Perhaps the most well-known of these is the Wilkinson framework (Wilkinson, 1996), which focusses on the impact of

social inequality on the health of populations. Wilkinson proposes that the level of social cohesion in any society may have an important influence on population health, and he provides a detailed discussion of the possible links between a society's structural inequities, the psycho-social meaning attached to one's position in the social hierarchy, and the resulting physiological pathways to health.

3.2 - Influence of a Population Health Perspective in Current Federal/Provincial Health Policy

The influence of the population health/determinants of health perspective on Canadian health policy is undeniable. As Raphael & Bryant (2000) have noted, "[its] influence is seen in the renaming of government branches and departments and the numerous documents addressing population health" (p.9). At the national level, the 1994 conference of Federal/Provincial/ Territorial Ministers of Health endorsed the population health perspective proposed in a discussion paper called *Strategies for Population Health: Investing in the Health of Canadians* (Federal Provincial Territorial Advisory Committee on Population Health, 1994). This document identified nine key determinants of health, based on the evidence provided by the CIAR and other population health researchers: income and social status; social support networks; education; employment and working conditions; physical environments; biology and genetic endowment; personal health practices and coping skills; healthy child development; and health services. Two years later, Health Canada officially adopted the population health perspective as one of its four main priorities, or 'business lines' (Health Canada, 1999).

In Manitoba, the provincial Health Department's *Planning Framework to*

Promote, Preserve and Protect the Health of Manitobans (Manitoba Health, 1997) is strongly influenced by the population health perspective outlined in the FPTAC's *Strategies for Population Health* document described above. The *Planning Framework* states that the population health approach focuses on those factors that contribute to the health of groups (communities, populations)– as opposed to a focus on care or treatment of individuals– and its description of the determinants of health is taken directly from the FPTAC document. In addition; Manitoba Health developed a set of population health indicators in order to assist the RHAs in describing the health status of their population in their Annual Report submitted to the province (Manitoba Health-Health Indicator Working Group, 1999). Significantly, these indicators included not only the traditional 'sickness' indicators, but also indicators of ability to function, sense of well-being, healthy child development, personal health practices, physical environment, employment/working conditions, education and income inequality. In a related area, researchers at the Manitoba Centre for Health Policy and Evaluation (1999) have been at the forefront of work on the development of population health information systems. A salient feature of this body of work is its stated goal of influencing provincial government health care policy and, specifically, of challenging the notion that more spending on health care services will improve population health outcomes.

3.3 - Defining a Population Health Approach to Policy, Programs, Practice

Dunn & Hayes (1999) propose that the collection of empirical observations (research) and integration of these into a coherent analysis (framework) of population health can be distinguished from the application of this knowledge to policy (approach).

While there may be general agreement about the need to address the broad determinants of health, the challenge of population health is how to use the emerging evidence about determinants and their interactions to guide development of the next generation of Public Health programs (Edwards, 1999). However, there has not been a lot of work done in defining what a population health approach to public policy, programs, or professional practice would look like. Certainly the most detailed delineation of a population health approach comes from Canada's federal department of health. In 1998, the Health Promotion and Programs Branch (HPPB) of Health Canada adopted a population health approach to guide its work. Noting that the definition is evolving and may change with experience, the HPPB (Health Canada, 1999) states that a population health approach involves the following three characteristics:

1. Strategies that include policies, programs and services that respond to evidence about the relative effects of multiple determinants of health;
2. Actions and outcomes that have an impact on populations and sub-populations, and which therefore address societal, community, structural or system level changes; and
3. Collaboration amongst multiple sectors, given that influence over most of the determinants of health lie outside of the health sector (p.4)

In 1998, *Taking Action for Health*, a position paper for the HPPB staff, outlined a set of principles to provide guidance for analyzing health issues and designing interventions using a population health approach. These principles are:

1. Health is a capacity, a resource for everyday living;
2. The determinants of health are addressed, recognizing they are complex and inter-related;
3. The focus is upstream;
4. Health is everyone's business;

5. Decisions are based on evidence;
6. Accountability for health outcomes is increased;
7. Management of health issues is horizontal; and
8. Multiple strategies, in multiple settings, in multiple systems and sectors are used. (cited in Health Canada, 1999, p.4)

Taking Action emphasizes that acting on just one or two of these principles would not be sufficient, but rather, it is their combined effect that fulfills the population health approach. One of the strengths of this document is that it includes very specific questions that individuals who are involved in planning programs should ask themselves to ensure that each principle is being adhered to. In 1999, the HPPB produced a comprehensive regional strategy for population health mobilization (Health Promotion and Programs Branch, 1999). The strategy consists of a five-pronged approach, including: broadening work on the determinants of health; focussing on specific populations and sub-populations; collaborating across sectors; developing knowledge and understanding of the determinants of health and the key concepts and principles of the population health approach among staff; and documenting experiences of the population health approach.

The strength of these Health Canada policy statements is that they clearly outline a comprehensive population health approach that fits fairly closely to the principles of HP in the *Ottawa Charter* (World Health Organization, 1986). However, the emphasis on achieving equity in health that is central to the latter document is missing in the Health Canada documents. The other problem is that they are intended as guidelines for *federal* programs. It is not clear to what extent provincial health programs have been influenced by the Health Canada guidelines. In fact, beyond the federal government, little is known about how health service organizations are dealing with the challenge of translating the

knowledge about the determinants of population health into program planning. One of the elements of a population health approach that frequently appears in federal and provincial health policy statements is the need for population health strategies to be built on a foundation of sound evidence about factors that determine health, and information about the potential impact of interventions and programs to address those determinants (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994; Health Canada, 1999; Manitoba, 1997). Yet, a survey of health regions across Canada late in 1998 found that research on the broad determinants of population health was not frequently used to guide policy and program planning decisions (Paluck, Williamson, Milligan, & Frankish, 2001).

3.4 - Population Health Approach to Professional Practice

Within the health professions there have been a few attempts to describe a population health approach to practice— or, at least, to consider the implications of the population health perspective for professional practice. While most examples come from Public Health practice, where there is more of a focus on the health of groups, one medical observer (cited in Rafuse, 1995) has suggested that physicians can incorporate the population health perspective into their practice. He suggests that physicians can use population health research and analysis to become better aware of factors influencing their patients' health, to advocate for needed health promotion and disease-prevention programs, and to ensure that resources are spent in the best way possible.

Butler-Jones (1999) proposes that a population health approach within the health sector involves five actions or tasks— **partnering, advocacy, cheerleading, enabling,**

mitigating (PACEM)— which must be undertaken at all levels of the health sector, including the level of the frontline practitioner. According to Butler-Jones, collaboration or *partnership*, both inter- and intra-sectoral, is necessary to address the determinants of health effectively. Health professionals are in an ideal position to *advocate* around issues of concern with respect to health in the community. *Cheerleading*, in the form of encouragement and non-obstruction of others working towards improving conditions for health is essential, as is working to *enable* those activities that build local capacity for the understanding and promotion of health and its determinants. Finally, Butler-Jones notes that one of the health sector's most important traditional roles has been to *mitigate* the effects of other determinants (e.g., providing vaccines to prevent diseases caused by social conditions). He suggests that “part of the challenge for health professionals...is to not only more effectively identify and modify subsequent risks, but also to engage in activities that address the underlying determinants and dynamics” (p.S64). One or two examples of each of these types of actions are provided, but the discussion is mostly at a rather vague, philosophical level.

Bhatti (1999) suggests that one possible way of understanding and acting on the population health approach is to place it in the context of healthy human development. He proposes that practitioners in the health field, by subscribing to such a developmental perspective, should be committed to two broad areas of action: increasing access to the determinants of healthy human development, and reducing the impact of risk conditions in the environments where people live, work and play. Unfortunately, further information about how practitioners might actually put these abstract ideas into practice is not

provided.

The population health approach to nursing practice is a little more challenging to define. On one level, the conceptualization of community health/public health nursing practice has always included a focus on communities and populations as client (Diekemper, SmithBattle, & Drake, 1999). Similarly, recognition of the broad determinants of health has long been evident in the community health nursing literature. Edgecombe (1999) notes that an understanding of the impact of the social determinants of health (such as poverty and lack of social support) and the physical environment (particularly contaminated water, overcrowding and pollution) on the health of populations was recognized by the first PHNs during the latter stages of the 19th century. However, the discussion about the determinants of health in the literature tends to be focussed on identifying the determinants of certain health behaviours (Boland, 1998; Fleetwood & Packa, 1991; Gillis, 1994; Palank, 1991), the determinants of health of specific populations (Bushy, 1990; Craig, 1994), or the ways that nurses can influence one or two specific determinants of health— e.g., social support (Stewart, 2000), social support and healthy child development (Buijs & Olson, 2001), socioeconomic status (Reutter, 2000). Galloway Ford (1997) provides an interesting Canadian example of how a group of PHNs, who were concerned about the isolated and difficult living circumstances of many young parents in their communities, utilized a variety of HP strategies to positively influence a variety of determinants of health, including: housing; social support; knowledge, skills, and education; and income.

There is at least one example in the nursing literature of a population health

approach to dealing with a particular health issue. Heaman and her colleagues (Heaman, Sprague, & Stewart, 2001) outline a population health strategy for reducing the pre-term birth rate, which involves using the five categories of health determinants proposed by the Federal, Provincial and Territorial Advisory Committee on Population Health in 1994 to discuss risk factors and propose policies and interventions to reduce the pre-term birth rate. However, there is only a brief mention of nurses' potential contribution to this population health strategy. Aside from this example, there has been very little discussion in the literature about a 'population health approach to nursing.'

3.5 - Population Health vs. Health Promotion: Do They Intersect?

In general, health promotion and population health seem to be treated as linked concepts— e.g., health promotion being a means towards the goal of population health. A review of the literature suggests that the *specific* relationship between the 'health promotion' and 'population health' *perspectives* has only begun to be explored. Frohlich & Potvin (1999) propose that the population health research agenda, which explores the role of the social determinants of health, can be useful to health promotion in its movement away from health education. However, several authors have raised the argument that health promotion and population health are not as compatible as they might seem at first. They suggest that the assumptions underlying the two perspectives are very different. Labonte (1995) initiated the debate when he challenged one of the CIAR founding member's assertion that population health is not a shift away from the traditional thinking in public/community health, but rather "it is a validation of and return to our historical roots, encompassing all the primary determinants of health in human

populations, globally as well as locally” (Frank, 1995). On the contrary, Labonte (1995) insisted, although much of what is claimed in the name of population health supports the concerns of health promotion— for example, how social forces determine health opportunities— there are some significant differences between the two perspectives. Labonte outlines a number of criticisms of the CIAR Population Health perspective, including: its assumption that economic growth should be the superordinate policy priority; its silence on ecological issues; and its reliance on research into the determinants of health framed exclusively in epidemiological methods, which reduce to individual (behavioural, psychological, or biological) level explanations, rest upon a reductionist biomedical theory of health, and claim to be value-free. He contrasts this with some of the key characteristics of health promotion, including: an explicit concern with values such as collectivism, community participation, and empowerment; an equal concern with people’s experiences of well-being as with their physical functioning; and a rejection of professional dominance. Labonte concludes that the CIAR Population Health perspective could “undermine the fragile legitimacy for empowerment, community development, qualitative research and political advocacy that health promoters have struggled for two decades to obtain” (p.167). Raphael & Bryant (2000) echo the arguments presented by Labonte, proposing that a HP approach is guided by values of equity, participation, and social justice— concepts that are absent in CIAR thinking. They also warn that “unless research aims to influence, rather than merely describe the determinants of health, it is unlikely to improve health” (p.9).

While some people have focused on the differences between population health

and health promotion, others have attempted to find a bridge between the two concepts. In 1996, representatives from the Federal, Provincial and Territorial Advisory Committee on Population Health, the National Forum on Health, the CIAR, the CPHA, several Centres for Health Promotion Research, and various Directorates of Health Canada's HPPB met for a Roundtable workshop in an attempt to resolve some of the tensions between population health and health promotion. The following is a summary of the key findings outlined in the Report on this meeting (Health Canada, 1996). Two important misconceptions were clarified early at the Roundtable. First, it was noted that when population health, with its focus on determinants of health, was gaining momentum, the focus of much of health promotion was on individual behaviour change and not on influencing social variables. Consequently, some advocates of population health equated health promotion with health education for individual behaviour change and rejected it, not realizing the theoretical or practical contributions to the determinants of health made by the field of health promotion over the previous decade. Second, it was noted that the increased popularity of population health with governments over the past few years had coincided with budget cuts to community-based health promotion action. Consequently, some people in the health promotion field believed that population health is concerned only with policy and does not support community action. On the contrary, it was proposed, a key vehicle for the work of population health is through community action. Once these misconceptions were clarified, Roundtable participants identified several other challenges that need to be addressed in order for population health and health promotion to bridge differences and move forward. First, although it was agreed that

population health and health promotion share values of a just society, proponents of the latter perspective felt that population health tends to be more 'mainstream' than health promotion in its political and economic perspectives. For example, whereas health promotion focuses its action on addressing inequalities in health status experienced by the disadvantaged, population health focuses on the gradients in health status across all socioeconomic levels. However, it was agreed that within each of the approaches there is considerable variation in political and social values.

Another area of tension that was identified relates to the different approaches to gathering evidence. While population health and health promotion may subscribe to a variety of approaches to gathering evidence in theory, in practice research in population health is primarily focused on quantitative epidemiological evidence while research in health promotion has primarily involved qualitative (experiential) evidence. Noting that governments appear to support the population health approach because of its quantitative research aspects, health promotion supporters expressed concern that qualitative research might become increasingly ignored. Participants agreed that both types of evidence are valuable and can support each other by appealing to different constituencies. A third area of tension relates to the fact that there has been a political power shift which has resulted in population health gaining a legitimacy and credibility at the policy level that health promotion has never had. Participants agreed that population health has succeeded in catching the ear of policy makers about the critical importance of the determinants of health that go beyond health care. However, they recognized that when those in power are collecting evidence to support their policies, they may capitalize on words without

adopting the values that were given by the originators. For instance, the population health argument that economic well-being is a key determinant of a healthy population can be used to support more wealth-creation at the expense of environmental protection or social equity. Conversely, health promotion's 'community empowerment' concept can be used as a euphemism for 'the community picks up the slack' when funding is disappearing.

A related area of tension stems from the fact that the increasing popularity of population health with governments has coincided with reduced funding for community-based HP action. As a result, the health promotion supporters expressed concern that population health is being used by governments to justify social policy shifts away from health promotion's ideals. For example, some governments seem to be using the population health model to justify hospital closures while ignoring the model's call to reallocate the savings to community initiatives that address the determinants of health. Participants agreed that population health must value community-based HP action as the key to addressing the broad determinants of health. Finally, health promotion supporters expressed concern that population health is being used by governments to support the dismantling of Public Health institutions and their broad experience of health promotion. Some participants warned that if the relationship between population health and health promotion was not clarified and operationalized quickly, there is a risk of losing the valuable legacy of health promotion. Overall, in spite of all of the differences between the two perspectives, participants agreed that they shared the common purpose of improving the health of Canadians by taking action on the full range of health determinants, especially those outside the health care system.

One of the outcomes of the Roundtable on Population Health and Health Promotion was the development of a three-dimensional model called the Population Health Promotion Framework (Hamilton & Bhatti, 1996). This framework combines the strategies for population health promotion outlined in the 1986 *Ottawa Charter* on one side, with the determinants of population health on another side, and various levels of potential intervention on the third side of the model (see Figure 1 in Appendix C). Both Prince Edward Island's *Health Promotion Framework* (Prince Edward Island and Community Services System, 1995) and Saskatchewan's *Population Health Promotion Framework* (Saskatchewan Health, 1999) are modified versions of Hamilton and Bhatti's framework.

The positive contribution of these PHP conceptual frameworks is that they address one of the main criticisms of the CIAR's Population Health perspective— that it doesn't provide a model for change (Labonte, 1995; Raphael & Bryant, 2000). Rather than simply identifying the broad determinants of health, the PHP framework proposes strategies for acting on them. Some of the limitations of these PHP frameworks, like the original Ottawa Charter model, are that they do not provide an explanatory model regarding the exact pathways between the pre-requisites for health and health status, and they offer few concrete details of "how to carry out" various PHP strategies or indicators or tools for evaluating them, leaving each one open to wide interpretation. In addition, following the logic of Labonte (1995) and Raphael & Bryant (2000), the PHP framework combines two sets of philosophical assumptions which are not necessarily complimentary.

3.6 - Summary

Several observations emerge from this review of the literature. First, it seems safe to say that there is no universally accepted definition of a 'population health' perspective. In Canada, federal and provincial policy statements indicate that the following assumptions are generally accepted regarding this perspective: (i) the belief that access to good quality medical or health care services is only one factor (and many would say the least important one) influencing the health of individuals and populations; (ii) the belief that health is determined by complex interactions between individual characteristics, social and economic factors and physical environments; (iii) the belief that health gains can best be achieved by focusing interventions on entire populations or sub-populations, rather than individuals; and (iv) the belief that health is a shared responsibility that requires healthy public policy development in areas outside of the traditional health sector. However, there is very little information regarding how the concept of population health is understood by those on the ground who have to put it into practice— especially at the level of the RHAs. A second, related observation is that, although the population health perspective (especially the CIAR analysis) has clearly had some influence on health policy at all levels of government— at least, in theory— preliminary evidence suggests that knowledge about the broad determinants of health is not necessarily influencing Canadian health policy or program decisions in practice. Whether or not RHAs in Manitoba are integrating this perspective into their program planning, as well as the barriers that they might be facing in attempting to do so, is unknown. Third, there have been only very preliminary attempts to outline a population health approach to

public health practice at the level of frontline practitioners, and the degree to which these practitioners are using such an approach is unknown. Fourth, while it may seem that there has been little opposition to the adoption of a population health perspective within government, criticism of this phenomenon is evident in the literature. These critiques have come primarily from academic circles. It would be interesting to know if individuals within the RHA have any concerns about the population health perspective. Fourth, the specific relationship between a population health perspective and health promotion has not always been clear. The origins of these two perspectives are different, with the former developing out of the field of epidemiological research, while the latter grew out of Public Health/Community Health practice. As a result, in spite of the mutual agreement that the health of the population depends upon taking action on a broad range of health determinants beyond the health care system, the implications for HP practice are very broad. There has been some effort to link the population health and health promotion perspectives into a PHP approach that identifies specific strategies for taking action on the determinants of health. However, as yet there is no information regarding the application of this framework in practice in Manitoba (or elsewhere), either at the provincial or regional level. It would be interesting to know how the individuals within Manitoba's health system view HP within the context of a population health approach and what role they see for the RHA in putting it into practice. Lastly, the discussion about the relationship between population health and health promotion raises the possibility that, depending on how one defines the two concepts, building capacity for one may not be the same thing as building capacity for the other.

PART II - THE DISCOURSE ON 'POPULATION HEALTH' IN MANITOBA RHAs

3.7 - Discussion of 'Population Health' Concepts Within the RHAs

While the concepts of 'population health' and the 'determinants of health' have become very popular among academics and federal and provincial health policymakers, I was curious about the degree to which participants were familiar with these concepts. I began by asking them if there had been any discussion about 'population health' and the 'determinants of health' within the RHA and, if so, what the nature of that discussion had been? Every participant, without exception, stated that there had been some discussion about one or both of these concepts within their RHA. Most people thought that this discussion had occurred more frequently at the board, senior administration, and program manager levels than at the frontline level. In Regions A and B, participants identified 'population health' as a basic principle adopted by the Board.⁹ However, in all regions, participants felt that there was some degree of commitment to these concepts— at least in theory— at the board, senior administration, and program manager levels. It appears that there were several key factors or events that served as catalysts for discussion of these concepts throughout the RHAs.

In all of the regions, participants identified the Community Health Needs

⁹In fact, at the time of these interviews 'population health' and 'acknowledgement of the full range of health determinants' were principles adopted only by the Board in Region A in their 'ends' policies. In Region B, the 'Population Health' or 'Determinants of Health' approach was used to guide the Community Health Needs Assessment process in 1998-99, but it was not until December, 2001, that the Board of Directors in Region B adopted a policy stating that corporate priorities would be established, based on a population health approach.

Assessment (CHNA) process as a prime catalyst in raising awareness of the concepts of 'population health' and the 'determinants of health' (DOH) both within and outside of the RHA. Nowhere was this more clearly evident than in Region B, where community education with partners and consumers around the DOH had actually begun prior to regionalization. This work resulted in the establishment of a local steering committee (one year prior to the official establishment of the RHA), composed of community partners representing various determinants of health¹⁰. The Steering Committee was responsible for the planning and implementation of the CHNA process. Under its direction, eight project teams were created, each based on a particular DOH (social support, physical environment, etc.). Each team was comprised of an average of ten interested individuals from the region, and an effort was made to keep each team as multi-sectoral as possible. The project teams were responsible for gathering data for their section of the CHNA report, which is organized according to the determinants of health.

Neither of the other two regions structured every aspect of the CHNA process so tightly around the 'population health' and 'determinants of health' concepts. On the other hand, the concepts clearly informed the assessment process in both regions, and this is evident in their CHNA reports. In Region A, the household survey portion of the CHNA asked people to rate the importance of six factors (lifestyle, environment, health services,

¹⁰The Steering Committee used the determinants of health that are outlined in *Strategies for Population Health: Investing in the Health of Canadians* (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). These are: income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services.

workplace conditions, education, income) on their health. Both objective and subjective data compiled during the CHNA process was organized and presented in terms of population health indicators and the report focussed on priority populations in the region based on these indicators. In Region C, the CHNA report organizes objective and subjective data into ten different subsections, six of which focus on broad determinants of health (geography, politics, demographics, economics, social profile, and physical environment).

The second most commonly stated catalyst for discussion of ‘population health’ and the ‘determinants of health’ within the RHAs was the discussion of these concepts within the context of the health planning process (in all three regions) and the accreditation process in one of the regions. A third commonly stated catalyst was the influence of key individuals within the organization— often within the context of the CHNA, strategic planning, and/or accreditation processes mentioned above. In two of the three regions, the Medical Officers of Health were most frequently mentioned as having promoted and discussed these concepts.

Other catalysts for discussion of ‘population health’ and the ‘determinants of health’ that were mentioned by participants include: communication with the public about these concepts through Region A’s newsletter; discussion of the concepts in orientation sessions for the District Health Advisory Committees (DHACs) in Region A and for CHNs in Region C; discussion of the concepts, and how they might be incorporated into nursing practice, at regional meetings of PHNs in Regions B and C.

These examples of the discussion of ‘population health’ and the ‘determinants of

health' notwithstanding, participants did express some concerns as well. The most common type of concern related to the level of understanding of the concepts. For example, while most participants felt that there had been a lot of discussion of these concepts within their RHA, many of them questioned the degree to which people really understood them. There was general agreement by participants in all regions that the concepts were best understood in the community health sector, and not at all well in the acute care sector. Some frontline staff and program managers questioned the degree to which senior administrators and board members understood the concepts. A DHAC chairperson in Region A acknowledged that DHAC members were at very different levels of understanding these concepts. Finally, in the northern region, the high rate of staff turnover in the community health sector meant that many frontline practitioners had not participated in the CHNA or health planning processes during the previous two years. As a result, they were more likely than their counterparts in other regions to state that they had not heard much discussion of these concepts within the organization. A further contributing factor in this region was the fact that it was the only region which hired PHNs who did not have a university degree. The PHNs who had graduated from a degree program within the previous five to six years were more knowledgeable about these concepts to begin with. A senior program manager in this region acknowledged that, for many employees, discussion of these concepts had been isolated, fragmented, and there hadn't been enough time for people to really absorb them.

The other type of concern expressed by participants related more to the challenge of operationalizing the concepts. Most people who raised this issue agreed that there was

a lot of talk about 'population health' and the 'determinants of health' in the abstract, but little discussion about concrete strategies based on these concepts. Several nurses said that they were finding it difficult to figure out how to incorporate the "buzzwords" into their nursing practice. A senior Health program manager acknowledged that day-to-day operational issues took priority over discussion about how to put these ideas into practice. These and other concerns about the population health approach will be addressed in more detail later in this chapter.

3.8 - Defining 'Population Health' Within the RHAs

Considering that the concept of 'population health' has been put forth as a guiding principle of health system restructuring in Manitoba, it seemed pertinent to find out how the participants themselves understood this concept. They were all asked the following question: "*When you hear someone referring to a "population health" perspective, what does that mean to you?*" The responses can be grouped into six categories, based on the main focus of the definitions provided.

A. Focus on target population for surveillance/assessment/intervention

The first, and most frequent, interpretation of a 'population health' approach or perspective was that it is a term that refers to the target population for the health system's surveillance, assessment, and/or intervention activities. Within this category there were different levels of complexity offered in the definitions. As an example, at the most basic level, one individual offered the following succinct response: "For me, it's always just looking at the entire health of a population, period, that's it." At a slightly more complex level, the idea of getting the 'broad' or 'big' picture was mentioned frequently, as well as

extending the focus beyond individuals– for example, “...you’re looking at a broad picture of population and how healthy is your population...as opposed to individual health.”

Others echoed this ‘broad’ or ‘big picture’ perspective, but focussed more on looking at the *effects* of an intervention– e.g., “To me it means, uh, more of a strategy that when you’re considering population health...you’re considering the effects of your interventions broadly on a defined population as opposed to on individuals or very small numbers.”

One participant gave an example of such a ‘population health’ approach or strategy: “To me that means something that benefits the population at large.... So there the strategy wouldn’t be a one-on-one counselling strategy. It would be like immunizations where you’re going to get mass immunity as well as individual immunity...”

More than one participant stated that a ‘population health’ approach is not limited to use at the individual level. For the following individual, whether or not the focus was on the individual or a larger group is less important than the differences in health status between groups:

Well, to me population health means looking at the health of populations or groups, even individuals. It can be at different levels, you know, individual level, community level, group level. And it’s looking at what makes one group healthier than another group and what can you do to increase the health of that certain population.

There were several examples of ‘population health’ being defined as an epidemiological approach to monitoring illness. As one person stated:

We were given to understand that the health of the population is sort of an umbrella so that you have in [x] region a general statement about the health of the population based on certain criteria, one of them being premature deaths and a few other ones. Once you have determined what the general state of the population’s health is, then you go to the deviations....Certain pockets have more

heart disease or whatever, so that you look at those.

Another version of this type of definition also looks at monitoring the health status of a population, but doesn't limit 'health' status to illness indicators, and distinguishes between different population groups based on age and/or socioeconomic status:

I guess that the first thing that comes to mind is numbers. That there are different age groups within a society and those age groups are at various stages of health or have a particular state of well-being....if I imagined what government was thinking about, they would probably categorize everybody into these groupings...and want to know how well or ill those particular groupings were....I think it [a population] can also be a category of people. People who have something in common. Even when you look at...the whole perinatal component of it. Yea, the babies are all the same ages...but the parents can be from different socioeconomic backgrounds.

Perhaps the most sophisticated definition of 'population health' in this category (at least, in terms of its articulation) makes the distinction between a focus on 'high-risk' populations versus the whole population:

A population health approach means to me that rather than looking at segments of the populations...what we used to do was take high risk populations so people that were at risk of heart attack or people that were at risk of using street drugs. We used to put our energies into those high risk groups a lot. Population health sort of looks at working with people so that the whole population follows those best practices models....So that you mould and shape according to what the needs of the population are versus what the needs of a select group are.

B. Focus on determinants of population health

The second common definition of a 'population health' approach focussed more on consideration of the factors that influence health status, rather than the particular target population:

It's looking at what affects people's health. What perhaps challenges they have

more or less in terms of attaining or maintaining health. It looks at what makes people healthy rather than just focusing on what doesn't make them healthy...

Participants who gave this type of interpretation frequently mentioned the concept of 'wholism' – i.e., using a wholistic approach that considers the broad determinants of health:

I see it as a very broad approach to looking at health or well-being. When I think of population health I immediately think of the determinants of health....It's a very wholistic or broad view and is looking at more than just a person's individual health status...it's looking at the environment they're living in and their working conditions and what not... and thinking about those things when they're going into developing programs or offering services...

Others focussed on the implications of this wholistic perspective for health promotion initiatives. As one individual stated, "It's going beyond teaching life skills or health counselling. It's affecting the things that affect people's health....Things like water, housing, income, sort of much bigger factors." Another participant echoed this interpretation and suggested that, although the "individual stuff" is still important to do, a 'population health' approach means working at a higher level:

It means working at a level that's different than we worked at before, particularly bigger than individuals or families or even communities...one example that I can think of ...is the changing legislation to increase the minimum wage which affects everybody in the province.

Only two participants focussed their definition on the reduction of inequalities in society. One frontline practitioner described the use of a 'population health' approach as thinking about "what makes a just society, " while another suggested that it is primarily concerned with reducing inequalities in health status between population groups:

...getting to that group which has the most needs and providing those services. I mean, it's been shown to be one of the more effective ways of getting the whole population to be healthy....

One senior administrator, who also defined a 'population health' approach as being focussed on the broad determinants of health, pointed out that a 'population health' approach is not something that the health sector can do on its own— i.e., by definition, it requires forming key strategic partnerships:

Population health by definition is not health care. And I would be sceptical of any jurisdiction that frames its health care business in a population health context because all the literature shows that we really don't control on the health side those kinds of things that actually contribute the most to good health. It's your education, jobs, income. And there's nothing in our responsibility of RHA that gives us any direct control over any of those....What we need to do and can do is to form partnerships with the players that affect population health. An example, the educational system...the local Chambers of Commerce, etc. Because that's in fact where you get to the population health agenda.

C. Combination of Type A and Type B

Definitions that combined a focus on the target population and the determinants of health were also common. The following example is typical of this category of response:

For me it's a big picture approach. It is looking from the top down over the large group rather than starting at the bottom on an individual approach...takes in all of the factors including things like environment and social issues, things like jobs and housing and everything together.

One participant (the only person who referred to a definition from the literature) offered a more formal definition, taken from Federal, Provincial, and Territorial Advisory Committee on Population Health's *Strategies for Population Health: Investing in the Health of Canadians* (1994):

A population health approach is defined [in the document] as having two elements; one, that if it is a population health approach it addresses the whole population as its target... and secondly, it addresses the whole range of determinants that affect the health of the population. So that is two sentences that kind of sums it up for me.

D. Focus on providing services that meet population health needs

A fourth category of definition focussed on a 'population health' approach as a more effective means of planning and delivering health services in the region. As one person stated, "it's not a standardized approach." The following definition was typical of this type of this perspective:

To me it means looking at the population you're trying to serve and looking at their health needs. So making sure that these programs and services that you're establishing really fit with what the needs of the population are.

One individual (a senior program manager) differentiated between a 'population health' approach and a *provider-based* approach to service delivery— the latter approach referring to the traditional means of health services planning according to historical patterns of service use and providers' demands for funding.

Several people pointed out that provision of health services that meet population health needs means recognizing geographic differences. As one person stated, "It's not appropriate to deliver health care in the same way in downtown Winnipeg as it is in Leaf Rapids [small town in northern Manitoba]. Populations are different. Their health is different." Other participants, like the following PHN, focussed more on meeting population health needs based on differences in age:

It means looking at the big groupings of ages and whether there's a young community, more elderly people and sort of trying to focus on things that are needed by those particular age groups whether it's parenting or early childhood health or whether it's an elderly population, they need more of senior type of services.

Several participants saw a 'population health' approach as a practical method of using information— i.e., health status indicators— to make more effective decisions about health services planning. One program manager expressed it as follows:

I see it as more of a numbers game. You know, O.K., we got 50,000 in the population. How many have diabetes, how many are schizophrenic....what are the age groups? It helps me to determine sort of where the need is, where the hot spots are....what is going on in various communities and how to address it or do some planning and to use that information over maybe a 3, 5 year period to see whether we've made impact or change.... It's making us take a different approach in how we deliver services rather than just whatever walks through the door we do.

Another participant contrasted this 'population health' approach to health services planning and decision-making with the former, traditional approach:

I think of it in conjunction immediately with evidence-based decision-making. And those are things that I am confident will lead to better services and to where it's needed. In the past, I think many decisions were made at the provincial level without any real understanding of what was even happening in some of the outlying communities....I really hope that regionalization is a step in gathering the information that's needed to improve, to predict and to put the money where it's most needed. Rather than where it makes the best headlines...

In contrast to those individuals who emphasized the importance of using *evidence* to plan health services, there were those who emphasized the importance of providing health services that focus on needs, *as expressed by* the citizens of the regions. The following response was typical of this perspective:

I guess the way I'm looking at it is that the population is dictating how we do the health care system. It's not me saying that you need to do a, b, and c. We're going to the population asking them what their needs are and then we're meeting those needs and working with that population.

A final variation of this type of definition was offered by one Board Chairperson, who saw a 'population health' approach as an integrated approach to health services delivery within the region:

We're dealing with everything from the diabetic programs that are being maintained on a provincial basis but administered here...we're looking at the mental health, health education components and just, I guess, a very global approach to population health as opposed to trying to refine it in an acute care centre scenario or in a particular mental health scenario. We're really trying to address a continuum.

E. Focus on health promotion and illness/injury prevention

A fifth category of definition described a 'population health' approach as one that emphasizes 'health' and focusses more on health promotion and prevention of illness than on treatment of illness. A typical example of this perspective is provided by a PHN:

Well I think that the population health approach seems to be a positive way of looking at things and I feel that people are sort of making a conscious effort to look at health and how to prevent things instead of how to treat them...

Given the focus of this study, it is interesting to note that this definition was less common than the previous categories and most frequently expressed by frontline practitioners. The role of HP within a population health approach will be discussed in more detail in section 3.12.

F. Miscellaneous

This 'catch-all' category contains a number of definitions which focussed on a variety of characteristics that didn't fit neatly into any of the previous categories. These

definitions were usually mentioned by only one to three individuals at most. For example, one program manager stated that the purpose of the population health perspective seemed to be cost-effectiveness— “you know, serve a larger group, get out there and spread the word to more people and try to do action in the community which is more cost effective than doing one-to-one work.” Three participants (none of whom were frontline practitioners) offered a definition that views a ‘population health’ approach as a method of funding of health services. As one person stated:

It’s been used over the last few years as a potential way of providing the appropriate funding for the people based on the population and the true needs as opposed to just the standard demographics and political persuasion.

It should be noted, however, that these individuals also remarked on the fact that this ideal method of funding was not in place.

A frontline health promoter offered the following unique perspective:

I see it as a long term process, built on developing trust and relationships with people. You don’t do population health *to* people, you work *with* people in making conditions that are, whatever the issue is, to improve their health. It [a population health approach] is very much a people process to me.

Finally, a couple of participants (both employed in a community health centre in their region) suggested that the concept of a ‘population health’ approach is integrally linked with the concept of ‘primary health care.’ One individual believed that “population health falls underneath primary health care.” The other individual felt that there is definitely a link between the concepts of ‘population health’ and ‘primary health care,’ but she was not yet clear about the exact nature of that link and was not able to articulate a definition.

3.9 - Defining the 'Determinants of Health' Within the RHAs

When asked to briefly describe what the term, 'determinants of health' (DOH), meant to them, the vast majority of participants in all regions stated that they thought of the DOH as the broad factors (especially social/environmental ones) that affect an individual's or population's health. One PHN talked about the DOH in terms of how they influence access to health services— i.e., whether or not an individual has the education/knowledge, or income, or social support to access the health services that they require. However, most participants emphasized that health services are only one— and perhaps not the most important— of the factors influencing health. The following comment, made by a nurse, was typical of these responses:

It means the things that keep us healthy, make us ill, and they're not necessarily health services. I think that's just a very small piece of the puzzle. It's broader. It's your attitude even to life. It's your happiness, your sense of belonging, your income, your feeling in control, and your work....It's bigger and broader than the small little health system.

Several people noted that, when they thought about the determinants of health, they were reminded that there are so many agencies and organizations that one needs to partner with in order to address all of these broad influences. As one person declared, "you cannot hope to achieve changes in many of the determinants of health...unless you get out of your office, get out of your own sphere of practice and work with others." One senior administrator suggested that assessing the state of various DOH at the population level— e.g., the state of the economy, levels of unemployment and education, etc.— can help an RHA plan programs. However, a program manager (in a different RHA) was skeptical, stating that whether or not the health system uses this knowledge to determine

health policies and plan health “is a different story altogether.”

There were other unique views of the determinants of health concept that are worth noting. For example, several participants (a senior program manager and two PHNs) thought of the DOH primarily as population health *outcome* indicators, rather than influences on population health. This view of the concept as an indicator of health, as opposed to an influence on health, was also expressed by a board member, who identified the high premature mortality rate in her region due to diabetes and hypertension as an example of a DOH. In another case; while most of the participants perceived the determinants of health and population health as interchangeable concepts, one PHN stated that she distinguished between them. She viewed the DOH as affecting the individual, whereas population health looks at the aggregate of individuals. One person, a DHAC member, stated that, when she thinks about the DOH, she thinks first about lifestyles, because this is something that can most easily be influenced or impacted.

Finally, several people couldn't quite understand why there was so much fuss about the concept at all. One participant summed it up this way:

It's logical. Even growing up, my grandparents would say, how could that family be healthy, God help them, they have no food to eat. Look at the house they're living in. So, I mean, it's not like this is new, except we have a word for it now which I appreciate.

3.10 - Concerns About the Population Health Perspective Within the RHAs

The next question that I wanted to explore was whether or not participants had any concerns about the 'population health' or perspective. I did not want to assume that they believed this to be an unconditionally positive development. Analysis of the

responses indicates that there are four distinct types of concerns about the current focus on 'population health.'

A. Concerns about the concept's utility

A number of participants were not at all impressed by the attention being paid to this 'new' approach. One program manager wondered if 'population health' is "just another fad." A PHN contended that, in the Public Health field, they have always used a 'population health' approach, and she concluded that the term is "just a new buzzword." This sentiment was echoed by a senior administrator, who made the following comment:

I'm always surprised when people talk about this new population health perspective because there's really nothing new about it. We were all knowing it in our bones. We know that you're basically healthier and happier if you have a job....But some sophisticated individual comes along and makes a career out of making it sound more sophisticated and it sounds new. But it really is some very basic common sense.

The lack of a consistent definition and interpretation of the term bothered several people. As one person complained: "...it's so vague that it means almost anything you want it to mean." Two frontline practitioners felt that the concept was too vague to be able to operationalize easily in their daily work. A few participants acknowledged that they lacked a good understanding of what the concept of 'population health' really meant— including a program manager who admitted that she wasn't sure that she had "truly internalized what that means." Another senior program manager acknowledged that staff may not have a solid grasp of the concept of 'population health':

I think somewhere along the way, people need to have the opportunity to understand what population health is, and whether they get that through formal training or by reading or having management who really support those concepts I guess doesn't matter all that much. But I don't think we can assume that people

will automatically be well grounded.

B. Concerns about implications of concept related to attitudes/beliefs/values

A number of participants mentioned that the successful implementation of a 'population health' approach requires political will and leadership, both outside and within the organization. As one program manager lamented, "I don't hear anybody talking about that [population health] right now politically or in communities." A nurse, who felt that a 'population health' perspective is valued (at least in theory) in her workplace, was worried that there "hasn't been enough of a paradigm shift" in other workplaces, and she wasn't convince that this approach would be valued if she went to work elsewhere. Another frontline practitioner expressed her scepticism about the philosophical 'fit' between a 'population health' approach and the current management style of the organization:

I think that the traditional way of managing is very much in conflict with the values of population health....I think that a lot of times, when the rubber hits the road, it's really hard for management to put into practice and to deal respectfully with their employees and with the community when it comes down to actually being challenged for the programs that they run...or how they decide which programs to keep going and which to cut. I still feel that, at that level, there's a real reluctance to listen well. And to give up some power. And I guess for me that's kind of essential to the whole idea of population health....Now we are accountable to the community and we take our direction from the community. And I don't really see that in actuality.

One participant suggested that a 'population health' approach requires shifting everyone's thinking "upstream," which is very hard to do when there are so many needs "downstream." Another individual noted that it's not enough for only the health sector to adopt a new way of thinking, but it also requires other sectors to buy into the approach as

well.

C. Concerns about implications of operationalizing concept (general)

This was the most frequently mentioned type of concern. Several participants felt that operationalization of a 'population health' perspective was too complicated. For some, the belief that it is well beyond the scope of the health care system to influence the broad determinants of health makes it seem too overwhelming a task to focus on the "big picture." As one program manager stated:

...of those determinants, how much is actually within the capacity or the control of a Regional Health Authority, let alone an individual public health nurse? So you can quickly feel overwhelmed by the magnitude of the problem.

One senior administrator suggested that health care workers might not be the best suited to carry out the population health agenda because of their training: "There'd be other professionals that might do the population health agenda much better than we can." A couple of frontline practitioners felt that it was the radical implications of the concept, not merely the complexity, that made it unlikely to be operationalized. One PHN referred to the approach as "a little socialistic," while another participant stated that it is unlikely to ever be more than rhetoric because of its emphasis on reducing inequalities.

The most common concern about operationalizing the 'population health' concept, expressed by frontline practitioners and program managers alike, was the perceived increase in workload as a result of implementation of new initiatives without an injection of adequate resources into public health/community health programs. PHNs frequently gave examples of provincial and Federal 'population health' initiatives, implemented now by the RHAs, which have dramatically increased their workload:

There's a lot more programs that they want to introduce. They've introduced a few more in the last few months. 'Baby First' initiative is one of them.¹¹ Immunization programs are more and more...and we just haven't had the manpower. We've been having to hire casual nurses.

Many participants also talked about the lack of time that they have to be involved in strategies, such as community development work or advocating for healthy public policy change, that they viewed as part of a 'population health' approach (see Chapter Six for more discussion about this issue). Several people insisted that the pressure to provide individual services will always outweigh the demand for population health' initiatives, and some northern participants were concerned that the particularly high demand for acute care services in their region would make it difficult to even consider implementing a broad 'population health' approach.

There were a variety of additional concerns expressed regarding the operationalization of a 'population health' perspective. One frontline practitioner stated that "it's pathetic and contrary" to think that a 'population health' perspective can be applied by RHAs— i.e., by definition, it requires a larger perspective than a local or regional focus. Several participants noted that there is no obvious policy mechanism or intersectoral infrastructure to operationalize a 'population health' approach. The need for

¹¹The 'Baby First' initiative is funded by Healthy Child Manitoba. The program focuses on building and enhancing family strengths— especially promoting healthy bonding and parenting skills— by offering regular home visiting for high-risk families with new babies from birth to three years of age. Using a specially designed screening tool, Public Health Nurses identify which families are eligible for the program and then supervise specially trained Home Visitors who work with these families (personal communication, Bluma Levine, Winnipeg Regional Health Authority, August 20, 2002; information also available on Healthy Child Manitoba's web page at www.gov.mb.ca/hcm/programs/babyfirst/index.html).

long-term planning (as opposed to the short-term planning that currently exists) and the fact that it may take years to see the outcomes of initiatives were also mentioned as a challenge. At least two people expressed concern that a 'population health' perspective may be used by the government as justification for cutting acute care services. One Health Promoter was unsure how community development fits in a population health perspective.

A number of concerns about operationalization related to the use of 'population health' indicators. One frontline practitioner talked about the potential danger of stereotyping people based on these indicators. She used the example of assuming that all poor people are sick because statistics show that socioeconomic status and population health are inversely related. Two participants wondered if a focus on population health indicators can lead to an over- emphasis on certain populations, at the expense of others, and may result in putting too many resources into that population without enough 'return' on the investment. One frontline practitioner felt that the current 'population health' indicators were too focussed on disease, while another worried that a reliance on these types of population-level indicators can lead people to miss subtle issues "under the surface" in areas which, outwardly (i.e., on the basis of population health statistics), don't appear needy. The latter individual, a PHN, used the example of widespread mental health problems caused by the flood of 1997 in an area which is considered to be quite 'healthy' according to population-level indicators. One person noted that government funding often depends on quantitative indicators of population health, whereas she felt that qualitative indicators are just as important using a 'population health' approach. One

last general concern about operationalizing this approach was mentioned by several individuals, who suggested that this would require increased resources for evaluation which, they noted, were not currently available.

D. Specific concerns related to implications for professional practice

The most common concern of this type, expressed primarily by PHNs, was that work with individuals might be neglected when operating within a 'population health' approach. This was viewed as problematic for two reasons. First, there was concern about 'high-needs' clients falling through the cracks. As one PHN stated: "I would be afraid that I would be missing some of the higher needs families that do need my individual support." This sentiment was echoed by a program manager:

For most of my staff, they also have a component of their practice that is with individuals, whether it's doing health assessment or teaching or advocacy, helping them navigate through the system to get the resources that they need. So that would be my one concern [about a 'population health' approach] that we don't go overboard and neglect the value of that primary trusting relationship between two individuals, where so often that's what gives you the information about that aggregate or population...

Second, it was generally agreed by participants with a nursing background that certain staff, particularly nurses, would always be most comfortable working with individuals, and so an approach that is perceived as focussing more on working with larger groups or populations was viewed with some trepidation. A couple of non-nursing frontline staff, however, were more concerned that a 'population health' approach might lead to less work with small groups, which they viewed as their main priority.

The issue of increased knowledge and broader skills that are required of health care provider who use a 'population health' approach was also raised by several

participants. Lack of comfort in dealing with the politics of population health was mentioned frequently by frontline practitioners, especially PHNs. One individual suggested that, unless staff buy into the 'population health' approach, they will fall back on what they know best— i.e., a focus on illness. Another frontline practitioner suggested that there may be resistance from certain health professionals to adopting a 'population health' perspective, as they may perceive this as somehow eroding their power or responsibilities. A program manager stated that, unless the concepts of 'population health' are integrated into health care providers' daily work, then they would remain of abstract value at best. Another program manager noted that PHNs are bogged down in mandatory program activities, so they have no chance to "live and breathe" a 'population health' approach.

3.11- Current Use of a Population Health Approach Within the RHAs

After discussing participants' concerns regarding the population health approach, I asked them to what extent they felt that they were utilizing such an approach in their daily work. An analysis of the responses indicates that participants can be divided into two main categories: those who felt that they were not using it very much (if at all), and those who felt that they were using this approach to a certain extent and who gave examples.

A. Not using this approach much, if at all, in their day-to-day work

There were two types of people who fit into this category. The first group— consisting primarily of middle-level and senior program managers, plus a senior administrator— suggested that the use of a 'population health' approach was either sporadic or non-existent. One senior administrator stated bluntly: "We have to be frank

about it. The first three years, most of our focus has been on health *care*. I think that we do that well. We can improve it. It's significant and important. It's also clearly not population health." One senior program manager stated that staff are acutely aware of the 'bigger picture' issues affecting mental health, but suggested that they don't have a lot of influence over those factors. Several Public Health/Community Health program managers expressed a common concern that only a small part of the work their staff engaged in on a daily basis can be considered a 'population health' approach— and these activities were primarily limited to disease prevention, such as immunization.

The second group of participants who fit in this category— consisting primarily of PHNs and a few other frontline practitioners— stated that dealing with the immediate needs of individual clients dominated most of their day-to-day work and prevented them from having a population health focus. For the most part, these individuals seemed to take the view that, if you are working primarily at the individual or even small group level, then you are not engaging in a population health approach. Time constraints were frequently mentioned as the main barrier to utilizing this approach. One of the more interesting explanations was provided by a non-nurse participant, who admitted to struggling with how to make the personal shift in practice to a 'population health' approach. This individual used the 'upstream-downstream' parable to convey how they were so preoccupied with what's happening downstream that they have difficulty focussing upstream on the 'bigger picture' of population health.¹²

¹² The 'upstream-downstream' parable, with its message of 'thinking upstream,' is usually credited to McKinlay (1979). In one particular region, this parable was mentioned frequently by a variety of participants, who credited a former Medical Officer of Health

B. Attempting to use a 'population health' approach (examples)

The second major category of participants were those who stated with some certainty that they were attempting to utilize this approach in their day-to-day work and they offered examples of this. All the PHNs in this group stated that, even though most of their work was at the individual and family level, they always try to consider the broad social, economic, and other environmental factors that might be influencing a particular situation or that might be creating a barrier to the client's ability to access services. For example; one nurse insisted that the use of a 'population health' approach fits completely with the Public Health nurse's role, since (according to her) PHNs always consider the broad determinants of health in their work with individuals, families, or larger groups in the community. Some frontline practitioners, both nurses and non-nurse participants, gave examples of how they tried to remove barriers that might be created by factors in their clients' environment (e.g., arranging transportation for isolated mothers so that they could attend a Peer Play group with their children). Others talked about the need to take into account an individual's education level and financial situation when considering potential strategies or activities to address their problems. One newly hired nurse expressed her desire to become involved in advocating for municipal legislation that would restrict smoking in public places, which she viewed as an important population health strategy.

Several individuals mentioned that the planning of programs/services, based on

with having influenced their thinking by frequently using the story in her discussions within and outside of the RHA.

community health needs assessments and other population health studies, was an example of how a 'population health' approach was being utilized on a day-to-day basis in their region (if not specifically in their daily practice). Several employees in a community health centre gave examples of broad strategies, including advocacy and inter-sectoral collaboration, that were being used to develop programs and services for youth in their area. One PHN offered a somewhat different view of utilizing a 'population health' approach for health services planning, which she equated with "listening to the community as to what they want." She went on to say that "if there's a request, there's a need. And then I just organize my time to meet that need."

One program manager noted that all job descriptions in the community health sector in her RHA were re-written to reflect a 'population health promotion' model, and she stated that her staff had played an educational role with colleagues in other parts of the health system regarding the concepts of 'population health' and the determinants of health. However, a frontline practitioner in that RHA suggested that they still need to determine what every staff member should be doing, within their scope of work, if they really want to use a population health model. Only a few individuals stated that the utilization of a 'population health' approach was the main focus of their work—most notably the Medical Officers of Health. One Health Promoter stated that "it [the population health approach] is so much a part of my belief system that it happens without me even knowing that I'm doing it. Because I really believe in it."

Perhaps the most interesting comment came from a senior program manager, who identified the influence of certain individuals as the key predictor of how extensively a

population health approach is utilized (or even understood):

My assessment is that it [the use of a population health approach] is quite variable and dependent some on individual staff philosophy about this. And also dependent on how intense the program manager is about staff having some knowledge about this. And we certainly have at least one program manager who has a very broad understanding of population health and really lives it in her practice and encourages her staff to live it in theirs as well....she's also in my view the most influential person in the regional health authority in promoting this concept. I think that she's really been quite effective in educating management and even to some extent the board around what population health is. In terms of day to day operation, I think it's mainly variable.

When asked to describe 'population health' programs operating in their region, most participants identified provincially- and federally-funded programs, including: a province-wide registry for infants at high risk for deafness; the provincial Diabetes Education program; the provincial immunization programs; and a variety of early childhood intervention programs (e.g., 'Baby First,' Women & Infant Nutrition, Aboriginal Head Start, 'Baby's Best Start'). There was only one RHA where a regional population health program was being planned. Several participants in this RHA mentioned their proposal to establish an early childhood development and parenting centre in a district with low socioeconomic status and poor health status (according to population health indicators).

In addition to the two main categories of responses regarding utilization of a population health approach, it should be noted that there were a few responses which suggested some confusion and uncertainty about the concept, at least in terms of their use of it in day-to-day practice. For example, one frontline nursing practitioner, who earlier defined a 'population health' approach as being much broader than individual clinical

interventions, later stated that “sitting down with someone and teaching them about diabetes is one population health approach.” Another nurse, who earlier defined a ‘population health’ approach as helping the public to acquire information about how to keep themselves healthy, admitted that she didn’t really know if she was using this approach or not, but (after much thought) stated that providing information about car safety and immunization to mothers in Child Health clinics might be considered a population health strategy.

3.12 - Relationship Between ‘Population Health’ and ‘Health Promotion’

After eliciting the participants’ views regarding various aspects of the population health approach, I was interested in discovering how they viewed the role of health promotion within such an approach. In particular, I wondered whether this differed in their minds with traditional approaches to health promotion.

Only one participant within an RHA claimed that there was very little difference between traditional health promotion and health promotion from a population health perspective. A program manager suggested that a ‘population health’ approach to health promotion is just “doing education on a bigger scale.” The rest of the participants identified five distinct characteristics of a ‘population health promotion’ (PHP) approach that could be contrasted with a more traditional health promotion approach. Some people focussed on only one of the characteristics as the distinguishing feature of a PHP approach, while others mentioned more than one. None of the participants mentioned all five distinct characteristics. The first five characteristics were mentioned by more than one participant. The last category includes a couple of unique characteristics that were

only mentioned by one person.

A. PHP focus is on larger groups

Whereas the focus of traditional HP work is on individuals and families, PHP is directed toward groups, communities, and larger populations. Interestingly, this characteristic was mentioned infrequently, and primarily by participants with nursing backgrounds.

B. PHP focus is on positive concept of health

Whereas traditional HP has often assumed that 'health' is the absence of illness, PHP is more concerned with promoting 'health' in its most wholistic sense. As one PHN stated, from a PHP approach, "you can still be healthy with an illness." Another participant was more pessimistic about whether or not this characteristic of PHP was being operationalized:

To my mind the difference would be that in a traditionally modelled biomedical orientation to disease, and calling it health, would mean that health promotion is really disease prevention and only disease prevention. If you take a population health perspective then health promotion should I hope be broader than disease prevention, although a heck of a lot of energy of most health promoters still goes into disease prevention. And yes, you need that, but to my mind it should be maybe 20% to 30% of the workload...whereas the more dramatic and important things are the health promotion things.

This individual went on to say that the most dramatic and important health promotion strategy is community development.

C. PHP focus is on the determinants of health

Whereas the focus of traditional HP work is on health education for behaviour change, and telling people what they shouldn't do, PHP focusses on the broad

determinants of health. This was one of the most frequently mentioned characteristics. Several people referred to PHP as a “socioenvironmental” approach, as opposed to a more traditional “lifestyle” approach to health promotion. In most cases, the major implication of this characteristic was expressed as a need for health care providers to consider these broader factors when dealing with individuals, families, or larger groups:

I think that in the traditional mode we'd say, now if you just eat well and exercise you'd be healthy, so let's just get you out there jogging and we'll give you the Canada Food Guide and you make sure you don't get fat and everything will be just fine. And now of course we would say to ourselves, this is a particular problem with a particular group... and we look for the characteristics and for the determinants of that particular problem. [program manager]

Several participants suggested a slightly more proactive role for health care providers in relation to this characteristic— i.e., a PHP approach involves taking action on those determinants of health. Assisting individuals to take action themselves was the most commonly expressed approach:

I think that within the whole spectrum of health promotion it's gotten away from just the education thing. Like it's bigger than that. It's making people aware of their environment and...empowering people to improve their situation or improve the situation in their community. [health promoter]

However, several individuals noted that, sometimes, it means that health care providers themselves must get involved. The example that seemed to stand out in the minds of many participants was the experience of the provincial Medical Officers of Health in Manitoba who advocated for an increase in the provincial minimum wage, arguing that this was a public policy change that would contribute to improved health of the population. One frontline practitioner noted that the broad focus of a PHP approach forces health care providers to be more creative in their thinking and how they approach

health issues in the community. There were a few people who pointed out that, because of its focus on the broad determinants of health, a PHP approach cannot be owned by the health sector alone. The comments of a program manager were typical of this type of response:

Most research shows that the most significant impact on our health status is from those factors that are related to policy and social issues, environmental issues that are beyond the health system....

D. PHP focus is on community participation in planning

Whereas the traditional approach to HP was characterized by programs that were planned and implemented by service providers (based on needs that they identified), a PHP approach is characterized by client involvement and planning based on their expressed needs. This characteristic was mentioned most frequently by frontline practitioners:

I think there was less participatory action [using a traditional HP approach]..... Now I think with population health...there's much more participation from the community and from the individuals and that's what I think will make things better, as opposed to the old traditional way of just coming in and saying, this is what we're going to do and then attempting to do it without assessing what the actual needs were... [CHN]

E. PHP focus is on evidence-based planning

This characteristic is linked to the previous one, in that it is concerned with who decides, and how they decide, which programs/services are implemented. Whereas traditional HP planning seemed to be based on historical trends and/or needs as perceived by service providers, the emphasis in PHP is on 'evidence-based' planning. The formal Community Health Needs Assessment, carried out in all of the RHAs during their first

two years of operation, was frequently mentioned by all types of participants as an example of this approach. In fact, it is impossible to separate this characteristic out from the context of the regionalization process itself– i.e., PHP is based on the evidence of regional population needs:

When I think about the traditional ways of having approaches to health promotion, often times it seems that they were initiatives that were determined elsewhere and you're importing either a program or a strategy that was determined elsewhere and you're adopting it and you're implementing it....But now I think we're very careful when we look at programming and we look at strategies to consider what the impact is on the community we want to target. So if we're considering population health in terms of our RHA, it's going to be different than population health in terms of the province. [program manager]

F. Other characteristics

One participant had a unique perspective regarding what makes a PHP approach different from a more traditional HP approach. This person suggested that, if one holds the belief that the socioenvironmental approach to health promotion is the only valid one (i.e., taking action on the social, environmental, or structural barriers to health, rather than focussing on changing people's behaviour or lifestyle), then the only difference with a PHP perspective is the inclusion of access to clinical services in the list of determinants of population health.

3.13 - More Thoughts on 'Evidence-Based Decision-Making' Within the RHAs

Although the interview schedule did not include a specific question about evidence-based decision-making, the number of participants who raised this issue while discussing the 'population health' perspective was significant enough to explore their comments in more detail. The most striking aspect of comments made about 'evidence-based

decision-making' was the degree to which one region dominated the discussion about this concept. Participants from each category in Region 'A'— frontline practitioners to program managers to senior administrators to board and DHAC members— had something to say about evidence-based decision-making. Frontline practitioners and program managers expressed their view that the RHA had a strong evidence-based approach to program planning and service delivery through the use of population health indicators and other information gathered during the CHNA process— information, they suggested, that can be used to measure whether there is an improvement in population health over time. A senior administrator gave an example of how population health indicators were used to identify a district in the region that had poorer health outcomes and greater needs for health (and other) services than other districts, resulting in the development of several initiatives (including the opening of a health centre) in the area.

Several PHNs identified evidence-based decision-making as the main distinguishing characteristic between health promotion within the context of a population health approach, and traditional approaches to health promotion. One nurse stated that she liked seeing the 'evidence-based' piece in the PHP model's foundation because "for years, we haven't measured what we've done." A DHAC member declared that, when she thinks about a population health approach, she immediately thinks about evidence-based decision-making, and a Board member confirmed that there had been a lot of discussion about this concept at Board meetings.

Why is there such a strong emphasis on evidence-based decision-making in this region? The influence of two key individuals within the organization— the Chair of the

Board of Directors and the Medical Officer of Health (MOH)— may be the answer to this question. It was noted by several people that evidence-based decision-making had been adopted by the Board as a basic principle of the RHA's mission. A Board member identified the Chair of the Board as being a major proponent of the concept:

Our Board Chair is a researcher by virtue of his previous life....he is very keen on evidence-based decision-making and has made a point of taking time to educate the Board about what a community health assessment is, why it needs to be done, what it is going to accomplish, how decisions from that are going to be used when we do our planning....

The other, perhaps even more, influential person in Region 'A' is the MOH, who was identified, and widely praised, as the architect of the CHNA process in the region (with its heavy emphasis on population health indicators) and a major proponent of using empirical evidence to plan health programs and services for the population of this region. There were a few references to evidence-based decision-making in the other two regions. However, a salient feature of the remarks in those regions was that they were made primarily by non-frontline practitioners. The following tentative comment by a senior administrator in one region was fairly typical:

I think we have changed some of the ways we're doing things. I think we've become more critical of some of the ways we're trying to do things and trying to say, well, what is working and what's not working and let's, you know, again, we need another buzz word, evidence-based.....

Another striking feature of the discussion about evidence-based decision-making was the lack of criticism about the phenomenon mentioned by participants from the RHAs. Concern about population health indicators leading to certain populations being over- or under-served has already been mentioned. One non-nurse frontline practitioner

expressed her concern that the organization lacked the research and evaluation staff required to support evidence-based decision-making in her region. Another individual acknowledged that evidence-based decision-making may occasionally clash with the demands of the public (as in the personal care home example).

3.14 - Current/Former Manitoba Health Employees Talk About the Population Health Perspective

Although the main focus of this study is on the perception of individuals within the RHAs, I was interested in obtaining the perspective of those individuals who were currently or formerly employed by the provincial Health Department as well. Three former employees and two current employees were interviewed.

To begin, the five current/former Manitoba Health employees were asked for their interpretation of a population health perspective. Interestingly, both of the current employees provided similar definitions which clearly fit into the category combining a focus on the target population (in both cases, identified as the 'whole' population rather than individuals) with a focus on the whole range of determinants of health (in one case, "beyond health care and health behaviours" was stressed). Both of these key informants implied that this was the standard definition of population health and one of the individuals stated that the definition was taken from the *Strategies for Population Health* document (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). The three former Manitoba Health employees provided different definitions. For one individual, a focus on the health of the entire population was the primary characteristic of a population health perspective. Another person stated that a population

health approach “is a recognition that as a population how we choose to live our lives, use the resources, live in our world, can have an impact either negative or positive on our health.” A third individual described a population health approach as “broader than the individual, and it is health not disease in its orientation, and it is life-long in its orientation and society-wide with heavy cultural implications to it.”

Regarding the differences between HP in the context of a population health perspective and traditional views of HP, only one individual stated that there was very little difference between the two. This person (a former employee who had worked in health promotion before and after the population health perspective became popular) felt that both were directed towards the entire population. Again, both of the current Manitoba Health employees gave similar descriptions, suggesting that the population health concept made the idea that HP is broader than educating people about healthy behaviour more explicit.¹³ This was the main distinguishing characteristic for another former employee, who emphasized that a lot of health promotion cannot be done by health professionals. The third former employee viewed traditional HP as being focused more on disease prevention, whereas PHP focuses on health. This individual added that the population health approach to HP must include a community development orientation. The most comprehensive description of the key characteristics of a PHP approach was offered by a current Manitoba Health employee, who views PHP as having both vertical (within the health sector) and horizontal (across sectors) dimensions. Whereas traditional

¹³These two employees do not work in the same unit within Manitoba Health and would not have much (if any) contact on a daily basis.

HP tended to focus more exclusively on changing individual level behaviour through interventions within the health sector, a PHP approach needs to utilize strategies at various levels (individual, community, government) both within the health sector and also across sectors. The participant used the example of tobacco prevention to illustrate this point.

The former Manitoba Health employees were asked whether or not there had been discussion of a population health perspective and concepts such as the determinants of health when they worked for the department. Interestingly, both of the employees who had worked in very senior program/policy development positions stated that there had been a lot of discussion about them. In contrast, the employee who had worked in a field position stated: "In my experience they were only vaguely discussed....I never saw any evidence of them actually being incorporated into any of the work that was going on down there." One of the former senior employees acknowledged that these ideas may not have filtered down to the field level of the department. The former frontline employee made another interesting observation about the discussion of the population health perspective within the department at the time of her employment as a frontline worker. She stated that although the language of 'population health' was increasingly popular within Manitoba Health it was viewed as a concept that was developed by the Federal government and, therefore, there was resistance within the department to adopting this approach. This individual did acknowledge that recent work of the department in developing population health indicators for the regions was one way that it has utilized a population health approach. However, she also suggested that many of the Health

Canada initiatives (e.g., Healthy Communities, Community Action Program for Children or CAP-C, Aboriginal Head Start, prenatal nutrition programs) are doing what Manitoba Health has not been doing— i.e., working with community groups to develop population-level health promotion programs.

The two current employees were asked to what extent, from their perspective, was Manitoba Health currently utilizing a population health perspective. One individual felt that the department was really only using a ‘population health’ approach to the extent that there is discussion about priority populations (e.g., children, aboriginal people, etc.), as opposed to priority diseases— but proposed that this “hasn’t really been operationalized” to any great extent. The other Manitoba Health employee (one of the most senior officials in the department) stated that there were only isolated examples of ‘population health’ initiatives— mostly in the area of disease prevention (e.g., immunization) and also some early childhood health initiatives (e.g., ‘Baby First’)— but that an overall, integrated ‘population health’ approach doesn’t exist from a provincial perspective. This individual noted that there had been discussions with a former Deputy Minister of Health about creating a Population Health Promotion unit within Manitoba Health, but the discussions ceased following the election of a new government and removal of that Deputy Minister from his position.

Lastly, the current Manitoba Health employees were asked if they had any concerns about the population health perspective. Both expressed concerns about the difficulty of operationalizing the concept. One individual noted that there was no obvious political or policy mechanism for implementing a population health approach. This person also

suggested that effective operationalization requires ‘champions’ within Manitoba Health. Unfortunately, the participant felt that many of the strongest champions had left the department. The other employee acknowledged that a lot of the work required to address the broad determinants of population health “is not in a way the responsibility of the provincial Health Department or the Regional Health Authority itself.”

One individual, a current employee of Manitoba Health, focussed on the ‘evidence-based decision-making’ aspect of the population health perspective. This individual had two major concerns. The first one relates to the nature of the ‘evidence’ itself:

Well, there has been a huge rhetorical stance about evidence-based decision-making, but we don’t question what we mean by evidence. Often it seems to me we assume that evidence is so-called ‘objective’ statistical data. We don’t question whether that data is valid....Working in a community setting, evidence would be a very different sort of thing. It would be the subjective knowledge of local people which would constitute the evidence and that would inform action....I don’t think we accept other sorts of evidence very readily.

The second concern relates to the way that evidence, in whatever form, is used:

Then, I’m not convinced that decisions are actually made on evidence to any great extent. I think that evidence is used to rationalize decisions or directions that are acceptable. Okay, so yeah, we want to go this way and here is the evidence....Then, let’s assume that we have legitimate evidence. If the evidence says maybe you should be doing this, and it’s contrary to current policy directions or public opinion or political interests or whatever, I don’t think we act on it then. So evidence is a tool, but it’s used within a political rhetorical context.

With regard to the first point, this individual’s concern about the importance of subjective information is reflected in the PHP framework, which clearly proposes that ‘evidence-based’ may include various forms of evidence, including experiential learning. Although it should be noted that the CHNAs in all three regions did use a variety of methods to obtain community members’ opinions about health, illness, and health care, it

is not clear to what extent this qualitative information has informed subsequent health planning decisions. It is also true that many of the participants talked about the need to *measure* the effectiveness of their interventions and any improvements in population health, so the ‘evidence’ regarding outcomes may be viewed differently than the ‘evidence’ regarding needs. This participant’s second point– that ‘evidence’ is something that can be manipulated for political gain or ignored for political expediency– is in marked contrast to the manner in which ‘evidence’ seemed to be viewed by the rest of the participants– i.e., as completely objective data that can form the basis of value-neutral health planning decisions.

3.15 - Summary

One of the most striking observations regarding key informants’ perceptions of the population health perspective is that, although there has obviously been considerable discussion of the concept (and related ones) within the RHAs– particularly within the Public Health sector– there is considerable variation in participants’ interpretation of the concept and even some acknowledged confusion about what it means. Interestingly, many frontline practitioners expressed doubts that senior administrators, Board members, and even some senior program managers really understood the concepts related to the population health perspective. Senior administrators and some senior program managers, on the other hand, suggested that frontline practitioners probably had less of a grasp of the concepts than they did. All participants expressed concern regarding their perception of a lack of understanding of the population health perspective in the acute care sector of the health system.

Perhaps most significant, for the purposes of this study, is the observation that the majority of participants didn't automatically associate the population health perspective with a focus on health promotion action. Certainly, recognition of the broad determinants of population health appears to be widespread among participants, but only a relatively small number of them included taking action on the determinants of health as a key element of a population health perspective. Significantly, only two participants focused on the need to reduce inequalities in health status. A large percentage of key informants associated this perspective with an approach to using either traditional epidemiological evidence or evidence from population-wide surveys or consultations to better plan services for the entire population or sub-populations within their region. This perspective was particularly predominant in one RHA, where the influence of the Medical Officer of Health during the CHNA and subsequent health planning process appears to have been a major catalyst for discussion of the population health perspective and the shaping of 'public' opinion within the region.

In spite of the fact that most participants did not automatically associate a population health perspective with a focus on HP, when they were asked how they viewed HP within a population health perspective as compared to more traditional approaches to HP, the vast majority did identify differences between the two. A focus on larger groups, on positive concepts of health, on determinants of health, on community participation, and on evidence-based planning were the five distinguishing features of a population health approach to HP. Most key informants associated the traditional approach to HP with a focus on lifestyle change to prevent disease. However, once again,

there was very little discussion about the specific action strategies of a PHP approach (e.g., community development, advocacy for healthy public policy, etc.), so it is unclear how participants conceptualize the difference between these HP strategies and those of a more traditional approach.

Regarding the question of whether or not RHAs are utilizing a population health perspective, most participants could give examples of planning or program activities within the organization that were influenced by a population health perspective, but it seems safe to conclude that a comprehensive population health approach was not operating in any of the RHAs. Significantly, in the RHA where the population health discourse seemed to be most deeply embedded, a senior administrator was adamant that they were only implementing a population health approach in the most sporadic sense. It is also important to note that, in all RHAs, the majority of programs that were identified as examples of a population health approach were federally- or provincially-funded initiatives which did not originate within the RHAs. Many frontline practitioners spoke about how they were trying to use a population health perspective in their day-to-day work, however they noted that there were many barriers to actually implementing this approach.

Concerns were expressed about the population health perspective at all levels in all RHAs. Not surprisingly, the concerns raised by participants were more practical in nature than those offered by academics in the literature. The challenges of operationalizing the concept and the implications for professional practice were the most frequently mentioned. For many people, the complexity of the task made it seem overwhelming,

while others were concerned about the radical implications of the population health perspective. However, only one key informant expressed strong doubts that this kind of perspective could be effectively implemented at a regional level. A salient feature of the discussion was the concern expressed by nurses regarding the implications of a population health perspective on their workload (which they felt had increased dramatically from the implementation of population health programs) and on the nature of their professional practice in general. PHNs in particular commonly associated the population health perspective with working at a group or population level, and they worried that their work with individuals and families might suffer. They also expressed concern that they did not have the necessary skills to engage in a population health approach.

An overall impression upon analysis of key informants' perceptions *within* the RHAs about the population health perspective is that, for the majority of them, this concept remains very much at an abstract level. The need for political will and leadership both within and outside of the RHA in order to integrate a population health perspective into the philosophy of the organization at all levels was a notable concern of several key informants who suggested that, without this happening, the perspective would remain an abstract concept. It is also apparent that, although recognition of the broad determinants of population health status is widespread among participants, individuals within the RHAs are clearly struggling to clarify what the organization's role is (and their own individual roles are) in addressing these determinants of health in their own populations. Lastly, it is clear that, for many of the participants, the conceptualization of a population

health perspective does not automatically include some of the key elements of a socioenvironmental perspective on HP such as a focus on reducing inequity and the use of specific *Ottawa Charter* strategies for HP. The criticisms by those individuals in the literature who argue that the dominant population health discourse lacks the focus on strategies for change and values of social justice of the socioenvironmental approach to HP appears to be germane to these findings. Therefore, it seems safe to suggest that the discourse on population health is a potential barrier to HP in Manitoba RHAs.

There are two salient features of the discussion by Manitoba Health employees regarding the discourse on the population health perspective that are worth highlighting. Although this is a very small sample and cannot be considered representative of the views of the entire department, it is nonetheless significant that the two current Manitoba Health staff (including a very senior official) felt that, at the time of the study, there was no integrated PHP perspective operating at the provincial level and no real policy mechanism for implementing such a perspective. At best, they saw only isolated examples of a population health approach operating at the provincial level. In addition, the failure to proceed with the development of a central Population Health Promotion Unit that could provide support and guidance to the RHAs indicates a lack of political will to implement a PHP perspective. It seems safe to suggest that, without the commitment to an integrated PHP perspective at the provincial level, clarity regarding the RHAs' role in PHP will be difficult to achieve.

A more in-depth examination of HP practice within Manitoba RHAs can be found in Chapter Six, but first, we will examine the phenomenon of health system restructuring

and its implications for health promotion in Manitoba's RHAs.

CHAPTER FOUR: HEALTH SYSTEM RESTRUCTURING: IMPLICATIONS FOR HEALTH PROMOTION IN MANITOBA RHAs

Perhaps the most significant contextual factor influencing capacity-building for HP in Manitoba— at least, in terms of its everyday impact— is the process of health system restructuring that has occurred over the past few years in the province. In Part One of this chapter, the literature on health system restructuring will be reviewed, with a focus on the implications for health promotion action. In Part Two, we will explore the perspective of key informants in three Manitoba RHAs regarding the advantages and disadvantages of the regionalization and integration of health services. The question of whether or not this particular form of health system restructuring will help or hinder capacity-building for HP will be addressed.

PART I - WHAT THE LITERATURE TELLS US

4.1 - Health System Restructuring: The Canadian Context

Health system restructuring is not a phenomenon that is unique to Manitoba.¹⁴

¹⁴Nor is it a phenomenon that is unique to Canada. Over the past two decades, there has been a widespread international effort to implement change in the organization and financing of health systems. It is beyond the scope of this study to explore these international efforts individually. However, it's interesting to note that a technical report prepared for the Fifth International Conference on Health Promotion in Mexico City (Lopez-Acuna et al., 2000) reviewed the progress of member countries of the Pan-American Health Organization (PAHO) towards reforming their health systems. The report noted that, in 1994, PAHO had defined five *Guiding Principles* that they proposed to monitor and evaluate health sector reforms: equity, social participation, financial sustainability, efficiency, effectiveness and quality. Using these principles as a guide, a preliminary assessment of health sector reforms in PAHO member countries found that there was a reduction of gaps in coverage of some basic services and programs, as well as greater receptivity by governments to increased social or community participation in health sector reform initiatives. However, the report concluded that "the driving motivations of reforms have centered so far on economic factors, relegating equity

Since 1990, most of the provinces in Canada have initiated major health system restructuring initiatives, commonly referred to as 'Health Reform,' based on the devolution of authority for decision-making regarding some or all of their health care services (and other human services, in the case of PEI and Quebec) to regional and/or local bodies (Alberta Health Planning Secretariat, 1993; Government of Quebec, 1990; Manitoba Health, 1992; New Brunswick Department of Health and Community Services, 1992; Nova Scotia Department of Health, 1994; Prince Edward Island Health and Community Services System, 1995; Province of British Columbia, 1993; Saskatchewan Health, 1992). In New Brunswick and Newfoundland devolution and regionalization were originally limited to hospital services, although Newfoundland has subsequently created a parallel regional system for community-based services (Church & Barker, 1998). In contrast, British Columbia, Alberta, Saskatchewan, Manitoba, Quebec, and PEI have attempted to establish integrated delivery systems at the regional level covering the full spectrum of health services (excluding physician and pharmaceutical services) (Lomas, Veenstra, & Woods, 1997d).

Hurley, Lomas, & Bhatia (1993) suggest that the rationales being used for these restructuring initiatives— improvement in the cost-effectiveness and efficiency of health systems and increased community participation in health care decision-making— are shared across the provinces. In addition, individual provincial Health Reform plans have

considerations and public health concerns to a secondary level” (Lopez-Acuna et al, 2000, p.4). Specifically, the report suggests that there have been greater gains in productivity and development of purchasing practices than in reorienting resource allocation, with no major shifts to increasing the degree of social protection in health.

outlined other specific goals which focus on population health as an outcome. For example, Manitoba's vision for Health reform is reflected in a set of goals that includes:

- improved general health status of all Manitobans;
- a reduction in inequalities in health status;
- establishing public policy that promotes health
- fostering behaviour that promotes health
- fostering environments that promote health (Manitoba Health, 1992, p.1)

The provinces are currently at various stages of implementation of their restructuring plans at this time, and so it is not surprising that there have not yet been any comprehensive evaluations of these initiatives documented in the literature— at least in terms of how well they are meeting their overall goals. In addition, there is little information about the *process* of regionalization and integration of health services in any of the provinces. One exception is the work done by Lomas, Veenstra, & Woods (1997a; 1997b), who surveyed the members of the boards of devolved health care authorities in Alberta, Saskatchewan, PEI, British Columbia, and Nova Scotia regarding their backgrounds, resources and activities, motivations, attitudes and approaches. The study found that, among other things, board members were grappling with the sometimes conflicting pressures of accommodating the expectations of provincial governments, providers, and community residents. Another exception is the report of a 1997 survey of members of Saskatchewan district health boards (Lewis et al., 2001). Some of the positive findings in that survey include the fact that 63% of respondents felt that devolution of authority from the province to the health districts had resulted in increased

local control and better quality of decisions, a large majority (80%) thought that their boards were responsive to the wishes of district residents, a small majority (59%) believed that health care reform had been designed to improve health rather than to reduce spending, and most (70%) believed that district residents supported their decisions and understood and respected board choices. Negative findings included the fact that 76% of respondents felt that boards were legally responsible for things over which they had insufficient control, 63% felt that they were too restricted by rules laid down by the provincial government, and 56% perceived that there was no clear vision of what the reformed health system should be like. Perhaps one of the most salient feature of this study is the difference between perceptions of those board members who were elected versus those who were appointed. Significant examples of this disparity include the fact that 64% of elected members versus 42% of appointed members felt that the board had less authority than expected when the districts were formed, 17% of elected members versus 3% of appointed members felt more accountable to their ward residents (as opposed to *all* residents in their districts), and 47% of elected members versus 29% of appointed members believed that health care reform had more to do with reducing government spending than with improving health. Lomas (2001) notes that many provinces that originally promised elected boards have since thought better of the idea, and he suggests that, while elections can increase democracy (if the 10% voter turnout in Saskatchewan's 1999 board elections can be called democracy), they constitute an expensive additional process that will not likely change board outcomes.

The third exception is the work done by Casebeer and her colleagues, who used a

case-study approach to explore an Alberta RHA's strategies for altering service delivery patterns towards increased community-based, health-promoting care. In the initial study (Casebeer & Hannah, 1998), ten variables were identified as being critical to the transition. Four of these variables were seen to be pre-requisites to effective change (sustaining political will, pacing, resourcing, committing to change), while the others (leading, communicating, informing, learning, planning, adjusting) were described as continuous process variables. In the later study (Casebeer, Scott & Hannah, 2000), both the positive and negative organizational and people factors influencing the shift were identified, as well as possible measurement indicators of and strategies for the desired shift. Negative organizational factors included lack of infrastructure, lack of control over funding, and the multisectoral nature of health. Negative people factors included leadership style, mistrust, lack of support from both professionals and the public. Positive organizational factors included shared vision, creating a new mindset, supportive structures, and sufficient time for change to occur. Positive people factors included people who have the skills to support the change process, commitment, collaboration and disciples (i.e., people who have had positive experiences within the new system). One of the limitations of this work is the lack of definition of what the goal of community-based health promoting care is. Another is that it only included the perspective of RHA board chairs and CEOs, not middle-level managers or frontline practitioners.

The literature does contain a number of reviews describing different Health Reform models and the status of Health Reform implementation in various Canadian jurisdictions (Canadian Medical Association, 1993; Hurley, Lomas & Bhatia, 1993; Premier's Council

on Health, 1993; Dorland & Mathwin Davis, 1996), as well as several more critical analyses of the advantages and disadvantages of Health Reform and regionalization (Burgess, 1996; Canadian Medical Association, 1993; Church & Baker, 1998; Gray, 1995; Lewis, 1996; Lomas, 1996a; Lomas, Veenstra, & Woods, 1997c). For example, Church & Baker (1998) make the case that regionalization in Canada is unlikely to meet the expectations for cost savings, efficiency of service delivery, equity in service provision, enhanced citizen participation, and increased accountability of decision-makers. They argue that regionalization faces major challenges, including: obstacles to integrating and coordinating services in a manner that produces economies of scale; requirements for an enhanced level of information that may be difficult to achieve; an unlikely ability to involve citizens in health care decision-making; and a likelihood that it may actually lead to increased costs. The authors conclude that, if governments in Canada wish to ensure a successful health care system, they must rethink their commitment to regionalization. The future of regional health authorities in Canada is also questioned by Lomas (2001), who notes that boards were created in an era of fiscal restraint, "at least partially to absorb and deflect blame from provincial governments for the tough choices that came with resource famine" (p.357). Lomas (2001) suggests that as we head into an era of re-investment in health care, there is the very real possibility of the pendulum swinging back toward centralization and the erosion of the authority and role of regional boards.

There is very little discussion in the literature, however, about the implications of regionalization for the Public Health sector specifically, and for health promotion within

Public Health in particular. In the late 1980s and early 1990s, virtually all provincial and territorial commissions reviewed their health systems and made recommendations for health system reform, and they all stated that there was a need for greater emphasis to be placed on illness prevention and health promotion (Angus, 1994). A review of a number of government strategic plans for health reform in the early 1990s suggests that one of the commonly expressed goals of restructuring is to shift resources from institutions to community-based care, primary care, and health promotion (Mhatre & Deber, 1992). Thus, in theory, Health Reform *should* have positive implications for health promotion in the Public Health sector in an integrated health system.

The most comprehensive argument in support of this position can be found in a position paper released by the Canadian Public Health Association (CPHA) Board of Directors, *Focus on Health: Public Health in Health Services Restructuring* (Canadian Public Health Association, 1996b). The two key messages that are explored in *Focus on Health* are (i) that restructuring will be successful if it is based on an investment in health, and (ii) that Public Health must be a full partner in the restructuring process. To have a health system that invests in the health of Canadians, the CPHA Board argues that the restructured health system needs to focus on *health* (not just *health care*) and address the full range of determinants of health including housing, income, education, employment and social supports. It also needs to make a commitment to healthy public policy; advocating for policies involving a wide range of sectors at the municipal, provincial, and national levels that contribute to population health. Finally, the CPHA Board argues that a restructured health system needs to include the full continuum of services, from

institutional care to community-based services. However, they warn that a shift from institutional to community *care* is not enough to ensure an investment in health. Rather, community-based health services must be oriented towards primary prevention of illness and promotion of health. In *Focus for Health*, a case is made quite convincingly that Public Health should play a key role in health system restructuring in Canada because of its unique combination of perspectives, skills and knowledge that may be offered collectively through an organized system of practice and that place it in an ideal position to reorient the health system towards an investment-in-health approach. Eight specific contributions that Public Health can make are outlined. These can be summarized as follows: (i) a focus on health, rather than illness, permeates all Public Health work, and the Public Health perspective addresses the health of individuals within the context of communities and societies at large; (ii) Public Health providers offer knowledge and support to build the capacity of individuals and communities to understand what contributes to health, what puts health at risk, and to develop skills to assist with healthy choices and effective changes where they can be made; (iii) Public Health is unique in that it has the mandate to undertake health promotion, disease prevention and health protection for the entire community; (iv) Public Health workers use epidemiological and social analysis tools to monitor and protect the health of the population; (v) Public Health workers help to improve overall health of the community by using an interdisciplinary, population-based approach for the planning and delivery of services; (vi) Public Health providers work in partnership with specific populations to identify health issues and develop solutions, strengthening their capacity to take charge and to effect change, both

collectively and individually; (vii) Public Health plays a leading role in developing partnerships across professional groups and between sectors to address health concerns and needs; and (vii) Public Health workers promote health in its broadest form, by advocating for the development of public policies that go beyond targeting high risk individuals to targeting high risk conditions such as housing, income, education and the ecosystem.

While *Focus for Health* may be the strongest theoretical justification for the central role of Public Health— and health promotion— in a restructured health system that has ever appeared in the literature, it does not deal with the potential barriers to putting these ideals into practice, and we have very little information about what is actually happening in the real world of ‘Health Reform.’ The only study that has been done looking at the impact of health system reforms on public health systems across Canada involved a survey (mostly by mailed questionnaire) of Directors or CEOs, and other Public Health managers in different regions of the country (Canadian Public Health Association, 1997). The overall response rate was 58 percent (54 percent in Manitoba). While there were individual provincial and territorial differences reported (unfortunately, details of these differences are not mentioned in the summary document), overall, health reforms were reported to have had a negative impact on health promotion, a positive impact on healthy public policy, and no significant impact on health protection, disease prevention and disease surveillance and control. The problem with these findings is that the different provinces were at very different stages of health system restructuring at the time that the study was conducted. For example, the survey was conducted prior to the end of March,

1997— i.e., *before* the devolution of authority for, and integration of, health services in Manitoba came into effect. It appears that some of the Manitoba respondents gave information in accordance with their current infrastructure (prior to the end of March, 1997), while others gave information based on expectations of their future infrastructure following implementation of the Regional Health Authority in their area. Unfortunately, asking respondents to assess the overall impact of health system reforms on Public Health effectiveness and efficiency at a time when Public Health was not even part of health system restructuring efforts in Manitoba renders the results virtually meaningless. The only information from the Manitoba section of this study that can be viewed as valid are the comments that respondents made regarding their hopes and fears for the future of Public Health in a regionalized and integrated health delivery system. When these respondents were asked to rate how they expected future health reforms to impact on the scope, quality, funding and staffing of programs and services, overall, respondents were optimistic.

As for some of the other provinces, in Prince Edward Island (PEI) a population health promotion strategy was chosen as one of the guiding principles of Health Reform, and a Health Promotion Framework was developed to guide strategic planning for health in that province (Prince Edward Island and Community Services System, 1996). However, it is unclear to what extent the philosophy has translated into actual resource-allocation for services and programs that focus on health promotion and prevention of illness. Similarly, in Saskatchewan (Saskatchewan Health, 1993) the vision of the health system is based on the concept of “wellness,” and one might anticipate that this type of

philosophy would influence resource-allocation decisions in favour of public health/health promotion programs. This remains to be documented. Both the Saskatchewan and Manitoba models of Health Reform feature a 'one-way valve,' which only allows resources to be re-allocated from the acute-care sector to the community, and not the other way around. However, this will not necessarily benefit public health promotion and illness prevention programs.

In Quebec, the 'Policy on Health and Well-Being' (Cote, 1992) clearly states the Ministry of Health's intention to shift the emphasis from medical care to prevention. In fact, up to 1996/97, the public health budget was protected from budget cuts.¹⁵ However, Desrosiers (1996) noted that, along with the second wave of budget cuts in that province, there was increasing pressure for the local community services centres (CLSCs) to focus on providing primary *medical* care, rather than disease prevention and health promotion. Desrosiers warns that the massive transfer of nurses from hospital settings to the CLSCs in order to consolidate specialized at-home care will not result in an increase in the resources allocated to preventive and supportive services intended for the most vulnerable or at-risk client groups.

One of the key factors that will influence public health services in the future relates to the designation of 'core' or mandatory services. Historically, health services defined as "medically necessary" have been publicly funded under the Canadian health insurance system. The Canadian Public Health Association (1996b) warns that, if these services

¹⁵This information was provided by Dr. Luc Boileau in his presentation on 'Public Health Regionalization in Quebec' at the CPHA Annual Conference, Vancouver, July 1996.

have not been defined by provincial and territorial governments as mandatory 'core public health services,' there is potential for a board (especially if dominated by a particular interest group) to decide *not* to fund certain services— such as sexual health or needle-exchange programs— that have traditionally been provided by the public health sector.

A review of core Public Health functions in six provinces (Newfoundland, New Brunswick, Ontario, Manitoba, Saskatchewan, and Alberta) found that mandated (or expected) responsibilities were almost entirely related to communicable disease control and health protection services (Sutcliffe et al., 1997). Many provinces had no evidence of mandated programs that were specifically 'health'-focused, that addressed broader determinants of health, or that addressed the prevention of non-communicable disease. The authors concluded that it is entirely possible, despite all the rhetoric about increasing the emphasis on health promotion and disease prevention, that regional health authorities faced with the need to ration scarce resources may only keep those mandatory programs which focus on the traditional "core" public health activities related to communicable disease control and health protection. In Manitoba, health promotion/education has been defined as a 'core health service' that will be required in every region (Northern/Rural Regionalization Task Force, 1997). It will be interesting to see how this is interpreted by the RHAs.

Over the past few years there has been increasing discussion about 'vertical integration' of health services, 'integrated delivery systems,' and breaking down the 'silos' in health service delivery (Pink, 2002; Moralis, 1997; Verlaan-Cole, 1996). In one

sense, Manitoba, Quebec, Saskatchewan, Alberta, British Columbia, Nova Scotia, and PEI may now be evolving toward integrated health systems (IDS), in that their regional health boards are responsible for the governance and delivery of a continuum of care, from Public Health to acute- and long-term care. However, as Vail (1997) notes, integration of the provincial systems has primarily taken the form of horizontal consolidation of boards and services. These services are still very much separated into 'silos' of care— Public Health services, home care services, acute care, and so on.

It is unclear at this point whether health reform in Canada will go beyond the initial stage of horizontal restructuring to develop innovative models of vertically integrated health services. There is debate about which IDS model is preferable in Canada (Vail, 1996). While a lot of the debate appears to center around the best method of payment— capitation versus salary— an important distinction is whether or not the model views primary care in terms of primary *medical* care or primary *health* care (PHC). In the former, the current public health functions would probably be limited to communicable disease control and preventive medicine on an individual basis. In contrast, the primary health care model that has been proposed by the Registered Nurses Association of Ontario and several other groups emphasizes interdisciplinary teams of health providers, inter-sectoral cooperation, greater emphasis on health promotion and community development, and public participation in identifying community health needs (Vail, 1996). It should be noted that, in Europe, there is a general trend in both publicly operated and social insurance-based health systems to integrate certain preventive and health promotion functions, formerly carried out by vertical public health programs, into

PHC models (World Health Organization, 1996).

In Canada, those who suspect that the changes to health care by provincial governments have been driven fundamentally by fiscal pressures, rather than by any deep interest in improving the effectiveness or the orientation of the health system, express concern that governments and authorities may see the structural changes (setting up of regional governance structures and consolidation of existing boards and services) as being all that are required under a managed-cost approach—and not proceed further (Vail, 1996). In such a situation, Public Health is likely to be given a low priority in an environment where rationing of scarce resources is most sensitive to the needs of the acute-care sector, and HP capacity would therefore be limited.. It remains to be seen how the new regional health authorities deal with this issue.

Another factor that may influence the future of Public Health programs in a restructured health system relates to the model of governance that is adopted by RHAs. One might hypothesize that, in jurisdictions where the majority of regional/district board members are elected, and where health care providers (including Public Health providers) are eligible for election— such as in Saskatchewan— that Public Health might have a higher profile. If that's the case, then the fact that most provinces appear to want to limit provider representation on boards (e.g. Quebec) or exclude them altogether (e.g., Manitoba) does not bode well for the future of Public Health in general, and HP capacity in particular. However, there are other issues to consider here as well. One of these is the extent to which a local board, whether elected or appointed, and whether consisting of provider representation or not, will function as a 'central enforcer' of provincial

government policy objectives or as a 'local mirror' of the communities that they represent (Lomas et al., 1997b).

Lomas, Veenstra, and Woods (1997) suggest that the strong feelings of accountability to, and representation of, local citizens expressed by the appointed Board members in five provinces that they surveyed (not including Manitoba) indicates the potential to counteract structural influences that might lead Board members to favour the interests of provincial governments and/or providers. The question then is whether or not the public places a high priority on health promotion and illness prevention. Evidence from jurisdictions where the public has been consulted regarding their priorities for resource allocation (e.g., Oregon and the U.K.) suggests that the general public appears to put greater emphasis than providers on the broad categories of high technology and acute institutional care and less emphasis on community services that focus on health promotion and disease prevention or services for disadvantaged populations (Bowling, Jacobsen, & Southgate, 1993; Bowling, 1996; Lomas, 1996b). It remains to be seen how public opinion influences RHA board members decision-making regarding allocation of resources to Public Health programs in regionalized and integrated delivery systems such as in Manitoba.

Before exploring the background to the current policy of regionalization in Manitoba and the perceptions of key informants regarding the regionalization process in Manitoba's RHAs, there is one additional reference in the literature that is relevant to this discussion about the implications of health system restructuring for health promotion. Keeping in mind that the *Ottawa Charter* (World Health Organization, 1986) identifies

equity in health as the primary focus of health promotion, an examination of premature mortality rates (PMRs) for regional health authority populations in Manitoba over the period from 1985 to 1994 found a widening regional inequality in PMRs despite an overall decline in provincial mortality (Mustard, Derkson, & Black, 1999). Significantly, mortality declines were observed in nine of the eleven RHA populations, while the two northern RHAs experienced increases in PMRs during the same time period. The authors propose that the devolution of authority for the management and delivery of health services to RHAs, especially if combined with the introduction of population needs-based funding to these regions, may help to mitigate the processes which are producing the widening regional health inequalities observed in Manitoba (although they acknowledge that neither of these policy initiatives are sufficient on their own to achieve this goal).

In summary, the literature review suggests that health system restructuring in Canada may be viewed either as an opportunity for building capacity for HP or as a potential threat to that goal. If it is accompanied by a true shift in perspective and commitment (both philosophically and materially) to 'investing in health,' then health system restructuring is a great opportunity. If, on the other hand, it is primarily viewed as an administrative realignment designed to improve efficiency and accountability, without any shift in perspective and commitment to 'investing in health,' then health system restructuring could make the task of building capacity for HP even harder. To date, we have no first-hand accounts regarding how the process of health system regionalization is evolving in Manitoba and whether or not individuals within the RHAs view this as a positive or negative phenomenon— especially related to its implications for building

capacity for HP.

4.1.1 - Regionalization of Health Services in Manitoba

Although regionalization of health services is not the *only* feature of health system restructuring, it is the predominant feature of the restructuring phenomenon that occurred across the country during the 1990s. Perhaps the first point to be made about health system regionalization in Manitoba is that it wasn't a policy initiative that was invented in the 1990s. While the particular form that it has taken since 1997 is unique, there is a long history of regionalization within the health system in this province. It is beyond the scope of this study to explore this history in detail. Fortunately, the task of documenting the history of regionalization in Manitoba (and the rest of Canada) from Confederation to 1990 has been carried out comprehensively by others (Carrothers, Macdonald, Horne, Fish, & Silver, 1991), and several key points made in their work are relevant to our discussion. First, Carrothers *et al* note that regionalization may involve the *decentralization* of administrative authority to regional units and/or the *centralization* of that authority within a defined geographic region. Second, they suggest that much of the discussion about regionalization in the literature fails to make the distinction between the decentralization of power and authority to regional/district units and the *deconcentration* of staff or organizational units from the centre to the field. Specifically, they observe that much of what has been practiced in the name of decentralization in Manitoba up to 1990 has actually been deconcentration. For example, they describe how, beginning in 1975, Manitoba was divided into eight *deconcentrated* provincial health and social services regions with little autonomy from senior bureaucrats in Winnipeg and no formal

community-based control. Third, Carrothers *et al* argue that regionalization initiatives are directly linked to the politics of restraint. In particular, they propose that “the decentralization of accountability for budgetary decision-making offers some level of assurance that scarce resources will be utilized to meet local needs best while, at the same time, relieving central government of a degree of responsibility for program implementation” (p.5).

During the early 1990s, a couple of developments occurred in Manitoba which set the stage for the most recent manifestation of health system regionalization in the province. First, in 1991 the Task Force on Rural Health Services¹⁶ reported that there was a severe lack of organization and direction of the health care delivery system in rural Manitoba and a feeling of lack of input into decisions that were made regarding programs that were delivered to rural Manitobans (Health Advisory Network, 1991). Second, in 1992 the Northern/Rural Health Advisory Council was established, and one of its key recommendations was a move toward a regional governance model; a recommendation that was accepted by the province (Northern/Rural Health Advisory Council, 1995). The *Regional Health Authorities and Consequential Amendments Act* (Government of Manitoba, 1996), commonly known as Bill 49, established ten rural and northern regional health authorities (RHAs) in the province that assumed authority for the delivery of health services on April 1st 1997. One year later, regional health boards for the cities of Brandon

¹⁶The Task Force on Rural Health Services was one of ten task forces set up by the Steering Committee of the Health Advisory Network, which itself was established in 1988 by Manitoba’s Minister of Health to review all aspects of the health care system in the province and to come up with recommendations for reform and improvement of health care services within fiscal limits (Health Advisory Network, 1991).

and Winnipeg took over authority for health services in those jurisdictions. Originally, there were two separate boards in Winnipeg, one for acute-care institutions; the other for long-term care facilities and community health services. In 2001, the two separate authorities were amalgamated into the Winnipeg Regional Health Authority.

Under Bill 49, the RHAs were made responsible for assessing the health needs of the region on an ongoing basis, developing objectives and priorities, preparing and implementing a regional health plan, and administering and providing for the delivery of all services—excluding physician and pharmaceutical services—to meet health needs (Government of Manitoba, 1996). Under Bill 49, the Minister of Health retained the authority to establish provincial objectives and priorities, prescribe by regulation core health services which must be provided or made available, give directions to RHAs, provide (or arrange for) health services, enter into agreements for the purposes of the Bill, expropriate lands or buildings, delegate authority, appoint inspectors, withhold funding for non-compliance and appoint an official administrator. A salient feature of Bill 49 was that it provided no specific guarantee for elected board members, stipulating only that directors may be appointed or elected. However, by April of 1998, the government of the time had decided to keep on appointing the boards on the grounds that elected boards had mixed success in other provinces (Paul, 1998). At the time of writing, board members continue to be appointed by the Minister of Health. Another salient feature of Bill 49 was the decision to make transfer of authority agreements between existing facility and district health boards and the new RHAs voluntary. Finally, Bill 49 gave the RHAs the authority to establish from one to four district health advisory committees (DHACs), which were

intended to advise and assist the boards (Government of Manitoba,1996).

PART II - THE DISCOURSE ON HEALTH SYSTEM REGIONALIZATION IN MANITOBA'S RHAs

As stated earlier, due to the fact that this study was conducted within the first three years after the RHAs were established, it was not appropriate to carry out any type of evaluative research– at least in terms of assessing the success or failure of the regionalization initiative in meeting overall goals. However, considering the fact that the regionalization and integration of health services does provide the context for Public Health practice, I was interested in discovering how participants viewed this phenomenon, what they saw as the positive or negative consequences of the process so far (either for themselves personally, or for the region in general), and in particular, whether or not they identified this process as being beneficial to the PH sector and HP activities in the region.

All participants in the regions were asked the following question: *“From your perspective, what have the main effects of regionalization been to date– in general, and specifically related to Public Health/Community Health programs?”* Interestingly, every single individual identified at least one benefit from regionalization. Many participants felt that there were both positive and negative aspects of regionalization, and a number of people believed that there were no disadvantages at all.

4.2 - Perceived Benefits of Regionalization

This category of responses can be divided into three distinct groups: (i) perceived benefits that *appear* to have occurred following the initiation of regionalization, but aren't necessarily *due* to regionalization; (ii) perceived benefits that participants felt were definitely the result of the regionalization process, and (iii) benefits that participants hope will result from regionalization in the future.

(i) Benefits that may or may not be due to regionalization

The main benefit that fit in this (the smallest) category relates to the perception of increased resources for community health programs in particular. In one region, several PHNs stated that they felt there had been, and would continue to be, more job opportunities for PHNs as a result of regionalization. A senior program manager in that region confirmed that “there has been more movement in community health staffing in the last two years than there has been in the last twenty.” However, several of those positions were due to expansion of provincial initiatives (e.g., immunization, Baby First). Similarly, in two of the regions, it was noted that there were increased resources for diabetes education since regionalization. However, it was acknowledged that this may have been due to the expansion of the provincial diabetes initiative, which has coincided with regionalization. One senior program manager in the northern region concluded that it was extremely difficult to assess the impact of regionalization when so many other variables were at work— particularly, provincial initiatives such as the diabetes program, expansion of immunization programs, and the introduction of alternative primary (health) care service delivery models (e.g., the Community Nurse Resource Centre located in the

northern region).

(ii) Benefits that are due to regionalization

The vast majority of perceived benefits fell into this category. Many participants in all regions mentioned that the administrative re-organization that had taken place as a result of regionalization was a positive change. For example, in all regions, comments were made about the integration of administrative structures being an important step towards breaking down the 'silos' within the health system (referring to the historical tendency for each component of the health care system to work in isolation from each other). Rather than competing with each other, regionalization was forcing everyone to think as one whole unit and move toward the same goals. A Board Chair summarized this perspective clearly:

In the past...there was a lot of turf protection. And an acute care facility would look very much inwardly at itself. A personal care home would kind of feel left out in the cold and basically just be responsible for the individuals that were in it. Mental health...I'm sure felt they were a very isolated component. And I think everything from Public Health, the Medical Officers of Health...I don't think they ever felt that they were part of an entire system. Whereas, under regionalization...I think that there's much more feeling that everybody is an integral part of the entire health system.

Mental Health and Public Health were two programs that were frequently mentioned as benefiting from regionalization. Participants in all regions noted that Mental Health, which has historically operated separately from the rest of the health sector, now had closer partnerships with other health services. Similarly, in all regions it was noted that there was increased cooperation and planning between Public Health and other health services, including the facilities. In one region, the reorganization of the administrative

structure of the health system following regionalization included putting all children's services together under one program, thus ending the historical fragmentation of these services. In another region, several participants felt that there was already some improvement in the seamlessness of care from discharge planning to home. Indeed, in all regions, improved efficiency and effectiveness in the organization and delivery of health services due to the integration and centralization of the administrative structures was perceived as a major benefit of the regionalization process.

Perhaps most germane to this study, there were participants in all regions who felt that one of the benefits of having the acute care and community services sector under one administrative structure was that it made it easier to change the traditional mind-set that health promotion is only the responsibility of Public Health staff— i.e., they saw more opportunities for integrating the principles of health promotion and disease prevention into the acute care sector. In all regions, there were participants who stated that the profile of Public Health seemed to have risen dramatically since regionalization, and the Public Health staff seemed to be valued more by the administration. The central role that the Public Health staff played in the planning and/or implementation of the Community Health Needs Assessment (CHNA) was identified as one factor contributing to the raised profile. In fact, the CHNA process itself was mentioned by participants in every region as a positive outcome of regionalization— especially in one region where this process was clearly on-going. One Public Health program manager summed up the change in profile of the Public Health sector this way:

...Public Health in our region has never had as high a profile as it has had since we became a regional health authority. We're well recognized as an important valuable program. There's been complete involvement of public health in developing new strategies, new programs...in incorporating proposals for the business plan....This has been good for Public Health in our region.

Another frequently mentioned benefit of regionalization was stated in a variety of ways, but can be summarized as the perceived 'democratization' of the health system. More opportunity for public input via regional Boards, the District Health Advisory Committees (in two of the three regions), and the CHNAs, and an increased ability to respond to local/regional needs were two of the most common perceived benefits of regionalization in all regions. Several people talked about the regionalization process forcing the RHA to be more accountable both to the public and to staff, and participants in all regions felt that the RHA was doing a better job of keeping communities informed of health system plans than had previously been the case. In the two regions that were spread across a wide geographic area, several people mentioned that regionalization forced both the staff and the Board to consider the needs of the whole population in the region instead of just one town or district. One program manager suggested that regionalization had resulted in a "stronger voice" for weaker communities, whereas prior to regionalization, the most sophisticated communities would be more likely to get the dollars.

Within the RHAs, increased autonomy from Manitoba Health was often mentioned as a benefit. In one region, a senior official felt that the increased autonomy of the RHA from the provincial department of health had resulted in a much improved level of sophistication in their decision-making capabilities. In this same region, several people

noted that they felt an increased ability to put in proposals and look for alternative funding sources and alternative partners now that they were no longer completely dependent on Manitoba Health. The fact that they no longer had to wait for provincial health department approval for every small request was mentioned by a number of frontline practitioners and program managers as a welcome change. The following remarks by a health promoter were typical:

The other thing that's a wonderful advantage for us is that there is the authority locally to make decisions that previously had to go to Winnipeg. And they'd get bogged down in tons of red tape. An example of that, that was constantly coming up in my work and I got my knuckles rapped for one time, was about [dealing with] the media...you had to go through the Communications Department in Winnipeg for approval and if there was any hint of anything that they didn't like, then you've missed the opportunity to talk....I can do media kinds of things easily within my workplace now. And I've become quite adept at writing up news releases and I've gotten to know the people in the media....And so I think that, in turn, what happens is that you, the RHA, doesn't look like we're sitting in ivory towers because we have a presence....And that wasn't the case before.

This increased sense of autonomy may explain the fact that participants in every region spoke of an increased sense of ownership and improved morale among staff since regionalization.

Another benefit of regionalization that was mentioned in all regions was a perceived increase in partnerships at the community level, whether this involved community health staff working more closely with community partners and sharing resources, or more interaction between communities (including First Nations) and between districts within regions.

While the separation of Health and Child & Family Services was viewed by many people as a negative result of regionalization, one Mental Health program manager (who

used to share office space with the Family Services staff) noted that there was a positive side to this development. For one thing, since Child & Family Services tended to absorb more of the dollars, following regionalization the Mental Health program has had more control of its budget. In addition, there was a certain stigma associated with Child & Family Services (i.e., it was associated with the 'welfare police' and the officials who had the power to take away your children), and this is now at a distance from the Mental Health staff.

Finally, several administrative processes associated with regionalization have had long-term benefits. In one region, the RHA accreditation process created teams across health system sectors that have continued to function, resulting in some cohesion among the RHA's programs. In another region, the health planning process has resulted in a more rigorous evaluation of the current and future state of all the region's programs.

(iii) Benefits that hopefully will accrue in the future

In all regions, participants expressed their hopes that regionalization will eventually result in a seamless continuum of maximally efficient and effective services that respond as well as possible to local needs. In the northern RHA, several people added that they hoped to be able to provide more services in the region than they had been able to do in the past, and one participant hoped that regionalization would make it easier to work with First Nations communities. In all regions, participants stated that they hoped that regionalization would result in more of a public health/ community health focus, as well as increased awareness by the public of those services, not just hospital services. Frontline practitioners were hopeful that regionalization might result in more job

opportunities and more educational opportunities.

One Board Chair expressed his opinion that a small number of regions have more clout with the provincial government than 175 facility Board Chairs did prior to regionalization, and he was hopeful that this would translate into increased funding. It is interesting to note that this Board Chair felt that the success of regionalization would depend on running the RHAs like an efficient business. In another region, a senior program manager predicted that the success of regionalization would depend on good managers and effective leadership at all levels of the organization.

4.3 - Perceived Disadvantages of Regionalization

Although most participants had something positive to say about regionalization, many of them had some concerns as well. For some people, the problems could be traced to the original legislation governing the establishment of the Regional Health Authorities in Manitoba. For example, one of the Board Chairs felt that the legislation contained two important flaws. In his opinion, too many regions were established in the first place, resulting in a lack of economies of scale in most RHAs. Second, the lack of legislative capacity to mandate the dissolution of all pre-existing boards, including faith-based boards, meant that the potential savings that regionalization was intended to achieve could not be realized in certain RHAs. He said that, in his region, he had been able to convince the faith-based organizations to integrate with the RHA, but that this was not the case in other regions. A unique criticism of the original design of the RHAs was offered by another participant, who complained that there had been a missed opportunity when the RHAs were set up like “mini-Manitoba Healths” instead of being conceived as

intersectoral entities.

In all regions, participants noted that regionalization had directly resulted in a loss of certain positions. For example, in the northern RHA a .5 EFT position was lost after regionalization because it was designated for a non-Federated First Nation community under provincial mandate. Unfortunately, two years after the RHA was established, two of their CHNs in a nearby community were still serving the First Nation community because the province had yet to hire a nurse of its own. This RHA had also lost a full-time support staff position when Child & Family Services was separated from the Community Health program (they had shared an office). The loss of these positions had resulted in an increased workload for the CHNs. In another example of this kind, the splitting up of a former region into three new regions resulted in the loss of a position that was designated for health promotion in Region 'B.' In Region 'A,' because there had been no designated HP position in their area of the larger region that they were part of prior to regionalization, the newly formed RHA was left with no designated HP positions at all.

The separation of Child & Family Services from Health following regionalization was another example of a structural change that was viewed negatively by some participants. Prior to the establishment of the RHAs, there had been one Regional Director for community health services and Child & Family services. Several people thought it was ironic that regionalization had increased the integration of the health sector, but had *decreased* integration horizontally across the human service sectors in all regions.

One of the major concerns that was identified in all regions was the loss of whatever central HP infrastructure that there had been prior to regionalization. Frontline staff and program managers in all regions noted that they used to be able to call consultants at the central Manitoba Health office in Winnipeg for advice or information, or they could easily utilize the Manitoba Health library and resource centre (which was dismantled following regionalization). Public Health staff mourned the loss of provincial public health linkages. Participants in all regions mentioned feeling isolated from other regions, and one individual expressed her feeling that this sense of isolation was not balanced by gains in connections between community health and acute care within the RHA. A PHN suggested that the loss of provincial Public Health linkages was just one more stage in the gradual loss of direction for PHNs that had occurred over the past decade:

I guess the other thing that I feel as a field worker....When I first started in Public Health, we were very tight provincially because we had the Public Health Nursing Directorate and that was a terrific time. But that became politically unpopular and it was disbanded, and just gradually there was less and less central direction for Public Health, and so the regions had to try to pick up the slack....When we were a health region under the old system, I knew the Regional Director very well and you felt that there was sort of a constant understanding of what you were doing as a public health nurse....There was a whole system, almost a support system for Public Health.... Now we're into this regional system where, for example, the CEO is responsible for many facilities as well as community health, and I have the feeling that we're just not as well connected any more.

This individual stated that it was especially isolating for solitary PHNs in outlying districts of their RHAs who were not in areas where they could make natural connections with a local facility or other services. However, it should be noted that another PHN in an outlying district in the same region stated that she now felt *less* isolated professionally now that she was part of a regional team.

It's interesting to observe that, although participants seemed to think that there was an increased *potential* for greater emphasis on health promotion and disease prevention within the RHA following regionalization, participants in every region noted that the needs of the acute care system continued to dominate the agenda. As one senior Public Health program manager stated:

I'm not sure how much hope I have that we're really going to make some of these shifts [from a focus on illness to a focus on HP/DP]. I think we're really in competition with hospitals. And hospitals and personal care homes are by far the biggest piece of services in the regional health authorities. So they're really commanding the attention of the executive level [of the RHA] and of government. So I think that we've got a very long way to go before we see any real active movement into these areas...There's talk, but that's all there is so far.

In every region, the feeling was expressed that there is a need for a strong Public Health and health promotion infrastructure at the provincial level— in spite of a regionalized system. The sentiment that there is a need to maintain a provincial perspective in the area of community/public health was echoed by a senior official within Manitoba Health, who agreed that “public health issues don't neatly end at the little boundaries that separate you from another region.” One health promoter expressed her frustration about the lack of a provincial Health Promotion Branch, stating that “there's no point in all of us trying to set up our own little system of experts.”

Concerns about the relationship between the RHAs and Manitoba Health also were apparent in comments made in all regions about the lack of real fiscal autonomy for the RHAs, due to the fact that Manitoba Health still “controls the purse strings.” Having to submit annual requests for funding was viewed as detrimental to effective RHA budget planning by administrators in all three regions. In addition to the lack of fiscal autonomy,

the Board Chair in one region and the CEO of another region both complained about Manitoba Health continuing to “micro-manage.” A DHAC member expressed some confusion about how Manitoba Health itself was being restructured and stated that it seemed that a lot of money was still tied up in “the old system” at Manitoba Health.

One of the most frequently mentioned concerns, mentioned by virtually every RHA employee, Board, and DHAC member in all regions related to the increased workload that has resulted from the regionalization process. Everyone complained of being tired, but especially the frontline practitioners and program managers. People who had participated in the CHNA process in all regions spoke of the extra work that had been involved in this task (without any overtime pay provided). PHNs in all regions expressed feelings of frustration regarding all of the extra committee work that they had been involved in since regionalization, which they saw as taking away from the time that they could spend with individual clients. They also complained about the loss of personal, day-to-day leadership from managers, who were having to spend much of their time developing regional policies and programs. However, it should be noted that many of the frontline staff (including the PHNs) also expressed their concern for the welfare of their managers, fearing that they might be approaching “burnout.”

Program managers in all regions agreed with the concerns expressed by the frontline staff. One senior program manager made the following comment:

I’m seeing managers, not just in this region, but wherever I go, exhausted. Just really, really exhausted. The work of regionalization has been horrific. It’s happening, but at a great cost to individuals working in health care...and that kind of has really impacted on management who aren’t there then to support and develop and nurture their staff who need it so badly.

Another consequence of this phenomenon was expressed by a senior program manager, who suggested that the increased workload, combined with the increasing demands for service, within a context of limited resources, meant that the Regional Health Plan was *not* driving day-to-day decisions. “I think that we’re just busy surviving as directors,” he said.

Although a senior administrator noted that restructuring had left the administrative level of the organization resource-thin, some frontline practitioners in regions ‘A’ and ‘C’ felt that their organizations had become increasingly “top-heavy” (meaning, more managers), rigid, and more of a corporate model. The latter comment referred to their perception of an increased emphasis on productivity, performance indicators, and statistics to show how well they are doing since regionalization— a development that they did not see as a positive one. In region ‘A,’ a PHN complained about the lack of participation in decision-making from the field staff level (a sentiment that was echoed by other frontline staff in this region), noting that, in order to truly enact a ‘population health promotion’ approach, you need to increase participation among the staff too, not just the community.

Concerns were also expressed about public expectations and fears about regionalization. In all regions, participants mentioned the danger of raising the public’s expectations, especially through the CHNA and DHAC process, then not being able to address them due to a lack of resources. A senior program manager admitted that she felt sometimes that the RHA really shouldn’t ask people for their opinions if it wasn’t going to actually act on them. “Don’t give people false hope,” she warned. Other participants

stated that the public has very high expectations and demands a certain level of service, which puts a lot of pressure on staff. In all regions, participants acknowledged that there had been a certain amount of fear among members of the public, who were afraid that regionalization was just another code word for 'downsizing' and it would result in the loss of services— especially hospital services— from their communities.

Other criticisms of regionalization included: the lack of an evaluation piece built into the process; the fact that different employees within the regions were under different union contracts; the increased complexity and inefficiency of communication within the RHA (because information now has to flow across the whole health sector, instead of only within each individual component of it); and the lack of regional policies for some programs to guide practice. The latter situation meant that staff were still using many Manitoba Health policies until their RHA could develop their own.

One criticism of regionalization that was unique to the northern RHA was raised by the staff of a community health centre in that region. This centre was part of a provincial initiative to establish a network of nurse-run community health centres in Manitoba— an initiative which happened to coincide with the establishment of regional health authorities in the province. The steering committee for the Community Nurse Resource Centre (CNRC) was intended to become its Board of Directors, but (from the perspective of the CNRC staff) this committee ended up being marginalized and disempowered by the formation of the RHA Board.

Finally, although this was not a disadvantage of regionalization *per se*, a couple of participants did express concern that a newly elected government might stop the

regionalization process, disband the RHAs, and they feared that this would create more turmoil. Since a new government was elected in the middle of the first round of interviews, this concern is a reasonable one.¹⁷

4.4 - Summary

It is clear that increased administrative efficiency of health services organization and delivery, an increased sense of local control within the RHA, an increased Public Health profile within the RHA and increased involvement of Public Health in organizational planning were viewed as major benefits of the regionalization process in these Manitoba RHAs. The latter two benefits suggest that there is at least the *potential* for expanding the emphasis on health promotion within the RHAs. However, there are indications that the regionalization process itself may have created certain conditions which will act as barriers to building capacity for HP in the regions. A few of these conditions stand out. First, the continued demands for acute care services in an environment of fiscal restraints means that the concerns of the institutional sector are likely to continue to dominate the RHA's agenda. Second, although the 'burnout' factor may be a temporary one due to the demands placed on health systems during the transition period, unless there is a large infusion of resources into the CH/PH sector, then the ability to move in new directions will be thwarted. Third, the formal severing of links between the Health and Child & Family Services sectors through the integration of health

¹⁷In July of 2002, after rumours that the province was planning to amalgamate several rural and/or northern RHAs, two of the smaller rural RHAs in the central/south western part of Manitoba were amalgamated. At the time of writing, there have been no signs of the regionalization process being halted.

services into regional systems has, ironically, *decreased* the potential for inter-sectoral collaboration— one of the crucial elements of HP. Finally, the loss of a strong, centralized provincial HP infrastructure (a process which, admittedly, began prior to regionalization) means that RHAs have become very isolated in their HP efforts. In fact, the question of the ideal role of the provincial Health Department in a regionalized health system— especially in relation to the task of building capacity for HP— was a recurring theme in discussions with participants. These and other barriers will be discussed further in Chapter Six.

We have now examined some of the contextual factors influencing HP capacity building in Manitoba's RHAs. In preparation for a more in-depth look at the nature of HP policy and practice in Manitoba, the next chapter presents a review of the literature on the role of HP in Public Health.

CHAPTER FIVE: HEALTH PROMOTION IN PUBLIC HEALTH PRACTICE: A REVIEW OF THE LITERATURE

Before looking in more depth at what the study participants had to say about the role of HP in the RHAs, it might be helpful to explore what is known about the role of HP within the Public Health sector in general, the role of HP in Public Health practitioners' practice more specifically, and any barriers to, or facilitators of, HP within the Public Health sector that have been identified in the literature.

5.1 - Core Functions and Public Health Practice: Where Does Health Promotion Fit In?:

The first question that needs to be addressed is, "where does HP fit in to the Public Health agenda?" The answer is far from simple. As we saw in Chapter One, there is no shortage of definitions of the concept of 'public health.' It should come as no surprise then to find that one of the salient features upon reviewing the literature on Public Health practice is the absence of a universal definition of the key principles and functions of that practice. Sutcliffe et al. (1997) note that the overarching principles, scope of practice, and target populations of Public Health have been broadly and variously defined. However, if you look at some of the reference texts related to Public Health practice that are currently available to students or practitioners in the field, it seems that the three broad elements of Public Health practice that are most frequently identified are disease prevention, health protection, and health promotion (Last, 2001; Wallace, 1998; Turnock, 2001). Green (1994) suggests that this popular characterization of Public Health has been influenced by the historical structural organization of U.S. public health policy into those three areas of services— with *prevention* referring to clinical preventive services such as

immunization and screening for disease, *health protection* referring to the reduction of hazards from the physical environment, and *health promotion* referring to the promotion of healthy behaviours and lifestyles. This division, according to Green, has had the unfortunate effect of narrowing the focus and vision of health promotion in the United States to a focus on changing individual behaviour. It is worth noting that, in Canada, two additional elements of Public Health practice— population health assessment and health surveillance— have been identified, in addition to the three mentioned above (Advisory Committee on Population Health, 2001).

The implications of the distinction between health promotion and the other elements of a Public Health approach to practice in Canada will be discussed shortly. However, there is another important point to note regarding the ‘prevention-promotion-protection’ triad of Public Health. As Turnock (2001) proposes, this common characterization of Public Health is referring more to the *outcomes* affected by Public Health practice rather than the processes (functions) of Public Health practice that are required to achieve those outcomes. Indeed, Turnock suggests that, over much of the past century, the mission and purpose of Public Health (what it *is*) and its functions (how it addresses its mission) were viewed synonymously with the provision of Public Health services: “In fact, public health’s services were frequently characterized as its functions. Public health was known more by its deeds than its intent” (Turnock, p.168).

This state of affairs changed, at least in the United States, in the late 1980s, when the Institute of Medicine (1988) released a report entitled, *The Future of Public Health*, which defined the mission of Public Health, the core functions of Public Health agencies

at all levels of government— assessment, policy development, and assurance— and the specific responsibilities unique to each level of government. One of the outcomes of the IOM report was the establishment of a Core Public Health Functions Steering Committee (CPHFSC) within the U.S. Public Health Service, which was set up to monitor the implementation of the IOM's 1988 recommendations. There are two salient features of the literature on post-IOM Public Health initiatives in the U.S. One is the degree to which there is a national consensus in the U.S. regarding the parameters of Public Health practice, including operational definitions that allow for the evaluation of Public Health performance. The other, ironically, is the degree to which the report further entrenched the concept of health promotion as an activity focussed on promoting healthy behaviours and lifestyles.

The Canadian experience seems to be the opposite of the American experience in both respects. A survey conducted in early 1997 by the Canadian Public Health Association (1997) identified only three provinces (Ontario, Quebec, New Brunswick)¹⁸ that reported having Public Health definitions/vision, goals, objectives, standards, and program guidelines in place or under development. On the other hand, a number of Canadian governmental and non-governmental policy/discussion statements have outlined a role for HP in the health system that clearly goes beyond the focus on individual behaviour change that characterizes U.S. Public Health policy initiatives. For example, in *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986),

¹⁸Actually, the report *suggested* that there were four provinces, but only identified these three.

health promotion is described as implying a commitment to dealing with the challenges of reducing inequities, fostering public participation, coordinating healthy public policy, and creating environments conducive to health (see also CPHA, 1996a, 1996b; Health Canada, 1999). The problem is that there is no evidence in the literature that any of these very eloquent policy statements have been adopted on a nation-wide level by the Public Health sector in Canada.

There is one other point that needs to be made before looking more closely at the role of HP in the Canadian Public Health system. While it has been noted that there are frequent references to the promotion-prevention-protection, and occasionally, policy functions of Public Health in the literature, it is interesting to observe that there is rarely any comprehensive discussion about the underlying values or principles of Public Health. The few exceptions to this general observation are noteworthy. In his classic paper presented to the annual meeting of the American Public Health Association over twenty-five years ago, Beauchamp (1976) criticizes the predominant view of Public Health as a technical activity and its acceptance of the ideology of 'market justice'— an ideology that emphasizes individual responsibility, minimal collective action and freedom from collective obligations except to respect other persons' fundamental rights. He argues instead that Public Health should be a way of promoting 'social justice,' which emphasizes the collective responsibility for well-being in society and is based on a commitment to the notion that all persons are entitled to full and equal protection against preventable disease and disability in society. This vision of social justice as the foundation of Public Health is reiterated by Krieger & Birn (1998), who point out that the

notion that improvements in public health can't be realized without efforts to ensure social and economic justice is still a contested proposition. Krieger & Birn argue that, at a time when the idea of Public Health as social good is being challenged by profit-driven agendas and virtually every nation is questioning the role of the state in fostering human welfare, it is useful to remember that the phrase "public health" was coined in the early 19th century to distinguish actions governments and societies should take to preserve and protect the population's health.

The underlying values of Public Health were also emphasized in a discussion paper regarding the future of Public Health in Canada by the Board of Directors of the Canadian Public Health Association (2001). This report identified ten principles that should guide Public Health practice: (i) acting on behalf of the *public good*; (ii) concern with the root causes or *determinants of health*; (iii) focus on *diversity, equity/social justice*; (iv) emphasis on *partnerships* at the national, regional, and community levels; (v) encouragement of *public participation*; (vi) use of *interdisciplinary* approaches; (vii) *based on the science* and research of many disciplines; (viii) concern with *efficiency/cost-effectiveness*; (ix) commitment to *continual improvement* in technology, approaches, best practices; (x) concern with being *responsive* to changing community needs, resources and *sustainability*.

The preceding examples clearly express a set of values that are missing in most discussions about the functions or processes involved in Public Health practice, and they have important implications for HP. For one thing, many of these principles imply that HP within Public Health practice is much broader than working with individuals to

change unhealthy personal behaviours. In fact, they fit more with the socioenvironmental approach to health enhancement where the focus of HP is 'upstream' and concerned with changing broader social, economic, and environment conditions of society. However, these lists of principles may be problematic as well. For instance, it is clear that some of these principles may clash with values that are promoted within certain segments of society, such as the 'public good' taking precedence over the individual's right to choose and concern with equity/social justice and diversity. There is also a danger of selectively focussing on one or two principles (e.g., science-based and efficient/cost effective) while ignoring the others. Another limitation is that not all principles will necessarily be compatible (e.g., 'efficiency/cost-effectiveness' and the 'public good'). It is these challenges to putting ideal principles into practice that are often not addressed in the literature.

5.2 - What is the Current Role of Health Promotion in the Canadian Public Health System?

In Canada, the mandate for Public Health within each province or territory is enshrined in one piece of legislation. In Manitoba (and several other jurisdictions), the legislation is called the *Public Health Act* (Government of Manitoba, 1987). A salient feature of this legislation is that it focuses primarily on the health protection and control of communicable disease components of Public Health, as opposed to the health promotion component of Public Health, and it outlines the roles and responsibilities of various Public Health officials (e.g., Medical Health Officers and PHNs) in these activities. Other Acts and Regulations are present in each province and territory and aim

to restrict hazards to the health of individuals or the public in general (Canadian Public Health Association, 1997)— e.g., legislation that controls sales of tobacco and alcohol to minors, or legislation concerning the handling of hazardous waste. In addition to the Public Health Act, some provinces and territories also have developed core programs or services guidelines and/or standards. For example, *Core Health Services in Manitoba* (Northern/Rural Regionalization Task Force, 1997) was developed as a guideline to programs and services that would be transferred to the Regional Health Authorities when they were established. Significantly, ‘health promotion/education’ and ‘prevention and community services’ are identified as core health services that will be required in every region in Manitoba. However, it is also significant that these services are not legally mandated under the Manitoba Public Health Act (only the communicable disease prevention and control services, mandated environmental health protection services, and Medical Officer of Health services are covered under the Act). Moreover, in a covering letter that accompanies the guidelines, it clearly stated that these guidelines represent a “starting point” from which RHAs can begin to deliver programs and services at the regional level. The guidelines are very broad and cannot be used as standards. As a result, it is unclear to what extent health promotion programs/services will be safeguarded within a regionalized health system.

In a survey of the content areas and core strategies of Public Health services in six provinces (including Manitoba) in late 1996, it was found that “many provinces had no evidence of mandated programs that were explicitly health focussed, that addressed broader determinants of health or used multiple strategies approaches” (Sutcliffe et al.,

1997, p.247). Programs to address non-communicable disease and health promotion strategies that provided for community involvement were mostly discretionary in nature (i.e., their availability depended on local initiative, decisions, and resources). This was the case for Manitoba. In other provinces, such as New Brunswick and Alberta, these programs were non-existent. It should be noted that, in a Canadian Public Health Association (CPHA) survey of public health infrastructure in Canada conducted in early 1997, respondents expressed concern that health promotion and primary prevention programs were most vulnerable to fiscal reductions because they were less likely to be legislated or mandated through program standards or guidelines (Canadian Public Health Association, 1997).

There is only one documented study which specifically explores the barriers to, and opportunities for, health promotion in Canada. In 1994, the CPHA conducted a survey of a cross-section of people working in health promotion across Canada, including: educators, researchers, consultants, health care deliverers and promoters, intersectoral advocates and lobbyists, and federal, provincial, territorial, and local government representatives (Canadian Public Health Association, 1995). The survey was part of a larger project exploring the contribution of health promotion in addressing the major health issues and influencing health-determining policy in Canada in the future. The major health issues identified fell under five main themes: social justice and equity; diseases and their determinants, lifestyle choices; resource allocation; environment (health and ecosystems); and empowerment. Slightly more than 50% of key informants believed that health promotion had achieved limited, little, or no impact on health policy

in Canada, while 44% saw limited, little, or no impact on programs and services. Indicators of low impact included cutbacks, poor reallocation of resources and the failure to transfer savings in the health care system to health promotion. Key informants identified several barriers that must be overcome to ensure that the contribution of HP to addressing major health issues was achieved: a general lack of awareness of HP issues among Canadians and a lack of understanding of the determinants of health; a lack of political will at the government level (more concern with short term economic gains than long-term health objectives); a lack of vision among all levels of government, health care practitioners, and health promoters; scarce financial resources, cutbacks, imbalance in resources allocated to HP; and competition among vested interests in the health care and health promotion sectors. Participants did identify a few opportunities to facilitate the contribution of HP. The building of coalitions and partnerships within the health sector and with other intersectoral groups was viewed as essential. The work of Public Health associations was seen as an opportunity to increase public awareness and the involvement of health and other sectors in HP. In addition, efforts to reform or restructure the health care system were viewed as a key opportunity to gain support for HP activities. One limitation of the study is that, although 'health care deliverers' were included, the discussion of findings does not distinguish between the responses made by the various categories of survey respondents, and so it is not possible to determine how the 'health care deliverers' felt about the subject (nor was this category defined— one can only assume that C/PHNs were included, but this is not clear). Another limitation is that the study was conducted before the latest manifestation of health system regionalization was

in place in many jurisdictions across Canada (including Manitoba).

It seems safe to conclude that the future of health promotion within the Public Health sector is intrinsically linked to the future of that sector as a whole. However, a review of Canada's main Public Health journal, the *Canadian Journal of Public Health* (CJPH), from 1990 through June of 2002, indicates that the future of Public Health in this country has not been a topic that has generated much debate in the past.¹⁹ Aside from those examples already mentioned (CPHA, 1996a; 1996b; Sutcliffe et al, 1997), there are only a few examples of commentaries in the CJPH during this period of time that have specifically addressed the current and/or future role of Public Health in the Canadian health system in a critical manner. Using a very creative approach to make his point, (Chambers, 1992) argues that local Public Health agencies should be role models for other groups and agencies in their communities in ensuring the implementation of the principles of the 'new Public Health.' He identifies several factors which appear to be preventing Public Health from functioning effectively as a role model (compartmentalization of thinking within disciplines, programs and sectors; lack of community participation; inadequate commitment to promoting continuing Public Health education for staff; tension between prevention and treatment; and an obsession with quantitative measures of evaluating performance) and he offers correctives for combatting them. One of the more interesting observations that Chambers makes is that Public Health suffers from *political phobia*, which he describes as a reluctance of Public Health

¹⁹ In the year since data collection ended (in June of 2002), the outbreaks of West Nile virus and SARS have led to increased attention to the capacity of the Public Health system to respond to such events.

practitioners (including Medical Officers of Health) to speak publicly about potentially political sensitive issues. He argues that the ethical accountability of Public Health practitioners is to citizens in the community, not to the employer, and he states that Public Health practitioners must be free to exercise their professional judgement. Six years later, Raphael (1998) similarly criticizes the narrow focus of Public Health on disease prevention and puts forward a proposal for a 'new Public Health' approach, one which emphasizes what he refers to as 'the 3 P's'— participation, policy, and political action.

Following the release of the final report of the Commission of Inquiry on the Blood System in Canada in 1998, sections of the report that commented on the role of the Public Health system were printed verbatim in a CJPH editorial (Mathias, 1998). Chronic underfunding of Public Health departments across Canada was identified as a major factor threatening the safety of Canada's blood supply.

In August of 2001, the Board of Directors of the CPHA issued a discussion paper that warned of a shift in emphasis in the Canadian health care system away from promotion, prevention, and protection toward containing costs of treatment (Canadian Public Health Association, 2001). The CPHA Directors identified two major factors that are challenging the survival of the Canadian Public Health system— (i) the increasing complexity of identifying the root causes of ill health and appropriate solutions, and (ii) the erosion of funding to the Public Health sector. They also identified seven broad categories of facilitators that are required in order to achieve population health in Canada: (i) balanced funding (including increasing Public Health funding by influencing and changing the health budgeting process and development of new funding models that

focus on health determinants); (ii) reliable information (including development of health goals, best practices, report cards and other accountability measures such as a Public Health watchdog/champion/ ombudsperson, as well as improvement of information on performance and results); (iii) better communication (including making better use of strategies such as social marketing to focus attention on Public Health); (iv) increased visibility and advocacy (including developing strong, knowledgeable Public Health leadership across all related sectors); (v) greater commitment to social equity to reduce socioeconomic inequalities affecting health; and (vii) increased intersectoral collaboration.

Lastly, it should be noted that in May of 2002 a special edition of the *Canadian Medical Association Journal (CMAJ)* was devoted to the state of the Public Health system in Canada. This appears to have been a response to an unpublished report commissioned by the federal, provincial, and territorial deputy ministers of health, completed in September of 2000 and obtained by the *CMAJ*— a report that documented serious deficiencies in the capacity of Public Health systems throughout Canada, but which was never considered or discussed by the ministers when they met in June, 2001, nor ever made public (Sullivan, 2002). Among the many concerns expressed in this unpublished report were the significant disparities between ‘have’ and ‘have not’ provinces and regions in their capacity to address public health issues; the curtailing, diversion or lack of replenishment of resources for Public Health programs across the country; lack of sufficient resources to deal with more than one urgent issue at a time; and a lack of resources to address longer-term health promotion and disease- and injury-

prevention strategies (Sullivan, 2002).

5.3 - Health Promotion in Public Health Practice: Rhetoric vs. Reality in Community/Public Health Nursing Practice

We have now explored the broader question of how HP fits into the Public Health agenda (both generally, and within Canada more specifically), but this discussion would be incomplete without exploring the role of HP in the practice of the largest group of practitioners within the Public Health sector— i.e., community/public health nurses (C/PHNs).²⁰ Perhaps the most striking impression that one gets after reviewing the literature on this subject is that the role of HP in nursing practice is full of contradictions. On the one hand, there is widespread consensus *within* nursing that, not only is HP a natural part of nursing practice and, indeed, a primary goal of nursing practice, but that nurses are in the best position to take a leadership role in HP (Badovinac, 1997). However, it has also been acknowledged that nurses have not been heard in the broader HP movement (Gottlieb & Rowat, 1987; O'Neill, 1997; Hayward et al., 1993. In fact, in one influential text on health promotion in the early 1990s, nursing received no acknowledgement as a discipline making a contribution to the knowledge base for health promotion (Bunton & Macdonald, 1992). The invisibility of nursing's contribution to the broad discipline of HP continues to be acknowledged today (MacDonald, 2002).

²⁰The decision to focus on the HP practice of C/PHNs was based on the fact that the majority of frontline practitioners in this study were nurses, including several individuals who were *not* working in nursing positions (i.e., they were working as Health Promoters or Health Educators). While it is acknowledged that there may be several aspects of professional practice among non-nurse participants that are unique to their particular disciplines, it is proposed that many of the HP practice issues identified by C/PHNs are likely the same for non-nurse practitioners.

Why is there such a discrepancy between the perception of nurses' role in HP from within nursing and the perception outside of nursing? Gottlieb (1992) suggests that it is simply a matter of nursing doing a poor job of articulating and communicating its unique HP practice beyond the discipline. It has been suggested that this may *partly* be due to the fact that nursing research and questions of community health have not been given high priority by funding agencies in the past, and that graduate education focussed on Public Health in Canada is fragmented, resulting in a lack of resources and skilled personnel to rigorously describe and evaluate practice and to provide evidence in support of the Public Health nursing role in HP (Hayward et al., 1993). However, subsequent analyses of this question suggest that there are more deep-seated reasons why nursing does not seem to have achieved the leadership role in the HP movement that was proposed by the World Health Organization (1989). For example, O'Neill (1997) suggests that the degree of effort over the past twenty years required to build a corpus of knowledge that would elevate nursing to the status of a science has led to a neglect of what is happening outside of nursing. He observes that, in a field as interdisciplinary as health promotion, the authors cited by nursing researchers are frequently almost exclusively nurses. He also proposes that taking a political stand on national issues, taking group action, or participating in the development of multidisciplinary fields of knowledge like health promotion is far from nurses' image of "normal" professional behaviour. This latter notion raises the question of whether or not there is something inherent to nursing as a profession that has prevented it from fulfilling a leadership role in health promotion. A review of the literature on HP within nursing practice suggests that

this is the case.

Badovinac (1997) has observed that, although the nursing literature is full of references to nurses' potential leadership role in HP, the concept of HP within nursing practice is often ill-defined and there is an assumption of a common understanding of the term— an assumption which is in direct contrast to the debates that have dominated the fields of health promotion and health education regarding the contested nature of the concept of HP and the fact that it is used differently by different people. She suggests that confusion about the concept of health promotion among nurses appears to arise, in part, because some nursing authors today continue to use the term in a generic sense, while others use it to refer to a specific approach to practice that derives from a particular philosophical or theoretical perspective. There is also a school of thought which suggests that *any* nursing action is inherently health-promoting (Benson & Latter, 1998). Maben & MacLeod Clark (1995) observe that the limited empirical work that has been done on nurses' health promotion practice (mostly in the U.S. and U.K.) indicates that their understanding of HP is firmly embedded in the more traditional approach to HP (i.e., focussing on individual responsibility for health) rather than the 'new paradigm' approach to HP which emphasizes positive health, a two-way participatory process, and the need for social change to improve health. While much of this empirical work has focussed on the perspectives of nurses in the acute-care setting, rather than the community/public health setting, O'Brien (1994) found that, for nurses in their study (including nurses in community, school, and occupational health settings), HP corresponded to an attempt to persuade, cajole, or otherwise influence individuals to alter their lifestyles, with great

emphasis being placed on the risk factors of smoking, drinking, stress, dietary and exercise habits of individuals.

The role of ideology in shaping the way that HP is approached, and nursing's failure to acknowledge this role, is explored by several observers. Williams (1989) suggests that the main characteristics of the classical liberal theory that dominates social, political, and economic thought in the U.S. translates into a belief that the major determinants of health are the personal behaviour patterns and habits of living that are assumed to result from the rational and free choice of individuals. From this perspective, the goal of individualistic HP becomes providing individuals with the information that they need to choose between health-promoting self-care behaviours and a health-damaging lifestyle. Caraher (1994) proposes that nurses' HP practice has shifted from an emphasis on communication skills designed to persuade people to change their behaviours to the development of counselling skills designed to help people cope with their situations and make good decisions regarding their lifestyle. Even so, he argues, this is not enough of a change and merely reinforces the idea of the individual being responsible for their health. O'Brien (1994) agrees that there is something inherent in the fundamental assumptions of nursing as a profession that constantly relocates the focus onto the individual. He argues that the new HP ideology of the 1980s, with its emphasis on socioenvironmental influences on health and the need for personal and collective empowerment, has been subverted in practice because it has become attached to the prior agenda and already-embedded professional and institutional relations which structure health care provision. Specifically, he argues that nurses play a major role in this subversion process. Noting

that nurses have been urged to take a lead in the HP movement because of their ability to access the 'whole person' in their 'total environment' using a 'client-centred' process,

O'Brien makes the following observation:

In reality, this 'holistic' focus in a 'client-centred' service is one of the major ways that the potentially radical thrust of the health promotion movement is subverted in practice. For it attaches prominence to forming and maintaining relationships between professionals and service users in the institutional contexts of health provision and acts as a primary vehicle for controlling health knowledge and information. The consequence of this control is to direct attention away from collective, political perspectives on health toward individualistic, behavioural perspectives (p.397).

Rush (1997) and Latter (1998) maintain that the dominant ideology of individual responsibility for health is reinforced by many of the popular nursing models, texts, course content, and even clinical placements found in nursing curricula in the U.S. and U.K. respectively, and they propose that there has been uncritical acceptance of this ideology within the nursing discipline. Rush (1997) also points to several other characteristics of nursing curricula that perpetuate the individualistic HP ideology: (i) the tendency in undergraduate curricula to gear HP to the behaviour of nursing students themselves by requiring them to assess their own lifestyle, identify their personal health goals, and implement a behaviour change plan; (ii) the emphasis given within nursing curricula to preparing students for role-modelling healthy behaviours, which can lead to students assigning blame to clients who fail to comply with recommended health-promoting behaviours without recognizing responsibility located at a socio-political level; (iii) the tendency to focus on communication and counselling as nursing roles in HP, which directs attention to the coping and problem-solving resources of individuals rather

than changing the social and physical environments that may be producing the undesired effect; and (iv) the format of many HP textbooks used in nursing education programs, involving sectioning of the text according to specific behaviours associated with HP—e.g., nutrition, physical exercise/activity, stress management.

All of this is not to say that there has been no discussion of concepts related to the socioenvironmental perspective on health promotion in nursing curricula since the 1980s. The problem is that discussion of socioenvironmental issues such as addressing social-economic inequalities in health, intersectoral collaboration and community participation tends to occur in one particular course or in one semester that focuses on health promotion, while students still are exposed to the ideas and situations listed above in other parts of their program. In an effort to address this problem, at least one undergraduate nursing program in Canada has completely revised its curriculum to reflect a socioenvironmental perspective on health promotion *throughout the entire curriculum* (Ploeg et al., 1995). Another Canadian undergraduate program has revised its entire curriculum around the concept of Primary Health Care, which places great emphasis on health promotion and prevention of illness and is based on a socioenvironmental perspective (Munro et al., 2000).

MacDonald (2002) provides the most comprehensive analysis of HP practice within nursing in Canada and elsewhere. She explores the major milestones in the historical development of HP as an interdisciplinary enterprise, and the response to these developments within nursing. MacDonald suggests that the lifestyle model of HP that emerged following the Lalonde Report (Lalonde, 1974) was reflected in the health policy

of various nations and that, for the most part, nursing adopted this approach because its premises and underlying ideology were consistent with the prevailing ethos in nursing (as described above). A critique of this lifestyle approach to HP, which MacDonald refers to as the 'structural' critique, emerged in the late 1970s, but the most noted proponents of this critique (Labonte & Penfold, 1981; Crawford, 1977) were not from within nursing. In fact, MacDonald submits, major nursing criticisms of the lifestyle approach to HP did not emerge until the end of the 1980s and into the 1990s, and did not become more than a marginal position in nursing until the late 1990s (it is not clear from MacDonald's analysis how much more than 'marginal' this critical position has now become in nursing).

She does suggest that there have been two major stages, or streams, of theoretical development in nursing related to HP since the mid-1980s. The first stream consisted of a critique of the narrow conceptualization of foundational concepts in nursing ('client,' 'environment,' etc.) and expansion of these concepts to be more congruent with the 'new health promotion paradigm.' For example, there has been increasing attention paid to the notion of 'community as client' (as well as related concepts such as working with 'aggregates' and 'population-based' nursing) in many of the popular community health nursing textbooks (Anderson & McFarlane, 2000; Clemen-Stone, McGuire, & Geiber Eigsti, 1998; Swanson & Nies, 1997) and in the non-textbook literature on C/PHN practice (Baldwin, O'Neill Conger, Abegglen, & Hill, 1998; Chalmers & Kristjanson, 1989; McKnight & Van Dover, 1994). One of the salient features of this literature is the degree to which the goal of the nursing process in that context is the identification of

community/aggregate/population health 'needs' in the form of problems and deficits (using traditional epidemiological 'sickness' indicators, for the most part), and the development of programs/services to meet those needs. Other characteristics include the primarily theoretical nature of the discussions; the lack of attention paid to the practical challenges of practising beyond the individual/family level; and paucity of first-person accounts. A notable exception is provided by Diekemper, SmithBattle and Drake (1999a; 1999b), who document the stories of CHNs as they develop the population aspects of their everyday practice. The authors find that there are two levels of development of population-focussed practice. Among generalist CHNs (including PHNs), whose care most often is targeted towards individuals and families, there is a *natural* development of a population focus as they "stumble on" the "big picture" in the course of their interactions with clients and begin to put the many individual and family stories together to address a population's needs. In the case of CHN 'specialists' who work in positions where they are responsible for program development with target populations, Diekemper et al (1999b) found that their population-focussed practice is *intentional*— i.e., not something that they "stumble upon" during the course of their work with individuals and families. An important observation among this latter group of practitioners is that their population-focussed practice was solidly based in their prior individual and family-focussed experience and expertise in program planning and evaluation. Of course, population-focussed practice doesn't necessarily mean a focus on community development or social change issues. Many of the examples provided by the CHNs in the study relate to meeting the population-level needs for illness prevention services— but this

is another matter.

One of the debates in the nursing literature centres around the question of whether population-focussed nursing practice should be considered a generalist or specialist role. This is relevant to the HP practice of C/PHNs, since the vast majority of them are baccalaureate-prepared nurses working in generalist roles. Diekemper et al (1999b), noting that some literature assumes practice beyond the individual and family level is more appropriately in the realm of the masters-prepared specialist, propose that population-focussed practice *is* possible at the generalist (i.e., baccalaureate-prepared) level. Their argument is that there are different levels of population-focussed practice. It is more likely that generalists (especially new practitioners) will develop a *natural* population-focussed level, rather than using *intentional* population-focussed practice. This empirical work reinforces and expands upon the perspective of (Peters, 1995), who supports the need for preparation for population-focussed practice at the baccalaureate level, as well as those who contend that a population-focus *is* the basis of C/PHNs' unique contribution to health care delivery at *all* levels (baccalaureate, masters, and doctoral) and in *all* settings (Baldwin et al, 1998).

It is interesting to note that, in some cases, the generalist vs. specialist debate has not centred around baccalaureate vs. graduate education as much as it has focussed on the manner in which PHN services are delivered. Again, this has implications for nurses' HP practice. The basic question has been, should PHNs be generalists who are responsible for all health issues within a defined geographic community, or should they be specialists in programs dealing with certain target populations— e.g., parent-child, mental health,

etc.? Mills & Relf (1994) note that PHN practice in some parts of Canada is community- or neighbourhood-based, while PHN practice in other parts of the country is programs-based. For example, since the latter half of the 1980s, there has been a shift to a more specialized, programs-based PHN practice in Ontario (Rafael, 1999; Underwood, Woodcox, Van Berkel, Black, & Ploeg, 1991), whereas, in Winnipeg, Manitoba, there has been a recent effort to shift PHN practice back toward a neighbourhood model (Manitoba Health, 1998). Concern has been expressed that programs-based models have resulted in the loss of PHNs' integral connection with the communities that they work in, and the erosion of a population-based practice that was the foundation of their work (Conley, 1995; Rafael, 1999; Zerwekh, 1993).

A salient feature of these debates regarding specialization in public health nursing—whether focussed on programs-based vs. district-based models, or on baccalaureate vs. graduate preparation—is that they appear to be the result of a widespread perception since the late 1980s that the status of the profession is in jeopardy. This is often discussed within the context of health system restructuring, and it is suggested that PHNs must rebuild or re-claim their unique role within the health care system. Some of the factors contributing to the vulnerable position of public health nursing that are identified in the literature include: a lack of PHN role clarity within the profession; perceived lack of recognition; erosion of funding for standard preventive and health promotion home visiting; perceived duplication of services and competition with primary care providers; the general passivity/non-assertiveness of nurses who have allowed nursing roles and functions to be determined by other professions; the continuing preferred status of

curative over preventive services; the lack of recognizable public health nursing content in nursing curricula; and the move to programmatic rather than community-based services (Chalmers, 1995; Laffrey & Page, 1989; Conley, 1995; Mills & Relf, 1994; Yiu Matuk & Chadwell Horsburgh, 1989).

In Canada, it has been noted that the adoption of the so-called 'new health promotion' or 'new public health' concept as a central policy by the Ontario provincial government in 1989 has translated at the point of service delivery into a trend away from traditional PHN activities (e.g., home visiting in the post-partum period, targeting of vulnerable families for long-term assistance, periodic monitoring of the needs and health status of socially isolated groups such as the elderly, etc.) (Hayward et al., 1993).

Hayward et al suggest that, for a variety of reasons, people outside the nursing profession do not see PHNs' work as being compatible with the new public health, which is a serious problem during a time when the health care system is experiencing increasing financial constraints. As a result, PHNs are being challenged to defend their HP role. Hayward et al make the case that, contrary to popular opinion, there is an ideal fit between the principles of HP (e.g., empowerment, participation, community development, and public policy change) and public health nursing. They do acknowledge, however, that the future of public health nursing in Canada will depend on solid evidence regarding the effectiveness of PHNs' interventions in achieving public health goals.

Others suggest that the key to C/PHNs' survival is a return to neighbourhood/community/population-based (a variety of terms are used to describe the same concept) nursing (Conley, 1995; Laffrey & Page, 1989; Salmon, 1993; Zerwekh, 1993)). However,

Zerwekh (1993) proposes that this neighbourhood-based model of practice should, ideally, be placed within a broader multi-disciplinary, community health centre model of health and other human service delivery.

Another foundational concept of nursing practice– the environment– has been challenged to expand from a traditional, narrow focus on the psychosocial environment of the individual to a broader focus on the sociopolitical context that affects the health of individuals, groups and communities (Chopoorian, 1986; Maxwell, 1997). This has led to consideration of an expanded conceptualization of a health-promoting nursing practice itself. Perhaps the most well-known proponent of an expanded notion of the environment in nursing practice is Butterfield (1997), who argued that nursing education and practice have been dominated by a theoretical perspective which views nurses' role in HP as altering the client's belief system (through providing information or counselling) regarding the benefits/barriers to engaging in preventive health actions. In contrast to this 'downstream' approach to HP, she suggests that it is time for nurses to utilize a theoretical perspective which focuses attention 'upstream' to the broad societal factors that shape individual behaviour. Using an 'upstream' approach, the nurse would be expected to make an effort to change some of the social conditions affecting her clients. However, Butterfield doesn't provide details of specific 'upstream' strategies for nurses.

The challenge of expanding the role of nursing to that of social change agent or social activist is raised by several nursing theorists, many of whom are influenced by critical social theory and feminist theory. For example, social change is viewed as a central concern of those who espouse 'emancipatory nursing,' which aligns nurses with

the oppressed to help people take action to change the forces that oppress them— as opposed to traditional nursing, which aligns with dominant interests to help people cope and adapt to their oppression (Kendall, 1992; Maxwell, 1997; Moccia, 1988; Starzomski & Rodney, 1997). Chalmers et al., (1989) propose a ‘community change’ model for nursing at the community level, in which the underlying social, political, and economic factors affecting health are examined and systematic efforts to change destructive structures and systems are made. Drevdahl (1995) notes the paradoxical nature of C/PHN practice, in which improving a population’s health is sought through nursing actions aimed at individuals. She argues that community organization and participatory research methods are emancipatory community-level nursing interventions that are particularly germane to working with disenfranchised communities. Much of this literature, however, remains at the level of abstract theorizing, with very little in the way of practical strategies for frontline nurses or discussion of the challenges of putting these ideas into practice (there are a few exceptions, which will be discussed later).

Macdonald (2002) suggests that the second major stream of theoretical development in nursing that is relevant to HP is the integration of a number of the central concepts inherent in the ‘new HP’ perspective into nursing theory. She mentions concepts such as *empowerment* (Gibson, 1991; Rodwell, 1996; Styles, 1994), *participation* (Hudson-Rodd, 1994; Jewell, 1994), *partnership* (Courtney, Ballard, Fauver, Gariota, & Holland, 1996), and *collaboration* (Clarke & Mass, 1998). To this list, one can also add *strengthening community capacity* (Kang, 1995; Scruby & McKay, 1991), *healthy public policy advocacy* ((Reutter & Williamson, 2000) and *community development* (Chalmers &

Bramadat, 1996; Ploeg et al., 1995). Macdonald notes that these concepts are generally not discussed within a specific model or framework for HP, but more as concepts that are directly relevant to nursing practice with specific groups or in certain settings. Salient features of this literature are the lack of first-person accounts of C/PHNs' experiences with integration of these concepts into their nursing practice and a lack of critical analysis regarding the barriers or challenges that nurses face in trying to do so.

An interesting observation is that, just as in the case of empirical studies finding that frontline nurses still focus primarily on individual behaviour change, empirical studies looking at the nature of nurse-client interactions have found that nurses often dominate these interactions, or at least try to control them, and they do not always function in the collaborative, participatory, empowering manner espoused in the theoretical literature (Chalmers, 1992; Kristjanson & Chalmers, 1990; Zerwekh, 1992). However, Zerwekh (1992) suggests that, sometimes, PHNs have to use coercion in order to carry out their responsibility to protect vulnerable populations (e.g., children who are in danger of abuse). This perspective is shared by Hayward et al (1993), who point out that the realities of PHN practice require them to be responsive and flexible within each particular therapeutic relationship. As a result, in some cases a more assertive 'top-down' approach to counselling is warranted. An interesting observation is made by Malin & Teasdale (1991), who found that the 'caring' function, which is considered fundamental to nursing practice— is at odds with the idea of empowerment because caring involves altruism, control, and paternalism. Erickson (1996), on the other hand, argues that caring and an empowering activist approach are not mutually exclusive.

Two Canadian nurse-educators (Lindsey & Hartrick, 1996), provide a unique and provocative perspective on the inherent contradictions between nursing practice and concepts such as 'partnership' and 'empowerment.' They critique 'the nursing process,' a problem-solving method that helps nurses define a client problem which is amenable to nursing action. The authors note that the nursing process has been integral to nursing practice since the 1960s, when it was developed in order to provide a systematic methodology (assessment, planning, implementation, and evaluation) that defined the independent function of nurses and provided a reliable and valid mechanism in determining the needs of the client and evaluating the effectiveness of nursing care. Unfortunately, the authors suggest, the nursing process is based on a world-view which is diametrically opposed to the world-view that underlies the 'new health promotion' approach. The key assumption of this methodology for nursing practice is that the responsibility for initiating and directing the interaction between the nurse and the client remains with the nurse. This, Lindsey & Hartrick argue, is inconsistent with the fundamental assumptions of the new HP approach, which include the belief that the power of defining health needs/problems/solutions belongs to those people experiencing them. In health-promoting nursing practice, the nurse-client relationship should move away from the traditional nurse-controlled model toward an egalitarian relationship promoting client autonomy and empowerment. The weakness of this argument (like many of the other examples in the literature) is the lack of acknowledgement of the practical difficulties of actually engaging in such egalitarian nurse-client relationships, as well as a continued focus on health-promoting nursing practice at the individual level.

There are several additional themes in the literature on HP in nursing practice that should be mentioned here. First, there is some suggestion in the literature that the common polarizing characterizations of 'individual-level versus aggregate/community/population-level focus' and 'lifestyle/behavioural change versus environmental/structural/social change' may not be the most helpful way to view HP within nursing practice. For example, Latter (1998) concludes from her review of the HP literature that there is a consensus that HP comprises *both* health education at the level of the individual and structural change at a more macro level— including strategies such as building healthy public policy and creating supportive environments for health. However, she suggests that these twin elements of HP can each be implemented according to different models which are underpinned by contrasting ideological perspectives:

For example, health education can be approached from either an empowerment or a medical model-derived, behaviour change perspective. Similarly, effecting change at the policy or environmental level can also be top-down, or follow a more negotiated, empowerment-oriented approach (p.ii)

This perspective is shared by Caraher (1994) who suggests that personal counselling for health by nurses can either be used to increase client power and to achieve an end, or it can be used to define or increase a sense of professional power and allow the health care worker to establish an expertise which absolves them from the consequences of any subsequent actions. In other words; it is too simplistic to suggest that an individual-level HP strategy is inherently bad while assuming that a HP strategy aimed at socioenvironmental change is inherently good. Similarly, we have seen how Diekemper et al (1999a; 1999b) found that the most effective community-level nursing practice is

likely to be the result of a strong foundation in work at the individual and/or family level. This notion, that individual- and family-focussed nursing practice is critical to effective population-focussed practice because it provides the linkages necessary to interact with the community, is also discussed elsewhere (Conley, 1995; Hayward et al., 1993; Leipert, 1992).

A similar, non-polarizing perspective can be found in a background paper prepared for the Registered Nurses Association of British Columbia (Labonte & Little, 1992). In this discussion about the use of empowering strategies for nursing practice, it is suggested that pitting individual-level case work against community-level activities is a false dichotomy. Rather, empowering strategies should be viewed as lying along a continuum, from personal empowerment to political action, and this continuum of empowering strategies should represent an *organizational* responsibility. That is to say; all of the strategies are important, but it is not reasonable to expect any one staff person to have the time or skills to function at each of the five points on the continuum. It is, therefore, part of the responsibility of an organization to ensure that the empowering actions of various professionals within the agency or interagency network are linked together. Hayward et al (1993) contend that PHNs have traditionally been engaged in laying the groundwork of empowerment work. Labonte & Little (1992) point out that, although individual case-work aimed at personal empowerment has traditionally been the focus of practitioners such as nurses, they can be involved in the other levels of empowering strategies as

well.²¹ This model of a continuum of empowering strategies has been used by Reutter (2000) to describe the potential health-promoting practice of C/PHNs in dealing with families living in poverty. However, in all of these cases, the practical challenges of utilizing these empowerment strategies are not addressed.

Another theme in the literature on HP within C/PHN practice that is worth highlighting is the distinct manner in which the role of HP in nursing practice has been addressed in the Canadian literature. Macdonald (2002) notes that, between 1987 and 1993, there was a major professional mobilization in nursing throughout Canada related to 'primary health care' (PHC) and the new health promotion. For example; the Canadian Nurses Association (1992) and the Canadian Public Health Association (1990) developed position statements that identified PHC— with its emphasis on health promotion and disease prevention, intersectoral collaboration, and community participation— as the conceptual foundation of C/PHN practice in Canada. In addition; most provincial nursing associations produced position statements on PHC during that time (Macdonald 2002). Within this PHC framework, health promotion, as defined in the *Ottawa Charter*, is identified as the primary goal of nursing practice (CPHA,1990). Since the early 1990s, much of the discussion about HP in C/PHN practice in Canada has been framed within the context of the PHC perspective (Beddome, Clarke, & Whyte, 1993; MacPhail, 1996; Munro et al., 2000; Reutter & Harrison, 1996; Stewart & Langille, 2000).

Macdonald (2002) suggests that the central role that Canadians played in

²¹Labonte (1993) later modified his original linear empowerment continuum, presenting it as a holisphere, in order to reflect the fact that practitioners may be involved in more than one strategy at one time.

developing Epp's *Health for All* framework and the *Ottawa Charter* might explain the fairly rapid diffusion of the new health promotion ideas within the Canadian government health bureaucracy, among the professional nursing associations, and by task forces and commissions for health reform across the country. However, she warns, "this is not to say that these ideas diffused as rapidly to the front lines of practice, or that there were not gaps between rhetoric and reality" (p.32). We will explore some of the reasons for these gaps in a few moments. But first, Macdonald raises one other issue that is worth mentioning. She suggests that we are entering a new era of HP that nurses will have to come to terms with— i.e., the era of *population health*. Noting the debate regarding the differences between population health and health promotion (see discussion in Chapter Three), she states that nurses will have to come to terms with the meaning of population health for their practice, given the shift in policy focus (at least in Canada) toward a population health approach. We do know that, in the early 1990s, when the Hamilton-Wentworth Department of Public Health Services conducted a series of workshops to advance consensus among PHNs regarding the practice of population-based health promotion, PHNs identified a need for more specific information on how to implement such an approach (Halbert et al., 1993).

We have seen that one of the salient features of the literature on nurses' HP practice is the gap between rhetoric and reality. This leads us to the final question, "what are the barriers or challenges to HP in C/PHN practice that are identified in the literature that may be contributing to this gap?" We have already touched on several key factors that can limit the scope and nature of nurses' HP practice. Perhaps the most fundamental obstacle

is the ideological assumption that forms the foundation of nursing as a profession. This ideological assumption, which places great value on individual rights and responsibilities, stems from the dominant ideology in western society and so it is not surprising that it would influence nursing theory or nursing education.

We have already looked at some of the characteristics of undergraduate nursing education that reinforce a perspective of individual responsibility for health and the HP role of the nurse as counselling or educating individuals to make healthy choices regarding behaviours and lifestyle. There are also concerns about the way that nursing education fails to prepare nurses adequately for a role in population-focussed HP. Chalmers & Kristajanson (1989) point out that only a small component of the curriculum in Canadian university nursing programs during the 1980s was devoted to community health, and the majority of the focus of community-related content in these baccalaureate programs was placed on learning to provide direct care to individuals and families in the community. In a study of educational preparation for community health nursing practice in Manitoba, community staff nurses and administrators noted that there was a growing emphasis on community development, rather than focusing on individual clients, but some nurses were struggling with this change in focus and did not feel that they had the skills or confidence to function in that role (Bramadat, Chalmers, & Andrusyszyn, 1996). Williams (1996) maintains that, even in graduate nursing programs, the skills necessary for population assessment and management are not given the in-depth treatment accorded to other components of the curriculum, particularly the direct care aspects. Chalmers & Kristajanson's (1989) observation that there is little evidence that community nursing

administrators promote the development of skills needed to work at this level of HP practice is not surprising under these circumstances— i.e., most likely these administrators have never developed the necessary skills themselves.

There are some organizational barriers limiting the scope of C/PHNs' HP practice that are identified in the literature. The organization of PHN services into programs-based, rather than district/population/neighbourhood-based delivery was discussed earlier. Several authors point to the conservative nature of the organizations that health professionals work in as a major barrier. They argue that the non-participatory structures within which nurses work, and the process of role socialization that occurs within those structures, inhibit population-focussed public health nursing (Chambers, Underwood, & Halbert, 1989; Williams, 1996). Clay (cited in Gott & O'Brien, 1990) argues that nurses have too little autonomy and too little authority within the health care system and, therefore, they have no power to relinquish. This view is shared by others, who suggest that health professionals end up being disempowered, making it very difficult for them to encourage the empowerment of others (Labonte 1993; Rodwell 1996). Organizational barriers identified by Latter (1998) include: conceptual frameworks used in practice that focus on the individual and on observable and measurable behaviour; and the manner in which nurses' work is audited (e.g., emphasis on numbers of patient and client contacts as a measure of performance) that acts as a constraint on the full development of nurses' HP potential.

As mentioned earlier, there is a distinct lack of attention in the literature to the challenges of applying specific HP concepts— such as empowerment, partnership, and

community development— in nursing practice. Aside from the few references mentioned above regarding nurses' own lack of empowerment being an obstacle to the empowerment of their clients, Chalmers & Bramadat (1996) offer one of the few critical analyses of C/PHN involvement in community development (CD) work. One of the major barriers that they identify relates to the organizational structures within which nurses practice. They note that Public Health agencies and community health centres may have varying degrees of support for the community development role, in that well-articulated policies may be lacking and, where present, there may not be adequate resources allocated for the work. In addition, the demands for mandated programs such as post-partum visiting and communicable disease follow-up may pre-empt community development work, and few standards exist for evaluation of nurses' community development work. Chalmers & Bramadat note that health organizations in which nurses are employed may be reluctant to share power with their nursing staff, let alone the clients with whom nurses work, and that nurses who are government employees may have difficulty in criticizing public policies impacting on population health. The authors also identify a set of barriers that originate with nurses themselves, including a lack of well developed collaborative skills, difficulty in giving up professional control, and a preference for working with individuals. Finally, Chalmers & Bramadat suggest that there are some barriers which originate in the communities that nurses practice in. For example, there may be resistance from sections of the community to particular initiatives that may not be perceived to meet their interests, including initiatives that challenge established gender roles. Drevdahl (1995) discusses additional challenges to community organization

interventions by C/PHNs. These include the difficulty of identification of community constituents and establishment of intervention goals, and the conceptual and practical challenges in defining community participation and empowerment and measuring community change.

Some authors note that nurses have, historically, been shaped by societal forces to be passive and non-confrontational (Chalmers & Kristajanson, 1989; Laffrey & Page, 1989; Maben & MacLeod Clark, 1995). This phenomenon could be an important factor in inhibiting nurses' involvement in social change-oriented activities, such as community development and advocacy for policy change. Kendall (1992) also recognizes the possibility for societal forces to block nurses' role in social change when she acknowledges that an emancipatory future within the health care system may be difficult given the persistence of the class system in the broader society.

There are relatively few qualitative, first-person accounts regarding what frontline C/PHNs view as the main challenges to their health-promoting practice. In one of the earliest examples in the literature, an ethnographic study of four Canadian PHNs' perspectives on their nursing practice, the main barrier that the nurses identified was a lack of cooperation by the client(s) in making necessary lifestyle changes (Field, 1983). Zerwekh (1991) interviewed thirty PHNs in Washington state to determine how they knew that their nursing actions had improved their clients' lives. One of the main findings was a growing sense of uncertainty among the PHNs about whether or not they were making a difference because the social conditions (poverty, drugs, violence) that their clients lived in often counteracted any HP efforts on the part of the PHNs. In their

study of the perceptions of 28 PHNs from Alberta regarding their nursing practice, Reutter & Ford (1996) elicited similar concerns about the challenges presented to the PHNs' HP efforts by socially and economically disadvantaged individuals and families as well as those clients with mental health problems. In these situations, the nurses admitted feeling powerless to bring about changes that might benefit clients. In some cases, this was due to a lack of skills or resources to address the underlying social problems faced by these people, while in other cases the clients clearly had different priorities than the PHNs did. By far the greatest stressor identified by the nurses, however, was insufficient time for reflection and planning, for developing relationships with clients, and for implementing innovative programs in the community. Another stressor which acted as a barrier to their health-promoting practice was the organizational constraint of having to provide mandated programs, which prevented the PHNs from engaging in community development work and advocacy for healthy public policy (which most of them viewed as part of their expanded role). In addition, uncertainty about their own job security and the future direction of public health nursing lessened the PHNs' commitment of time and energy to embark on new initiatives. The PHNs also expressed concern that the general public and other professionals do not understand their role, associating PHNs with the tasks or concrete activities they perform (e.g., immunizations) but not with broader functions such as community development work where the outcome is not immediately apparent. In a later analysis of the findings, Reutter & Ford (1998) note that, although a decrease in resources was the major reason that PHNs were pulling back some of their services, in some cases they were obliged to pull back as other professionals took over

tasks that were previously done by them. This was particularly the case in the schools, where activities such as health education, hearing and vision screening, and some counselling were now being carried out by other professionals. Many of the PHNs expressed concern that the loss of these activities meant a loss of an 'entry point' to address other potential health needs.

There are three other Canadian examples of a first-person account of barriers to C/PHNs' health promoting practice. Craig (1991) focused on the experience of nurses in two Ontario public health units following the implementation of a new public health policy in 1989. This study explored the perceptions of nurses regarding implications for their practice of the new policy which required practitioners to develop, implement, and evaluate programs and services with extensive community participation and intersectoral cooperation, and the use of a community development approach. The research findings demonstrate a strong sense of loss about giving up traditional practice, considerable confusion about the concept of community development, a lack of confidence in knowledge and skills required, and fear that individuals and families with complex needs who were formerly served would not receive service. Rafael (1999) interviewed thirty PHNs from Public Health units across Southern Ontario about changes in their practice over the period between 1980 and 1996. As was the case for the PHNs in Alberta, there had been a shift away from home visiting and direct provision of services in the schools, but the major change identified by PHNs was the shift from district-focused nursing to programs-based nursing. Many nurses ended up feeling distanced from their communities because they now focused only on the portion of their community affected

by a specific program and because direct services to communities were replaced by indirect contact with community agencies. PHNs were particularly concerned that prevailing interpretations of community development had shifted the Public Health focus to those who were healthy and empowered enough to identify their needs and avail themselves of Public Health resources, while service gaps were created for the most vulnerable and marginalized populations. Finally, Leipert's (1996) phenomenological study of eleven CHNs working in the Health Department of a large urban Canadian centre found that one of the main barriers to their HP practice was the perceived lack of CHN role clarity among clients, other disciplines, nurses in non-community practice, and even among themselves— all of which served to undermine awareness, valuing, and use of community health nursing services.

To summarize; there are several salient features of the literature describing the role of HP within nursing practice. First; there appears to be a strong assumption that nurses, no matter what setting that they work in, can play an important role (some would argue, a leadership role) in HP. However, it is equally apparent that there are different interpretations of what that HP role should be. For example, it seems that some people view every nursing action as health- promoting, whereas others view HP as a specific strategy or activity. Second; although HP is viewed as an important component of nursing in general, it is considered to be the primary domain of PHNs. However, there is a tension that runs through the literature between the idea that the heart of PHN practice is a population focus and the idea that nurses' main focus will always be the individual or family. Indeed, most of the studies in the literature describe a HP practice that continues

to focus on changes at the level of the individual. In fact, it is not clear exactly what 'population-focussed' nursing practice means. Sometimes it is used in the literature to describe the organization of PHN service delivery— i.e., PHNs being responsible for meeting the HP needs of the population in a specific *geographic* community or district, as opposed to a focus on a particular program, such as mental health, maternal-child health, etc.. At other times it seems to refer to the planning and delivery of programs based on the assessed needs of a particular population or aggregate because of specific characteristics which place them 'at risk' for certain diseases or other negative health outcomes—e.g., the elderly or children. Still another manifestation that appears in the literature is the idea of certain HP strategies that are aimed at the population level, as opposed to the individual level— e.g., advocacy for healthy public policy change.

Another tension that is apparent in the literature regarding C/PHNs' HP practice is that, although there is an increasing acknowledgement of the need to pay attention to the broader social and environmental factors influencing health status, attitudes, and behaviours, there is some evidence that nurses view their main role as helping people cope with their social and environmental circumstances rather than changing those circumstances. Similarly, there is some attention in the theoretical literature to the potential role for C/PHNs in emancipatory nursing with the goal of social change— but there is little empirical evidence of how nurses are putting these ideas into practice. A fourth theme in the literature is that most of the emphasis is on the potential or ideal HP role of C/PHNs. The discussion regarding barriers to HP in C/PHN practice is largely theoretical in nature, and it is often mentioned briefly in passing, rather than being a

central focus of the discussion. Finally, there are relatively few studies documented in the literature that focus on C/PHNs' own perceptions of their HP practice and there are none that explore changes to C/PHNs' HP practice within the specific context of regionalization in Canadian health systems.

5.4 - Summary

This review of the literature on HP in Public Health practice suggests that there are a number of potential barriers (both extra- and intra-system) to building capacity for HP in the Public Health sector. Barriers that originate at the extra-system level include: a lack of consensus regarding the mission, values, principles, functions, and standards of Public Health, and the specific scope of HP practice within Public Health (either at the national or provincial level); the fact that HP is not legislatively mandated within the Public Health sector at the provincial level; the current political and social climate where concern for cost- effectiveness/efficiency and individual rights may clash with traditional Public Health values of social justice/equity and the common good; the societal acceptance of individual choice and responsibility for health; a lack of political will at the provincial government level to increase investment in HP; public demand for acute care services; and cutbacks in transfer payments from the federal government to the provinces and the erosion of funding to the Public Health sector. Some organizational barriers mentioned in the literature include: limits on the changes to public policy which can be affected at the local level; different conceptual frameworks, decision-making processes, and levels of autonomy, making intersectoral collaboration difficult; compartmentalization of thinking within disciplines, programs and sectors; inadequate

commitment to promoting continuing Public Health education for staff; workload and performance indicators which do not capture certain population-level HP strategies such as community development; lack of well-articulated policies and guidelines for HP work; the re-organization of professional practice into program-based rather than neighbourhood-based models, and hierarchical, non-participatory management structures that do not promote empowerment of staff, let alone clients. A number of barriers to HP mentioned in the literature originate at the level of individual practitioners. Looking at the example of the largest group of Public Health practitioners— nurses— many barriers to their role in HP appear to be the result of traditional values, principles, and roles in the nursing profession. These include: acceptance of the dominant ideology of individual choice and responsibility for health; a preference for working with individuals or families; a focus on teaching or counselling regarding healthy lifestyles or behaviours; difficulty giving up professional control when working with clients or other disciplines; and an emphasis on helping people cope with the negative social or environmental conditions that they live in rather than on being agents of social change. Lack of necessary knowledge/skills and, perhaps more importantly, lack of comfort in engaging in certain HP strategies (for example, community development and healthy public policy advocacy) are also cited in the literature. Other barriers at the individual practitioner level relate less to factors that are inherent in nursing practice but, rather, to working conditions. Lack of time to engage in anything other than mandatory programs activities (due to high demand and staffing deficiencies) is the most commonly mentioned barrier in this category.

Lastly, there are relatively few first-hand accounts of HP practice within the Public Health sector and little is known about the challenges to capacity building for HP that are faced at the level of the organization or individual practitioners in Manitoba's RHAs. In the next chapter, we will explore this perspective.

**CHAPTER SIX:
HEALTH PROMOTION PRACTICE IN PUBLIC HEALTH:
THE VIEW FROM MANITOBA'S RHAs**

In this chapter, the views of key informants from the three study sites about HP practice in Public Health in their regions will be presented.²² In Part I, we will focus on the climate for increasing the emphasis on HP within the RHAs at the time of the interviews, and then we will explore the nature of HP practice in the RHAs in more depth. Parts II and III will discuss barriers and actual/potential facilitators to HP action. A summary of the findings will be presented in Part IV.

PART I - THE NATURE OF HEALTH PROMOTION PRACTICE IN MANITOBA'S
RHAs

6.1 - Discussion About Reorienting the Health System Towards a Health Promotion

Focus

The need to re-orient the health system to include a focus on health and health promotion, including the development of a strong health promotion infrastructure within national and local health systems, has been a central recommendation in a number of key international HP policy statements since it was first articulated in the *Ottawa Charter* in 1986 (Lopez-Acuna et al., 2000; World Health Organization, 1997b; Ziglio et al., 2000). It was also one of the three main priorities identified in the CPHA's (Canadian Public Health Association, 1996a) *Action Statement for Health Promotion*. For this reason, all participants from the RHAs were asked whether there had been any discussion about the need to increase the emphasis on health promotion and prevention of disease within the

²²This topic also came up in several of the interviews with current/former Manitoba Health employees. Some of their comments are included in footnotes.

organization.

Overall, participants noted that there had been varying degrees of discussion about the subject. Board members in all regions stated that there was strong support for HP on their boards. This self-assessment was confirmed by the CEO in one region, who stated that the board was very knowledgeable about HP and discussed it a lot. Another senior administrator in that region stated that there was increasing discussion about HP at all levels of the organization, and that senior management and board members were “getting much better” at talking about HP issues. According to a senior CH program manager in this RHA, the level of discussion had increased following the former MOH’s parting presentation to the board and senior management. The MOH had warned that integration of health services on its own was not enough, and emphasized the need to ‘think upstream’ and to increase investment in HP. According to a DHAC member in another region, there were varying degrees of commitment from DHAC members to the idea of increasing the emphasis on health promotion. In the third region, a senior program manager stated that there had been a lot of discussion recently about the need to make health promotion a part of everyone’s job.

The majority of participants, however, suggested that discussion about HP had been overshadowed due to other demands and priorities— particularly, the need to focus on setting up the infrastructure of the new RHA organization during the transition phase and the demands for acute care services. Several senior administrators and Board members were cynical about the provincial rhetoric regarding increasing the emphasis on HP. They said that there had been a fair amount of discussion among themselves about the dilemma

of resource allocation for HP initiatives when acute care was so underfunded. One senior administrator had this to say:

Well, the discussions that have occurred are those hard-nosed discussions saying, O.K., if we really believe in this philosophy, then we should be transferring 'x' percent of our budget from the acute care sector to the community side. Because if we don't make that shift, we're never going to get at the issue. But...I don't believe that you can do it that way. I believe that there has to be concurrent investment because the investment on the health promotion, prevention side is long term. You're not going to change or see the results of health promotion, prevention strategies tomorrow.

Perhaps the most striking characteristic of the participants' responses to this introductory question was the way in which most of them used the term, 'health promotion.' In most cases, when they were providing examples of discussion about health promotion within the organization, they referred to activities that focussed on prevention of disease and promotion of a healthy lifestyle. For example; one of the board chairpersons described the board's support for HP this way:

It's something that we certainly support. It's a heck of a lot cheaper to promote and educate against certain health risks than it is to have to address them in the acute care setting. Everything from diabetes prevention, smoking, and cancer prevention, heart disease.....

In another region, DHAC members stated that the discussion about HP had focussed primarily around support for a health resource centre and a proposed community 'wellness' centre. Frontline practitioners also gave examples of increased discussion about diabetes prevention (within the context of the provincial diabetes initiative), and the need to provide community members with more information about various health risks (poor nutrition, smoking, high-risk sexual behaviours). No one mentioned any discussion about the need to increase intersectoral collaboration or advocacy for healthy public

policy or to decrease inequalities in health. It is also noted that several individuals, when asked to provide examples of discussions within the organization about increasing the emphasis on HP, responded by saying that there had been increased emphasis on population health, and that this was integral to the orientation of new board members and corporate strategic planning– i.e., they equated HP with a population health perspective.

6.2 - Frontline Practitioners Talk About Their Health Promotion Practice

The next set of questions focussed on participants' HP practice. Since senior administrators, Board members, and DHAC members were less likely to be engaged in HP activities in their day-to-day work, the decision was made to limit these questions to frontline practitioners and program managers in Public Health. However, the latter group of key informants frequently found it difficult to respond to questions that required them to summarize aspects of their staff's practice, especially in situations where they supervised individuals from different disciplines. As a result, with the exception of one question about RHA support for involvement in HP strategies, only the responses of C/PHNs and other frontline practitioners are reported here.

6.2.1 - HP Strategies Used Most Often

Using the PHP model as a guide (see Appendix C), frontline practitioners were asked which HP strategy– excluding *reforming health systems*– they were most likely to use in their day-to-day practice. Out of 33 frontline practitioners who responded to this question, 31 stated that 'developing personal skills' (DPS) was the main focus of their day-to-day practice, although one of these individuals stated that 'strengthening community action' (SCA) was equal to DPS. Among PHNs, the strategy of DPS

primarily involved providing clients with information about self-care or infant/child care, as well as assisting clients to develop healthy coping skills. The 'Baby First' and 'New Beginnings' programs were cited as examples of population-based initiatives that focus on developing personal skills to promote healthy child development among families at risk for poor child health outcomes. Teaching clients about nutrition, cooking, and budgeting, and supporting them to develop literacy, employment, or general self-awareness skills were examples given of DPS by several non-nurse participants. In addition, a nurse in the northern region stated that part of her job was to develop the personal skills of auxiliary health workers under her supervision in several outlying communities. Only two frontline practitioners, both in designated HP roles, identified strategies other than DPS as the main focus of their day-to-day practice. One of these individuals stated that SCA and 'advocacy for healthy public policy' (ADHPP) were equally the focus of her work, while another identified 'creating supportive environments' (CSE) as her main focus.

An important observation was made by several participants, who suggested that DPS was often a necessary condition for the other strategies to be successful. For example, a PHN pointed out that, if a new parent can develop good coping skills and self-esteem, then they are more likely to establish a supportive environment for their children. Other participants noted that individuals with solid life skills and a sense of personal empowerment were more likely to engage in community development or community mobilization activities, and that the role of frontline practitioners should be to assist clients to develop the skills that they would require to advocate for healthy public policy

change on their own behalf– rather than having to rely on others to do it for them.

A salient feature of this discussion was that all twenty-four nurses (PHNs and CHNs) in the study selected DPS as the strategy that they were most likely to use in their day-to-day practice. One of the twenty PHNs stated that DPS plus SCA were equally the main focus of her work. All four CHNs employed in the CNRC stated that DPS was the main focus of their work, which was interesting given the fact that community development was viewed as a central philosophy of their health centre.

6.2.2 - HP Strategies Used Least Often

Frontline practitioners were then asked which of the HP strategies– excluding ‘reforming the health system’– that they (or their staff) were *least* likely to use in their day-to-day practice. Of the 32 frontline practitioners who responded to this question, all but three individuals identified ADHPP as the strategy that they were least likely to engage in. Two individuals (a CHN and a PHN) stated that they were least likely to be involved in CSE. One PHN stated that SCA was something that she was the least likely to be involved with in her daily practice. Interestingly, when frontline practitioners were asked if it was appropriate for them to be involved in each of the HP strategies, only three participants (two PHNs and another health professional) stated that it was inappropriate for someone in their position to be involved in each of the strategies. All three of these individuals singled out ADHPP as an activity that was more appropriate at higher levels of the organization. While most of the frontline participants felt that it was appropriate for someone in their position to be involved in each of the HP strategies in theory, many of them emphasized that there had to be enough time, resources, and support by

management. It was also pointed out that the level of involvement in activities such as ADHPP and SCA would vary, depending on the issue, and that these activities might be a low priority when mandatory programs demands were high.

6.2.3 - Influence of Educational Background on the Use of Particular HP Strategies

I was interested in knowing whether the frontline practitioners' professional education had prepared them to engage in one type of HP strategy more than another. Most nurses stated that their education prepared them best for DPS, in the sense that their focus was on health teaching and assisting clients to cope with various situations affecting their (or their family's) health. Nurses who had graduated from a university degree program stated that health promotion in the community had been a significant component of their nursing education. One nurse, who had recently obtained her undergraduate nursing degree, stated that the main focus of her program had been on health promotion in the community, and that she had gained practical experience in community development and advocacy for healthy public policy. However, most nurses stated that there was far more of a theoretical emphasis on community health than practical application in their programs, and several participants suggested that other factors were just as likely, or more likely, to influence their involvement in particular strategies. As one degree-prepared nurse stated – "I don't know if [it's] an educational background or personal preferences or [it's] just a feeling of, that's where the needs are. That, by the nature of our job, that's [referring to DPS] where we're forced to focus, so over the course of time, that's where your energy goes." Another nurse made it clear that her personal beliefs influenced her use of DPS more than her educational background.

She stated that, ultimately, individuals are responsible for their own health and, therefore, that her most important contribution was help people develop the knowledge and skills that they require to lead healthy lifestyles.

The majority of non-nurse frontline practitioners also stated that their education background had prepared them more for DPS than for any other HP strategy. One exception was a participant with a background in social work, who stated that there was an equal emphasis on DPS, CSE, SCA, and ADHPP in her university program. Another individual, with a background in recreation, stated that her university education had prepared her primarily in health program planning.

6.2.4 - Perceived RHA Support for Staff Involvement in HP Strategies

Frontline practitioners and program managers were asked if they thought that the RHA would be equally supportive of their involvement in all HP strategies—excluding *reforming health care systems*. The majority of frontline practitioners expressed the opinion that their RHA Board and senior management would probably support their staff's involvement in any of the strategies, in theory, although, in practice, they felt that DPS was more likely to be supported by the RHA than any of the other strategies. As one PHN explained, this is the strategy that has the best fit with the mandated role of the PHN:

They would support us to do any of this, in theory. But, in staffing, I don't think that the support is there. We have support to do the 'developing personal skills' because we have programs that are mandated that we have to do, which are immunization, STDs, communicable disease and maternal-postpartum program. So you can see, with all four of those areas, we're having to make individual contact, and developing personal skills is the most common thing that you would be doing in those areas. So, I think that the support is there for doing everything if you're such

a creative person that you could figure out how to do it in the time that's allowed. But, realistically, I think they're supporting this one [DPS].

Another frontline practitioner pointed out that most of the Public Health programs are very client-based, and are evaluated based on the number of client contacts made. As a result, she felt that it is logical for frontline staff to think that the RHA supports DPS more than any other strategy in practice, no matter what their theoretical support for any of the other strategies may be. It should be noted that frontline staff (CHNs and other non-nurse service providers) at a community health centre in the northern RHA were more likely to state that they would receive practical as well as theoretical support for all HP strategies than the rest of the frontline practitioners in their region or in the other two regions. In addition, participants who worked in designated HP positions were more likely to state that the RHA would support their involvement in all strategies equally.

Program managers also felt that staff would be supported in becoming involved in all of the HP strategies, at least in theory, although they acknowledged that mandatory program demands usually take precedence over activities such as SCA and ADHPP. As one senior Public Health manager conceded— "I think we've really got an overworked work force and so choosing to be involved in this kind of thing is almost an add-on to a role that is defined in a particular way, and I think that most of our roles are quite clearly defined to somehow engage with people around illness." However, participants in one region did feel that the RHA had a serious commitment to SCA and mobilizing community which was not limited to theoretical support. A senior health official described the real changes that had occurred in her RHA:

...I see that as being a big change....to do partnerships. And to do community action. And then to influence communities and to actually go out to talk to council. You know, fifteen years ago, you would never see a health care provider going to city council and actually trying to influence them to change zoning by-laws. You wouldn't have seen someone going to the economic development officers and saying, you've got to change the policy strategies when it comes to finding viable work for mental health clients. So I think that they're [the Board and senior management] much more open to that, to health care providers being community action-oriented.

Another manager in this region agreed, stating that RHA support for frontline staff to be involved in strategies other than DPS had started even prior to regionalization:

...before we made the transition to be established as an RHA...there was very strong encouragement, in particular for the public health nurses, to be involved in their communities in setting up community health committees to prepare the communities for the change to the RHA. So there was a strong organizational push to involve the public health nurses in these types of strategies...

Other noteworthy comments about RHA support for HP strategies included the observation by a PHN that, in order to get RHA support for any strategy in the future, it will be necessary to show that the time spent on a particular activity is important for positive community health outcomes. In addition, a non-nurse frontline worker suggested that you need to "live and breathe" a philosophy like HP, which can only happen if it is promoted from the top of the organization down to the front-lines.

6.2.5 - Influence of HP Activities on Determinants of Health (DOH)

I was interested in exploring to what extent frontline practitioners felt that they influenced the DOH, listed along the left side of the PHP model. They were asked which of the DOH— excluding biology and genetics²³— they were *most* likely to influence in their

²³The category of 'Biology and Genetics' was excluded for the obvious reason that, aside from providing medications which alter physiology or being involved in genetic engineering experiments (neither of which is the focus of any of these

day-to-day practice, and which of the DOH they were *least* likely to influence in their day-to-day practice?

A. DOH *most* likely to influence

In all regions, the two main DOH that were identified as being most likely to be influenced in day-to-day practice were personal health practices/coping and healthy child development. For example, all twenty of the frontline PHNs who participated in the study identified one, or both, of these DOH as the most likely to be influenced in their daily practice. Thirteen of the twenty PHNs stated that these two DOH could not be viewed separately and were of equal importance. Four PHNs felt that facilitating access to health services was an additional, and equally important, determinant as the other two. Two PHNs felt that facilitating social support was an additional, and equally important, determinant as the other two. Among the other frontline practitioners (e.g., dietitians, health promoters/educators, etc.), social support was most frequently mentioned, in addition to personal health practices/coping and healthy child development, as being most likely to be influenced in their daily practice.

Although most participants stated that a primary focus of their work was to influence personal health practices and coping skills of their clients and/or healthy child development, it was among the frontline PHNs that this was most obviously the core of their day to day work. Providing information about pre-natal, post-partum, and infant nutrition, normal physical and social milestones in child development, parenting,

participants), there really isn't any way that they could be expected to influence this determinant of health.

communicable disease control (especially routine childhood immunization), reproductive/sexual health, exercise, and stress management were most often mentioned as examples of how PHNs influence these DOH on a daily basis.

As far as their influence on client's social support networks was concerned, most frontline practitioners stated that they always try to assess the amount of social support that their clients have, and then to inform clients about, and link them with, support services available in the community when necessary. The most common types of support services mentioned were support groups for new mothers, parenting groups, play groups, Family Resource Centres, and support groups related to particular conditions/diseases (e.g., Alzheimers, Alcoholics Anonymous, etc.). In the northern region, participants gave examples of two types of support groups that target the local Aboriginal population— a 'crafting and conversation' program, consisting primarily of women, and a men's support group that addresses issues such as domestic violence and alcohol abuse. Several people noted that, frequently, they were aware that they were probably the only social support system that their clients had, and they felt that it was very important to link these people to other services. Giving people the encouragement and skills that they required to find their own supports was seen as being an important intervention.

Several nurses mentioned health services as another health determinant that they influenced the most in their day-to-day work. They frequently facilitate access to necessary services through referrals to physicians, dieticians, audiologists, and the Mental Health and Home Care programs, and through advocacy when their clients' efforts to access needed services are being hampered.

B. DOH *least* likely to influence

In all regions, income/social status and working conditions/employment were identified most frequently as DOH that frontline practitioners were least likely to influence directly. Many nurses stated that it was not uncommon to discuss stress-related problems originating in the workplace with clients, however the focus of these interactions was on assisting clients to cope with stress in a healthy manner, rather than changing the conditions in the workplace. One PHN did recall a situation where she had advocated for some changes in a workplace environment that was causing stress for its workers, and another PHN noted that she had made a couple of referrals to Workplace Health & Safety related to dangerous physical conditions in a workplace— but these were exceptions.

As far as directly influencing income/social status, virtually every participant stated that this was something beyond their scope of practice. “I don’t think that we can ever do much about that,” was a typical response. One nurse suggested that this was the hardest health determinant to address because “it is tied up in the whole social class system of society” and that changes to this system required having “the power to influence government decision-makers.” However, upon some reflection, many participants felt that they had some indirect influence on this health determinant. Nurses and other frontline practitioners spoke of the ways in which they assist clients to access income support services on a regular (if not daily) basis, such as: social assistance benefits, the Women and Infant Nutrition program, Baby’s Best Start supplements, free contraceptives, child care subsidies, and subsidized housing. As one PHN described it:

“we try and make sure that they know what’s out there and available to them and what’s free.” A frontline practitioner who works primarily with youth talked about being involved in a multi-agency initiative to find jobs for unemployed youth, and another participant discussed her role (in her capacity as a Health Promoter) on the local Social Planning Council, which advocates for people living in poverty. However, referring to the formal human service system as a whole, she concluded, “I think we do a pretty sad job of working with people in poverty.”

Like income/social status, the physical environment was a determinant of health that participants initially felt they were least likely to influence in their day-to-day work. However, when asked to give an example of where they might do this, most nurses felt that they occasionally did have some influence, if only in an indirect way. For example, all of the PHNs noted that a lot of their teaching when doing home visits to newborns or families with young children involves providing information about creating a safe environment for children (dangers of second-hand smoke, proper use of smoke detectors, removing physical or chemical hazards). Several PHNs noted that they had occasionally had to notify public health inspectors about homes where conditions were not safe or healthy (due to poor wiring, moulds, rats, and so on), a few PHNs had been involved in efforts to create smoke-free environments in public places, and one PHN had worked on playground safety issues. A group of nurses in the northern region described their efforts to improve housing conditions in one community. Two PHNs in one region expressed their concern about the quality of drinking water in their districts (this was pre-Walkerton), and hoped that this problem would be addressed in the near future, but they

did not feel that they could influence the situation other than to voice concern about the situation and to encourage community members to regularly test their water.²⁴

Influencing the formal education levels of their clients was another health determinant that participants felt they were least likely to influence in their day-to-day work. However, both nursing and non-nursing frontline practitioners stated that they did take the opportunity, whenever possible, to encourage their clients to continue or upgrade their education. In the case of teenage moms, several PHNs described more active efforts to help facilitate their return to school.

6.2.6 - Ability to Meet the Needs of Vulnerable Populations

I was interested in finding out to what extent the DOH that frontline practitioners influenced in their day-to-day work coincided with the DOH that they believed were most important to the health of the people that they worked with on a day-to-day basis—especially the most vulnerable of their clients. In other words; if knowledge about healthy personal health practices is a health determinant that frontline practitioners feel they have the most influence on, is this the health determinant that they view as most central to the well-being of the most vulnerable people that they work with in their day-to-day practice? Participants were asked: *“Think about the most vulnerable people that you work with day to day. What determinant (or determinants) of health would be most influential in promoting their wellbeing?”*

Frontline practitioners in all regions identified income/social status and personal

²⁴This was at a time when the provincial government of the day had stopped paying for well-water testing and turned responsibility for testing back to individual well-owners.

health practices/coping as the two most important DOH for their most vulnerable clients. Improved socioeconomic conditions (increased income, suitable employment, and better housing) were viewed as being of critical importance to their clients' health. It should be noted that this was a health determinant which participants had earlier identified as the one that they were least likely to influence directly through their daily practice, although they did feel that they had some indirect influence, mostly in the form of linking clients up with services that might assist them to access required resources.

Personal health practices/coping, a determinant of health that participants had earlier identified as being the most likely to influence in their daily practice, was also mentioned in all regions as being essential for their clients' health. This was equally divided between those who felt that clients required more knowledge about how to have a healthy lifestyle and how to access the resources that they need, and those who felt that clients required a better attitude (more motivation to change their lives, better self-esteem, and increased value put on being healthy). Other DOH mentioned were: social support, including social cohesion and a sense of community in addition to individual support networks (mentioned in Regions 'C' and 'A'); more recreational/social opportunities for teens (mentioned in Region 'C'); better education levels (mentioned in Region 'C'); more Aboriginal human services workers (mentioned in Region 'C'); and better child care services (mentioned in Region 'C').

PART II - BARRIERS TO HEALTH PROMOTION

After getting a sense of the level of discussion about HP and the nature of HP practice in the regions, the next step was to examine the practical issues of putting HP concepts into practice. Specifically, I was interested in identifying the barriers (and facilitators) to HP action in the RHAs. To begin with, participants from every category in the RHAs were asked, “*what are the barriers to increasing the emphasis on HP in this RHA?*” Following the discussion of barriers to HP in general, frontline practitioners and CH/PH program managers were asked to identify the barriers to two specific HP strategies— advocacy for healthy public policy (ADHPP) and strengthening community action (SCA). A summary of the responses is presented according to the following categories, representing different types of barriers: (i) attitudes; (ii) resources; (iii) organizational structure/policies/ processes; and (iv) knowledge/skills. Wherever possible, a distinction is made between those barriers originating within the RHA organization, and those barriers originating outside of the RHA.

6.3 - Attitudinal Barriers to Increased Emphasis on Health Promotion (General)

One type of barrier to increasing the emphasis on HP relates to attitudes and philosophy, both at the individual and collective level, within and outside of the RHAs.

6.3.1 - Attitudinal Barriers Originating *Within* the Organization

A barrier that was frequently mentioned by participants in all of the regions was the perceived resistance to ‘buying into’ the HP philosophy by staff in the acute/long term care facilities. Participants noted (sympathetically, for the most part) that direct care

providers in the facilities were having enough difficulty coping with their role as it stood, let alone having to adjust to a whole new way of thinking. One senior administrator observed that it is very difficult to break down the 'silos' between facility and community health managers, when managers of facilities are much more concerned with the day-to-day challenges of keeping their institutions running (dealing with a chronic nursing shortage) than with HP. Although many of the public health staff acknowledged that HP shouldn't belong only to the community health sector, they suggested that, within all three RHAs, HP is viewed as the domain of the public health/community health programs. However, a Mental Health program manager pointed out that Mental Health is still viewed, both within and outside of the organization, primarily as providing crisis intervention, maintenance and restoration services, rather than needing a HP component.

One individual suggested that staff in the acute care sector— especially nurses— were feeling threatened by talk of shifting the emphasis to HP and DP in the community because of a perceived threat to their job security. A senior administrator concurred with this perspective, suggesting that there is support for increased HP within the RHA in theory, but not if it means taking money away from current programs or services. Another senior administrator cynically suggested that it is not in the doctors' best interest to be good preventive specialists, and he felt that they were probably suspicious about any initiative that they perceived as being government-driven. It should be noted, however, that resistance to organizational change was not viewed as being limited to facilities staff, and one CEO acknowledged that a credibility-building process was required to eliminate the cynicism of some RHA staff in all areas about putting more emphasis on population

health. Similarly, although many frontline Public/Community Health (PH/CH) staff expressed the view that staff in the facilities did not value their work, two participants (one a senior administrator, the other a PHN) suggested that PH/CH staff don't value the work of facilities staff either.

While there was general agreement among participants that there was greater resistance to increasing the emphasis on HP among staff from the acute and long-term care sector, not everyone blamed the mind-set of their colleagues for this problem. There were individuals in each region who placed the blame at the top of the organization, criticizing their Board of Directors and senior administrators for 'buying into' the need for more doctors and not really being committed to the idea of increasing the emphasis on HP. One frontline worker stated that she didn't think her Board was ready to commit themselves to increasing the HP focus because it was perceived as requiring them to give up some other service that they now provided. In addition, one senior administrator suggested that some board members see their primary role as protecting medical services for their areas, especially where an RHA covers a large geographic area with more than one hospital, and they have little interest in HP activities.

In one region, a senior community health program manager acknowledged that their philosophy as an organization, including their position on the importance of HP, had not been articulated enough throughout the organization (interestingly, this was the individual who raised the question about how to create a health-promoting organization). She also expressed her concern that senior administrators did not always understand or value the work of community health practitioners. A HP worker summarized her

thoughts about attitudes towards increasing the emphasis on HP within the organization this way:

There might be acceptance [of the idea] but there's not commitment. And I see that there's a huge difference. That's when you accept something and say, yes, that makes sense...but it's going the next step. It's a commitment to do something about it....I think what happens is that people who are in the hierarchy or make the decisions, the boards and people in authority, that it's the squeaky stuff that gets it. And health promotion isn't squeaky.

In the northern region, several participants noted that frequent staff turnover, including both frontline and middle management positions, had created a situation where frontline staff and program managers sometimes had different values and philosophy. They pointed out that there were a relatively large number of nurses working in Public Health who had recently transferred from the hospital, and who did not necessarily value the philosophy of HP as much as other PHNs did. Several PHNs who had previously worked in the hospital setting did acknowledge that staff in the facilities tend to think more traditionally about HP— that is to say, their focus is on teaching patients about self-care.

In all regions, participants agreed that there were still staff in the community health sector who viewed HP primarily as teaching people about healthy behaviour, who still have the idea that they know what's best for people, and who would have great difficulty in giving up control (although no one admitted to holding these views themselves). This was seen as a particularly serious problem in the northern region, where several people suggested that there was a certain 'mind-set' among some field staff about working with First Nations communities to promote health.

In all regions, the perception of both frontline staff and middle-level managers was that HP was viewed by their supervisors as an activity that you do if you have time leftover after your 'regular' work is done. Several participants stated that taking time to give a presentation in the community or attend a community meeting did not seem to be valued by their supervisors. An interesting observation is that senior administrators and senior program managers were more likely to state that HP should be part of everyone's job, whereas frontline practitioners and middle-level managers were more likely to suggest that this should be left to HP specialists. There were some frontline staff who admitted to feeling uncomfortable or unconfident with HP work, largely due to the perception that they did not have the knowledge or skills required to do the work. However, most frontline staff stated that they simply didn't have the time for HP work due to other demands.

6.3.2 - Attitudinal Barriers Originating *Outside* of the Organization

By far the most frequently mentioned external attitudinal barrier to increasing the emphasis on HP (mentioned by all types of respondents in all regions) was the perception that the public's top priority is the availability/access to acute care services, even when they acknowledge the value of HP. One board member used her own situation as an example:

When I have an attack of angina that is not relieved by my three doses of nitro, I want a hospital close by and I want to have access to that....There is a certain time of life when you're quite willing to listen to the prevention and promotion, but when you're in the sick part, you don't care a darn about prevention and promotion because at that time you want acute care.

The consequence of this public attitude, according to the participants, is that there is a

lack of political will to focus on 'wellness' from both government and the RHA, both of which must respond to public demand. As one frontline practitioner remarked:

When we were out doing the community health needs assessment...we talked about the determinants of health, what they were and why we were doing the community health needs assessment. And you could tell, depending on what group you got to speak to, that they were not with it. Like this terminology is news to them. It's just not where they're at. Where they're at is, why can't I have my MRI when I need it? Why did my mother have to wait six months or ten months before she could have this done? Those are the kinds of questions that are asked, not whether or not Suzy Smith is out there doing prevention kinds of activities. So, until you get the population to start thinking that's where the money should go, it's not going to happen.

The need to respond to public demand was acknowledged by senior administrators in all regions, one of whom summed up the dilemma succinctly:

...on the acute care side, you've got people showing up at the door and you've got to treat them. You don't have the same public outcry when you don't have public health nurses, you know. And it's not that it's any less important, but you don't have the same political pressure or motivation. If we can't serve a client in Emergency in a timely fashion I'll have a complaint. If we can't provide immunization or counselling at the school...you don't get a complaint about that. And unfortunately, when you have governments planning in four-year time frames in terms of their mandates, you don't have that longitudinal perspective there either because they're going to deal with the political hot potatoes.

Another senior administrator suggested that politicians won't risk their re-election on increased HP funding if it means any reductions to hospital funding, and they are most likely to approve funding to projects where results will be apparent quickly, not ten years down the road. A couple of participants suggested that part of the problem might be that health promotion is viewed as a healthy lifestyle issue, which boils down to individual responsibility, rather than something that the health system should be responsible for. Indeed, many PHNs stated that the public had a very narrow view of the role of the

nurse— i.e., providing bedside care— and that there was a profound lack of understanding about the role of community health practitioners. They proposed that most citizens were probably not familiar with Public Health programs unless they had received services.

On the other hand, several frontline practitioners pointed out that ‘special interest’ groups who oppose specific Public Health programs for ideological reasons— particularly reproductive and sexual health programs, and immunization programs— were having some success in certain areas in influencing public opinion against these services. PHNs noted that the anti-immunization movement appeared to be gaining momentum in certain areas of Manitoba.

Another type of barrier mentioned by several individuals relates to attitudes towards Public Health programs that are influenced by culture or socioeconomic status (SES). In all three regions, a comment was made that vulnerable groups tend to mistrust Public Health personnel, whom they view as linked with Child & Family Services. It was also suggested that SES affects the public’s interest in formal prevention programs, in that lower SES resulted in less interest in prevention because of low levels of education, higher rates of disease requiring acute care, and the likelihood that most of their energy will be expended on dealing with the challenges of getting through each day rather than planning for future good health. Others noted that cultural attitudes towards health, illness, food, recreation, respect for elders, community involvement (to name just a few that were mentioned) affect the public’s attitude to HP initiatives. This can, and does, lead to situations where certain groups feel healthy, in spite of ‘unhealthy’ (from the health professional’s perspective) behaviours. This opinion was mentioned by many

people in the northern region but it was not exclusive to that region. In the northern region, however, several participants suggested that there was a 'mind-set' among both First Nations and non-First Nations people that acted as a barrier to working together effectively on HP initiatives.

Most participants felt that the shift in emphasis toward health promotion would require a long-term change in public thinking. One senior administrator stated that it would require the public to view 'health' as something that is created by communities/societies that recognize and respond to the needs of their citizens, rather than something that you buy at the store or get at the hospital. However, two individuals (one a senior administrator, the other a board member) seemed to feel that individual choices related to lifestyle were the key to health promotion, and they expressed skepticism about being able to change human behaviour. One board member also raised the provocative argument that increased investment in HP now would lead to increased costs down the road, and that this might not be viewed as desirable by some people in government.²⁵

6.4 - Resource Barriers to Increased Emphasis on Health Promotion (General)

A second set of barriers to increasing the emphasis on HP relates to the resources (fiscal, human, physical, informational) available to the RHA. In this case, it is difficult to distinguish between those resource barriers that originate within the organization and

²⁵A former Manitoba Health employee suggested that the major barrier to building HP capacity in the health system as a whole was the dominant liberal ideology of the past century or so, which has led to more concern for individual rights than for the 'the common good.'

those that originate outside of the organization, since all of the funding for human and other resources ultimately comes from the province. Therefore, where there is a clear distinction it will be noted, otherwise the discussion will simply identify resource barriers in general.

Certainly the most frequently mentioned barrier by board members, senior administrators and senior program managers in all regions was the degree to which demands for acute care services dominated the agenda, and the resulting lack of flexibility that the organization had to allocate more funds to community health programs. They noted that, historically, overall health funding to the regions had been lean for many years, and had been cut even further prior to the establishment of the RHAs. Since that time, demand for services has increased, as has the complexity of client needs. As a result, the first couple of years following regionalization had been dominated by managing the deficit and there has been little or no latitude to shift resources from the acute care sector. One board member summarized the dilemma this way:

...the difficulty that we always have is that the acute care facilities have been hurt so badly by funding cutbacks over the course of the last six or seven years that they have already been basically stripped to the bone as far as what you can pull away....We are today operating at about a two and a half million dollar shortfall, a good portion of which is from the acute care side. And it's because we have no place to find the funds. And so when we're looking at trying to increase the focus on prevention and community, there's no place to take it from the acute care setting.

Several individuals also remarked on the fact that funding based on population health needs, which had been discussed by the provincial government, had never

materialized and this was a barrier to HP.²⁶ For example, in the northern region it was noted that this would have resulted in extra dollars for diabetes prevention.

Many senior administrators and senior program managers stated that there was a lot of talk about HP by governments, but little action. The following comment was typical:

...the regional health authorities have no additional funding for health promotion and prevention. So, although public policy is, provincially, that health promotion and prevention is the way to go, and nationally that's also the strategy, all levels of government have never put any additional funding at the ground level. There's no budget for health promotion and prevention at all. Zero.

Participants pointed out that most of the new money for HP had come from province-wide initiatives (e.g., WIN, Baby First). New regional HP initiatives, on the other hand, require RHAs to submit annual requests to the province for extra funding. Participants noted that the majority of their requests for new funding in the previous two years had been rejected. An interesting observation was made by two of the CEOs, who felt that the provincial government was reluctant to invest in HP because they viewed these activities as not costing any money. One board chair added that the private sector was also reluctant to invest in health.

Participants in all regions commented about the lack of human resources available

²⁶A proposed framework for needs-based funding of Manitoba's RHAs was developed, at the request of the Manitoba government, by researchers at the Manitoba Centre for Health Policy and Evaluation in 1997 (Mustard & Derksen, 1997). However, this policy was never adopted by the government. Only one key informant offered an explanation for the abandonment of the needs-based funding option. A senior administrator for one of the RHAs suggested that the Minister of Health did not want to antagonize some of the larger RHAs by asking them to give up resources to smaller regions.

to do adequate HP work. In the northern RHA, participants noted that the difficulty of recruiting and retaining qualified personnel in general, and a high turnover of community health and mental health staff in particular, created unique challenges which drained energy and attention away from HP work. This region had only two half-time positions dedicated to HP/HE at the time. In the other two regions, staffing shortages— especially in the area of community/public health— were also mentioned. Compounding the problem, the inequities in resources that existed between regions prior to the establishment of the RHAs ended up being inherited by them. For example, in one region (for reasons that no one could explain) there hadn't been any designated positions for HP prior to regionalization, whereas some regions in the province had designated HP or Health Educator (HE) personnel for many years prior to regionalization— positions that they were able to keep after the RHA was established.

Nurses working in outlying areas, especially (but not exclusively) in the north, pointed out that the nurse is often requested to do many things beyond what is in her job description, leaving less time for HP activities. Also, if you are the only health professional in the area, then the demands for individual care increase. As one nurse remarked, “you can't say to someone who walks in to your office and needs help, sorry, but this time is reserved for health promotion work.” A major drain on human resources that was raised by virtually every PHN and public health manager in all three regions was the dramatic increase in the workload of frontline PHNs related to expansion of mandatory programs, leaving less and less time for HP work. The three main contributing factors that were mentioned by participants were the expansion of

immunization programs, the introduction of the 'Baby First' program, and the increased tendency of early discharge post-partum. In outlying areas of the northern region, this problem was compounded by the fact that the PHNs are responsible for doing Home Care work in addition to their public health duties. As one PHN stated, "we're too busy dealing with all of these diabetics that are getting diagnosed, which prevents us from focussing on health promotion." It should be noted that, in the one region where there were no designated HP personnel and where one senior official claimed that HP should be viewed as part of everyone's job, virtually every PHN stated that they had less and less time to engage in HP activities. A senior Public Health program manager in this region confirmed this view:

I think it's been a source of frustration that the health promotion component of the public health nursing program doesn't happen as well as it should...you know, public health staffing in this region changed by one staff year last year to accommodate the Baby First program. Prior to that, we're probably talking twenty years since there was any additional staff brought on board. And there's been changing programming, changes in mandates, workload that has increased, early discharge programs. All of these things that impact on the day-to-day business of public health nursing. And there's been less and less and less health promotion activity over the years.

Transportation and climate were also identified as barriers to HP activity of field staff, limiting the amount of time that they had available for any activities other than mandatory programs work. This was not limited to the northern region, as one might expect. A PHN who covered an isolated district in one of the southern regions stated—"it's nothing for me to take half a day to do a post- partum visit. I can drive an hour, take an hour to do the visit and an hour back. That would be fairly normal."

In all regions, senior administrators and senior program managers expressed

concern that there still weren't adequate information systems providing data on a regular basis about all programs and services that could help them identify where limited resources need to go. Similarly, frontline staff in all three RHAs complained about the lack of workplace access to the Internet and the loss of the provincial health library and resource centre. One HP worker expressed her belief that it was ridiculous for each RHA to have to develop their own resource materials. However, a senior official in one region suggested that it should be easy for everyone to access the Internet and obtain the information that they might need.

Lack of resources for both internal in-servicing and continuing education, and external health education use was mentioned in all regions. One program manager noted that she had a total of \$600 for staff education. Another program manager complained that there was no money in the budget for travel to outlying communities to do more HP and preventive education work. However, this individual also acknowledged the irony that increased community education work resulted in an increased demand for services, which puts even greater pressure on limited resources.

Although most of the participants identified resource barriers to HP that related to the RHA organization, several participants in the northern region pointed out that many people in the communities that they served lacked the resources that they required to make healthy choices— for example, not enough income to be able to afford the high cost of food in northern communities. As a board member in the northern region stated, “it’s too simplistic to say to somebody who lives there, give your child milk as opposed to pop, when pop is \$2 a can and milk the same size is \$5.”

6.5 - Organizational Barriers to Increased Emphasis on Health Promotion (General)

Participants identified a number of organizational barriers— in terms of structures, policies, processes— to HP capacity-building. Barriers originating within and outside of the RHA will be discussed separately, although the distinction between the two is not that clear in some cases. Please note that these are barriers to capacity-building for HP in general. Barriers to implementing specific HP strategies (e.g., building healthy public policy, strengthening community action/community development) will be discussed later in the chapter.

6.5.1 - Organizational Barriers Originating *Within* the Organization

Program managers and senior administrators pointed out that the demands of the transition period following the establishment of the RHA had taken the focus away from the task of increasing the emphasis on health promotion. For example, there are the obvious challenges involved in creating a new administrative infrastructure at the regional level. One Public Health program manager stated that she was told it might take up to five years before the new RHA infrastructure was developed enough to move forward on program development. In the northern RHA, the difficulty in recruiting and retaining professional staff was also mentioned as something that preoccupied senior administrators and board members. Program managers and frontline staff in all regions mentioned that there was so much administrative work for managers that there had been no time for mentoring and development of staff. PHNs in all regions noted that there were no regional policies yet for some programs to guide practice.

Adding to the inherent challenges of creating a new administrative infrastructure

are the demands on the acute care system, which participants viewed as a driver of the day-to-day decisions within the RHAs. Senior administrators and board members in all regions talked about the huge inefficiencies in the acute care system that needed to be dealt with before “moving on to the next level.” Clearly, they did not view HP as one of the basic services of the RHA. As one senior administrator explained:

It’s like a growing child, you know, you have to take care of the basic needs first and help them grow and, once they get to a certain stage, then they start to branch out and see things more globally. We’ll come around full circle again. Then health promotion will become more of an issue. We always come back to health promotion.

Even if the administrative infrastructure was well developed, and the demands on the acute care sector decreased, participants in all regions expressed concern about a lack of leadership and direction from the top of the organization in developing a strategic health promotion plan for the RHA. One participant (who was not a Health Promoter) questioned the level of support that the Health Promoters in the RHAs were receiving. Two participants (one a senior program manager, the other a Health Promoter) suggested that a regional focus conflicts with a broad population health promotion perspective.

The issue of specialized HP staff versus all staff being health promoters is one that there appears to be some disagreement about. While this is ultimately an issue that boils down to philosophy and attitudes, the very fact that some regions have designated HP personnel while others don’t is an important one. For instance, in one RHA, when participants were asked to comment about health promotion activities, they frequently responded by directing me to the individuals who were designated as HP staff. One PHN in that region did make a distinction, however, between HP at the macro-level— which she

saw as the responsibility of the designated HP staff— and HP at the micro-level. She felt that she included a HP component in everything that she did on a day-to-day basis. It was interesting to note that, in the RHA where there were no designated Health Promoters or Health Educators, the view of senior program planners was that HP was everyone's job. However, frontline practitioners in this region (as they were in all of the regions) were very vocal about not having enough time to be involved in large-scale HP activities.

Senior program managers in two regions identified an organizational barrier to capacity-building within one particular program. It was noted that Mental Health program delivery had always focussed primarily on managing the mentally ill in the community, not on promotion of mental health. While there was an expressed desire to engage much more in the latter type of activity in both regions, demands for crisis management were continuing to prevent this from occurring in any significant way.

6.5.2 - Organizational Barriers Originating *Outside* the Organization

The challenge of finding the correct balance between the autonomy of RHAs and the need for guidance/support from the province became apparent. On the one hand, several senior administrators complained about Manitoba Health continuing to 'micro-manage' the regions. On the other hand, frontline practitioners and program managers in all regions complained about the lack of a strong, centralized HP infrastructure at the provincial level to provide direction to the RHAs. Several participants noted that the RHAs were isolated from each other, each trying to create their own way forward, without being able to share their experiences and to find out what is working in other places. They felt that a provincial HP coordinator or department was necessary to

alleviate this problem.²⁷ Several participants mentioned that Manitoba Health has failed to capitalize on the opportunity to connect with the federal government's HP resources, and that this has contributed to the lack of a strong provincial infrastructure for HP.²⁸

The continued organization of various human services into separate 'silos' and the lack of coordination of services across sectors is another barrier that was mentioned by a number of participants. They spoke about the irony of two sectors— Health and Child & Family Services— having worked together prior to regionalization, but now they are totally separate. The other major jurisdictional barrier to HP that was mentioned in the northern RHA was the historical federal-provincial division of responsibility to First Nations communities.

Two additional organizational barriers that originated outside of the RHA have

²⁷According to a Manitoba Health official, there was a plan at one time to create a centralized Population Health Unit at Manitoba Health, which would not only have coordinated initiatives throughout the RHAs, but also would have been a champion for population health strategic development in other sectors as well. It is not clear whether this Unit would have supported community-based HP strategies, or if it would have been more of a research-oriented unit. In any case, the plan apparently died when the Deputy Minister of Health who had been supportive of the plan was removed from his portfolio.

²⁸Interestingly, this concern was also expressed by a former Manitoba Health employee, who stated: "Over the years, what I've felt has been a real waste is that the federal government has had really, really good programs...they've had lots of health promotion programs developed and they've got the health promotion people that are in the regions that are working with communities and they are doing community development and health promotion programming, but we've never been able to hook into any of their programs or any of their resources. Manitoba Health has always been very resistant to federal government involvement...the province has always maintained that they are not interested in taking any direction from Ottawa...and that's been a real loss, especially for the RHAs."

been mentioned before but bear repeating. First, there are the inequities between regions inherited by the RHAs that have contributed to the lack of HP infrastructure at the regional level. For example, some areas of the province never had any positions mandated for HP or HE, while others had more than one. Second, there is the anomaly of Mental Health programs having always been organized separately from other community health/public health programs at the provincial level— an anomaly which appears to have been reproduced within the newly formed RHAs- as well as being focussed historically on managing mental illness rather than health promotion (as discussed in previous section). Finally, one senior administrator made the provocative suggestion that the health system may not be the best sector to focus on HP, proposing that the school system might be in a better position to influence population health.²⁹

6.6 - Knowledge/skills Barriers to Increased Emphasis on Health Promotion (General)

Participants in every region stated that a lack of knowledge about HP concepts and HP skills was a barrier to capacity building, and there seemed to be general agreement that staff at all levels of the organization, as well as at the board and advisory committee level, could increase their knowledge (and skills, in the case of frontline practitioners) in this area. At the top level of the organization it was noted that it is more common for senior administrators to have experience in the acute care sector than in the community health sector. However, even within the community health sector many

²⁹Another interesting external organizational barrier to HP was identified by a former Manitoba Health employee, who suggested that the provincial Public Health Act has been a barrier because it is interpreted very narrowly as a legislative tool to guide health protection and disease prevention rather than health promotion.

people noted that very few staff come to the job with a lot of experience in HP. That is to say, their knowledge tends to be more theoretical than practical in nature, and there is a very steep learning curve required.

This seemed to pose an even greater problem in the northern RHA, where a much higher percentage of their PHNs had a diploma education in nursing, which involves little or no community health promotion theory or practice, rather than having completed a degree program, which does include that content. One of the Public Health managers stated bluntly:

I can just speak for our own region because that is the case here...we have a really difficult time getting the degree nurses here. And that's what we really need in community because a lot of the degree, the training and the education that you get actually gives you a bit of the basic knowledge to come in and start working at that level. So, yea, it does impact on how quickly we can move on things. I mean it's taken a lot of my energy to try to develop the staff to go beyond just doing the bandaid sort of approach.

In all regions, program managers acknowledged that there could be more systematic staff development, but added that they simply didn't have the resources for proper in-servicing. As was mentioned earlier, one Mental Health program manager pointed out that she only had \$600 allocated for staff in-servicing for the entire year. In one region, a senior administrator felt that they could use an educational needs assessment for all staff in the RHA. In another region, a senior administrator stated that he would like to see a whole department of HP specialists who could provide education and resources to all of the RHA staff. However, one program manager cautioned that it was simply not realistic to think that everyone can be skilled at HP.

Although the participants focussed primarily on knowledge/skills barriers

originating *within* the organization, it was pointed out that some communities have better educated people with more leadership skills than other communities where they haven't had the same opportunities— and that, in the latter case, this could be a barrier to a successful HP initiative. Another external barrier to building capacity for HP that was mentioned by one senior administrator was the lack of evidence about the effectiveness of many HP interventions, information that would help RHAs make informed decisions about implementing HP initiatives.

6.7 - Is There a Role for RHAs in Advocacy for Healthy Public Policy (ADHPP)?

Before identifying the barriers to ADHPP, participants within the RHAs were asked if they thought that there was a role for the RHA in this activity. One senior administrator stated that he didn't think that Manitoba's RHA legislation assigned an advocacy role to the Board,³⁰ and he was concerned that such a role doesn't combine well with being the operational entity. Three participants from another region (a Board member, a senior administrator, and a senior program manager) were very cautious about RHA involvement in ADHPP. They saw the RHA role more as supporting *others* in the community to do advocacy work, rather than doing advocacy work on behalf of the community. One Board member stated that the most appropriate role for the Board was in advocating for health *services* policy, rather than healthy public policy in general. The rest of the participants all responded that they did see an active role for the RHA in

³⁰This is correct. The list of duties and responsibilities of a Regional Health Authority outlined in the *Regional Health Authorities Act* (Government of Manitoba, 1996) does not include any specific reference to advocacy being a board responsibility.

ADHPP, although the nature and degree of that involvement varied.

Some participants were adamant about the importance of the RHA's role in ADHPP, arguing that there is an ethical/moral obligation to engage in this strategy, particularly if you are serious about using a population health approach. A couple of participants stressed that there is an important role for ADHPP, mostly when the issue can be resolved at the local level, and that the RHA was especially well placed to carry out this function because of its knowledge of issues affecting their region. The main area of debate centred around where the major responsibility for ADHPP lies— at the board level only, or at all levels of the organization. There were two general perspectives on this issue.

The majority of participants stated that they felt there was a role for the RHA in ADHPP *as an organization*, rather than at the level of individual programs or people. Some participants felt that this was a role for the Board only, while others saw this as a role for both the Board and senior management. For instance, one senior administrator stated that effective ADHPP requires unified lobbying by Board Chairs and CEOs. Most of the participants in this group felt that there were simply too many barriers for frontline practitioners and program managers to be involved in ADHPP (see discussion in sections 6.8-6.11). One of the program managers stated:

When you phrase it as the regional health authority having a role, then I'd say yes. Because...when we're thinking about policy in terms of the field staff, it's much harder to separate the staff person from a social activism kind of thing. In terms of the regional health authority, I do think that there is a role because the regional health authority's impacted so much by the consequences. There's a social responsibility to be involved in the decisions about what impacts on the health of the population. So I do see it as a role. I see it probably as split up into an RHA

executive role and a board role, where both entities would probably have equal responsibility in being involved in that kind of a movement.

A smaller number of participants stated that, although the Board needs to set the direction for engaging in this type of strategy, there is a potential role for ADHPP at all levels of the organization— especially among the community health sector staff. One program manager felt that employees' potential to influence healthy public policy (HPP) had been enhanced since regionalization because they had greater freedom to raise HPP issues now that they were no longer direct employees of the provincial government. However, the people who shared this perspective did suggest that the nature and degree of involvement by people at different levels of the organization would depend on the specific issue.

It's important to note that, no matter which perspective participants had, the majority tended to agree that ADHPP was *not* happening on a *regular* basis at *any* level of their RHA at that time. However, participants did provide some examples of ADHPP activity that had occurred, or were currently occurring, within their regions. For instance, in all three regions, RHA staff had been involved in lobbying efforts to develop more affordable, safe, and/or supportive housing for particular population groups (seniors, mentally ill, low income). As well, in all three regions RHA staff had been involved in advocacy for various tobacco-reduction policies. In the northern RHA, staff had been involved in lobbying a municipal council and school board to make the schools in the area more accessible in the evenings and during the summer for recreational activities for youth, and the MOH had lobbied Manitoba Environment and Northern Affairs to

strengthen regulations to improve water quality in the region. In another RHA, staff had assisted a young mothers' group to lobby the town council for more parks in the community and lobbied the Highways Department to plow seniors' driveways that were full of snow. In a third RHA, one of the designated HP staff sat on the Social Planning Council and was involved in that group's lobbying efforts for free bus passes for individuals on social assistance.

There is one other example of ADHPP that is worth mentioning, even though this initiative did not originate within the RHA. Participants in all three regions mentioned the effort by the province's MOHs (who remain employees of the provincial government) to lobby for an increase in the provincial minimum wage.

In summary; there were a couple of features of the discussion about examples of ADHPP in the RHAs that stood out. First, being an advocate for one's individual clients appeared to be viewed as a responsibility of most frontline practitioners. For instance, a Mental Health program manager stated that the role of frontline mental health workers is always to be an advocate for a vulnerable population in the areas of social welfare, housing, and justice. PHNs vocalized the same sentiment. However, advocacy in the form of lobbying for policy change was viewed as something that had to occur at a higher level. Second, in most cases, the advocacy work that was done appeared to be undertaken by individual staff members on their own initiative or as part of a team initiative, rather than the RHA Board advocating for any organized HPP initiative.

6.8 - Resource Barriers to ADHPP

In all regions, the number one resource barrier to getting involved in advocacy for

healthy public policy was *time*— or, more specifically, lack of it. For frontline practitioners and their managers it was simply a matter of not having the time, either due to lack of staffing or mandatory programs demands or a combination of the two. The following comment was typical of PHNs' responses:

It's more time limits and financial resources that really limit how much we can do. I work a .8 position now...and that's just a new change. That means that I have even less time to do some of these kinds of things, whereas I maybe would have had a bit more time before. The other things have to get done. The babies who aren't feeding well and those kinds of things.

A board member provided his perspective:

Huge amounts of time are spent by everybody within health care, including board members, to keep the system running and to try to enhance it. To break off and spend a lot of time advocating particular changes is time consuming. A lot of research has to be done. Presentations, and things like that. And I don't think the barrier is people aren't wanting to do it, but the barrier is how much time you have to spend on that. Board members spend a lot of time on board issues, strategic issues and things like that. And ask them to spend another block of time in advocating something else is problematic because these are, for the most part, volunteers. Having your staff do it is equally problematic because we are today so short-staffed. And so now if you're going to tell them that one of their responsibilities is to actively participate in advocating a particular thing, what are you going to tell them they don't have to do anymore?

One participant did raise the issue of external resource barriers. Using an example from her own experience, a PHN described a situation in the local high school where she wanted to get the school to improve the ventilation in a particular department of the school, but she backed off because she was afraid of personal repercussions if the school was forced to spend large amounts of money to fix the problem. She pointed out that changes in public policy may not always be affordable. The lack of comfort in engaging in this type of activity that is embedded in this PHN's comments leads nicely into the

next barrier.

6.9 - Attitudinal Barriers to ADHPP

6.9.1 - Attitudinal Barriers to ADHPP *Within* the Organization

Attitudes and beliefs pose a significant barrier to engaging in advocacy for healthy public policy. Within the organization, a couple of participants suggested that many staff are dealing with immediate needs and, therefore, they just don't think about the 'bigger picture.' However, most participants felt that it boiled down to individual comfort level with engaging in this type of activity. Many PHNs acknowledged that there was quite a bit of variety in nursing practice, and that everyone had their favourite activities where they might spend extra time. Several PHNs claimed that it is a matter of personal interest and personality. "I'm not a political person," "It's not my style," "I'm a cautious person," were some of the comments they made. In one case, a participant, noting that a colleague who had been recently hired was "very keen in policy development and working on political things," suggested that this was "a unique characteristic" of that individual. A few participants felt that different levels of comfort with this particular HP strategy among PHNs were influenced by different educational backgrounds. That is to say, those PHNs who had recently completed a degree program were more likely to express comfort with this strategy— at least, in theory (they did not necessarily engage in this activity more often, primarily due to time constraints). However, many nurse-participants felt that nurses as a group have not traditionally been socialized to be political.

Participants in every region noted that many RHA employees still have the view that advocacy is a conflict of interest and they fear losing their jobs. This belief stems

from their previous position as government employees, when any activity of this kind was strictly prohibited. Although RHA staff were now considered to be employees of the RHA, not the provincial government, there was clearly a lot of uncertainty among participants about whether or not the same conflict of interest rules applied. Here is how a senior administrator in one region responded to this question:

All of our community and public health staff very recently transferred from government status...and the reason that regional health authorities were created was supposedly to make them at arm's length from government....But as long as the purse strings are still dictated by the provincial department, you'll never escape that....they are still government employees who are not in a position to speak out against the government at all...Now that will dissipate somewhat as what the RHA is planned to be does come about.

An interesting question is whether or not RHA employees would feel comfortable advocating for change in public policy if it conflicted with the position of the RHA.

Many frontline staff expressed concern about this situation. One individual commented:

I think staff are fairly uncomfortable, generally speaking, advocating. You may have someone who thinks that the policy on staffing levels at nursing homes is atrocious, just absolutely unacceptable. But you work for the RHA and the staffing levels are set by the RHA. So you may have one worker saying...that home is under-serviced and people are not being looked after properly...but it's very difficult for them to go to the RHA and say that....You're actually saying to the board that your public policy stinks. And if you make a statement like that it goes on your record. So they're hesitant to do it and there's a lot of frustration. You can't write to the government. You can't advocate. The most you can do is to whisper to the client's family, "I didn't say this, but...."

Some frontline practitioners stated that they were concerned about alienating clients or communities through lobbying activities. It was also pointed out that some staff might be philosophically opposed to certain issues, such as abortion or homosexuality. One senior manager thought that it was important to choose appropriate individuals in the

organization who can do this type of work effectively. A health promoter suggested that there are different levels of advocacy; there is individual-level advocacy and advocacy for social policy change. Some people might not feel comfortable advocating for the latter, but they might be perfectly comfortable advocating at the individual level for their clients. This distinction appeared to fit the experience described by most PHNs.

6.9.2 - Attitudinal Barriers to ADHPP *Outside* the Organization

Participants in all areas pointed out that the public sees the RHA's responsibility as being limited to provision of traditional health services; they don't make the connection with the broad determinants of health. Even if, in the long run, changes to public policy may be more influential to population health than access to medical care, the public expects certain services to be delivered. Similarly, participants felt that the public's view of the role of certain frontline practitioners is very narrow. For example, PHNs stated that most citizens would not expect advocacy for healthy public policy to be part of the PHN's role. It was suggested that RHA staff need to be accepted by community members and have credibility before engaging in this type of activity, which might be particularly challenging in a cross-cultural setting. Some people warned that, unless the initiative comes from community members, they are unlikely to 'buy into' it. Several participants in the northern RHA also mentioned that there are cultural barriers to advocacy for healthy public policy change. One example given was the Aboriginal view of tobacco as sacred, and therefore, not subject to legislation of any kind.

A number of participants pointed out that a small-town or rural atmosphere can be an impediment to engaging in advocacy for public policy change because small things can

be blown out of proportion and it is very difficult to go against the mainstream opinion. A senior Public Health official suggested that there is a danger of upsetting the often-delicate relationship between the RHA and some communities by pushing for certain unpopular policy changes, and that this can jeopardize other initiatives. She used the example of a debate over smoking policies in a community centre:

What you see on the surface is a little tussle about smoking. But what's underneath it is often years of antagonism among parties over other things that have nothing to do with smoking. And the RHA is involved with that particular area in issues that are, in the long term, much bigger than whether or not a community hall will have a smoking policy. So if I'm to stand up and say, I think the hall should be declared a non-smoking facility, then in fact I screw up a lot of other things that are, in the long range, more important.

A couple of attitudinal barriers were identified at the provincial level. First, there is the possibility that key individuals in government who might influence policy change don't always see an issue as a problem in the same way that the RHA might. Second, it was suggested that, if the provincial Health Department began to advocate for public policy changes, then other sectors might feel threatened. One individual claimed that an earlier effort to create an inter-sectoral healthy public policy committee of Cabinet failed because of suspicion on the part of other Ministers that the Health Department was wanting to take over control of the committee. Finally, it was noted that during the provincial government election campaign (occurring at the time that the first set of interviews were conducted) politicians only seemed to be interested in discussing health services policy, and not at all interested in addressing policies related to the broader determinants of health.

6.10 - Organizational Barriers to ADHPP

6.10.1 - Organizational Barriers to ADHPP *Within* the Organization

There were several references to barriers at the Board level. First, it was noted that provincial legislation doesn't assign an advocacy role to the RHA Boards. Therefore, many Board members might not see this as part of their mandated role. Second, a senior administrator suggested that it might be difficult for the Board to act as an advocate when it's responsible for the operational aspects of the organization. He gave an example of a hypothetical conflict of interest situation where the Board is being asked to advocate for no-smoking in public places, but the restaurant owner who wants to allow smoking in his establishment is the spouse of a Board member, or may even be a Board member himself. One participant warned that the RHA needs to be careful about supporting certain advocacy activities that might be controversial and interpreted by the government as 'anti-government.'

At the level of field staff, a common concern was that involvement in this type of activity by RHA staff might conflict with the organization's policy/mission/value statements. On the other hand, it was noted that there could also be a situation where the Board or senior management might take on an issue that staff don't agree with. For example, in one region, several participants discussed their view that the RHA needs to be more cautious about getting involved in partnerships with the private sector. They noted that certain industries, such as the tobacco companies, had strategically engaged the health sector in order to garner public support for their products. Several frontline practitioners stated that, if your supervisor does not actively support that kind of activity,

then it won't happen. PHNs noted that there was organizational support, in theory, for this type of activity, but that the support would probably disappear if those activities took away from traditional public health nursing duties. One relatively new PHN spoke of being very unsure of what the boundaries of her role were, and if they would include this type of activity.

One interesting observation was made by a senior program manager regarding the relative position that one has in the organization being a barrier to effective advocacy for healthy public policy. This individual believes that it's harder to engage in this strategy the higher up in the organization that you are situated because there is greater political sensitivity at the upper levels of the organization than at the level of frontline staff.

6.10.2 - Organizational Barriers to ADHPP *Outside* the RHA

At the provincial government level, the lack of a comprehensive inter-sectoral, Cabinet-level, healthy public policy committee to address broad population health concerns, and the lack of comprehensive structural mechanisms for effective inter-sectoral collaboration at either the provincial or regional levels were noted. One senior administrator complained:

Everybody's focussing on their little pieces. We still get Economic Development, Social Services, Recreation doing their own thing. And every once in a while, you'll have a person come along who puts it all together...and everyone says, yea, that's right. And then they all go back to try and solve their own little problems.

A Board member remarked that, in order to be effective in advocating for macro-level public policy change, you have to have the ear of the relevant officials in government. However, it's not always clear whose department is responsible for a

particular issue and where you need to go for your advocacy concerns. This Board member also talked about the difficulty for an RHA of taking action on certain public policy issues, such as social housing, pointing out that the RHA would only get the program dollars, not capital dollars needed to build the facilities. In other words, the silo structure of different sectors is a barrier to RHA involvement in advocacy for effective public policy change. Lack of political continuity, either due to a change in government or a change at the Deputy Minister level, was also identified as a potential barrier to ADHPP at the provincial level—resulting in some policy changes taking a long time.³¹

There were other challenges identified to effective advocacy for healthy public policy at the regional level. One was that, although some policies such as smoking in public places can be easily influenced at the local level, others (income security, for example) clearly can not be influenced at the local level. In addition, one individual suggested that sometimes it is difficult to advocate for policy change at the local level because municipal governments often adopt weak provincial policies and make them into by-laws. The municipal governments argue that the provincial government is satisfied with that level of policy, so why does the municipality need to go any further? This can be a barrier to those who want to see a much tougher policy in place than the provincial

³¹Another barrier, originating at the provincial level, was identified by a current Manitoba Health employee, who suggested that the provincial Public Health Act (PHA) itself could be viewed as hindering the development of HP capacity in the RHAs because it doesn't include broad concepts such as ADHPP as a legally mandated function of the health care system. This individual stated that the issue was debated during the discussions involved in the PHA review process, but that no one could figure out how to define expectations or legally defined powers related to healthy public policy development in a way that would be feasible to enforce.

policy.

A number of participants noted that individual health care practitioners may be blocked in their efforts to advocate for healthy public policy by the bureaucratic structures of the institutions that they are trying to influence. For instance, several PHNs talked about the difficulty of getting changes made within the local school systems that they worked in. Individual health care practitioners may also be blocked by the bureaucratic structures of their own health system. For example, a couple of participants pointed out that the regional Medical Officers of Health (who have remained employees of the provincial government) were chastised for commenting on provincial government policy related to increasing the minimum wage. As one individual observed, whenever you engage in this type of strategy you're "rocking the boat" and "challenging the status quo," and this will not always be met with approval by the powers-that-be.

Finally, it should be mentioned that two participants identified the major external barriers to effective advocacy for healthy public policy as originating well beyond the level of the organization. They expressed their concerns that local, provincial, and even national governments don't always have the power to influence healthy public policy because of the power of transnational corporations to influence the policies of nation states.

6.11 - Knowledge/Skills Barriers to ADHPP

Participants only identified intra-organizational barriers for this category. Most participants in all regions (from Board members and senior administrators to frontline practitioners) stated that they lacked knowledge and skills in the area of advocacy for

healthy public policy. As one Board member stated:

I think that there needs to be a pretty strong understanding of what is a policy that affects health. And, if there is such a policy, where is it made and what does it take to influence the change. Now I don't know. Maybe nowadays people are all getting that education, but it took me a lot of years to get that through my head.

Frontline practitioners were especially concerned about their level of knowledge and skills in this area. Although PHNs who had recently completed nursing degree programs felt that they had theoretical knowledge about this strategy, they all felt that they could learn more, and very few stated that they had much practical experience with this strategy. Most frontline practitioners stated that, if you aren't involved with something on a regular basis, then you won't feel comfortable doing it. The comment made by one individual— "My strength probably would be more in dealing with individuals and education and that sort of thing, as opposed to advocating for public policy change"— was fairly typical of the responses made by this group of participants.

6.12 - Strengthening Community Action (SCA) in the RHAs

After describing the SCA strategy, participants were asked if they had been involved in SCA activities as part of their role and, if so, to describe them. Although most people focussed on the various barriers to participating in this type of work (see sections 6.13-6.16), a number of examples of SCA were identified.

Senior administrators in all regions stated that they supported this strategy, and they noted that their RHAs were actively involved in regional inter-agency committees. In fact, inter-agency work was the most frequently mentioned example of SCA identified by participants. Many frontline practitioners, both nurses and others, gave examples of

personal involvement on an inter-agency committee. In one region, PHNs had each chosen a community agency to work with. Most of the inter-agency work that PHNs were involved in focussed on disease/injury prevention issues or promotion of healthy behaviours such as addictions awareness, tobacco reduction strategies, preventing adolescent pregnancy, reaching 'high-risk' families, diabetes prevention, and promotion of breast feeding. In general, non-nurse frontline practitioners were most likely to give examples of inter-agency work that focussed on issues other than disease/injury prevention or promotion of healthy behaviours— for example, involvement in the Social Planning Council's anti-poverty work, involvement in efforts to develop recreational activities for youth, and involvement in coalitions for better housing and a green environment. However, CHNs in the northern region were more likely than nurses in other regions to give examples of involvement with non-illness-related SCA activities (working to develop a youth centre, organizing a multicultural awareness event, and trying to increase social cohesion in a low-income community). Nurses in all RHAs who worked in outlying areas of their region stated that they were more likely to engage in this type of work than a nurse in a larger centre because they frequently are the only professional in the community, and there is more pressure to get involved in community issues.

It was less common for participants to give examples of SCA activity that involved working directly with community members on issues that were initiated by them. Most practitioners gave examples of work on committees which included the *participation* of community members or consumers of specific health services. For

instance, several PHNs in one region were involved in local perinatal committees, involving consumer participation, to address issues related to health services for pregnant women in their districts. A few nurses in this region had also been involved in the local community health action committees that were established by the regional health organizations to give a voice to citizens during the transition to development of the RHA– committees which had frequently ended up focussing on broader CD issues. Mental Health staff in the same region were involved in a committee which included consumers of mental health services who were concerned about the lack of supportive housing for people with mental health problems in the community. In the northern region, CHNs involved youth in planning a youth drop-in centre.

Nurses in each region did mention their efforts to mobilize community members to get actively involved in issues related to community health– for example, helping to organize a local health fair, or actively participating in a childhood injury prevention initiative. It was also quite common for PHNs to describe their role in organizing and acting as a resource person to various support groups (such as parent support groups or specific disease support groups), which have ended up addressing broader community health issues than the ones that they might originally have intended to focus on. Two non-nurse participants in the northern region described their experience in involving grassroots people directly in the organizing of a diabetes conference.

A program manager responsible for services to a particular sub-population in her region stated that much of her work was based on the notion of SCA:

My whole role in working with communities is really [based on] this approach. If the community sees the need to develop support services, I go out and help find people with the skills and the interests to sit on a board and then I help that board evolve to where they can actually become an organization that provides services.

Perhaps the most interesting example of a SCA initiative was provided by participants who worked in a community health centre in the northern region. In that case, CHNs and other non-nurse frontline staff were involved in an effort to develop relationships with residents of a low-income neighbourhood with very poor housing conditions in a small urban setting in the hopes of stimulating some community action for change. Unfortunately, the CD initiative was a failure (see section 6.13.2 for a more detailed discussion of this initiative). However, it was one of the few examples of RHA staff participating in a SCA initiative involving direct work with community members (as opposed to work with other agencies) and with the goal of strengthening overall community capacity (as opposed to strengthening the capacity of a small group of individuals). One other initiative is worth mentioning here. A program manager in another RHA described a plan to develop an early childhood development and parenting centre in a low-income, high-needs district. Although this initiative was being planned and developed by the RHA and other agencies, the ultimate goal of the centre is to create a foundation for strengthening community capacity in a community that exhibited very low capacity.

6.13 - Attitudinal Barriers to SCA

6.13.1 - Attitudinal Barriers to SCA *Within* the RHA

Participants in all regions identified the personal comfort level of frontline staff

(excluding those individuals who were designated as HP staff) as the most likely attitudinal barrier to capacity-building for SCA. Most PHNs/CHNs concurred that many nurses are not comfortable in a role that involves community development (CD) or community mobilization (CM) activities. While a few participants acknowledged that some nurses simply do not accept that these types of activities should be a part of their role, they suggested that this was more likely to be the point of view of nurses working within the acute care sector. One CHN, who was involved in the development of a youth drop-in centre in her area, described the response of colleagues working in the hospital to her CD work:

I have nurses who work in other areas of the health authority who say, why is that your job to do that, and what is it that gives you the go-ahead or whatever to start a project like this, and is it really my job as a nurse to start something like this.....Like they just don't get it, how it fits in, which means I have to then talk about the determinants of health and move through it like that to be able to get people to understand.

However, it was acknowledged that it is not only hospital nurses who are resistant to this type of role for nurses. For example, it was pointed out that some nurses in the Public Health/Community Health (PH/CH) sector purposely choose nursing as a career because they enjoy working one-on-one with people. One PHN believed that some of her colleagues do resent time taken away from working with individuals:

I think that some of my co-workers at times resent or are fearful that they're being pulled away from field work and one-to-one situations....a good example of that is if you're away at a meeting in the community all day...you're not available to that new mom who's home breastfeeding and maybe there's concern about whether the baby's getting enough milk, so the whole risk business of dehydration in newborns is an issue. How can you feel comfortable that you've covered and are still providing safe practice for your individual clients [when you're] undertaking these broader things at the same time? It's a juggling act. And some people

aren't as prepared to juggle....

The opinion was also expressed that this type of work requires a certain personality type or maturity level, and that some nurses simply don't have those qualities. However, most participants felt that resistance to SCA activity among nurses in the PH/CH sector was more likely due to feelings of incompetence and lack of confidence as a result of infrequent experience with this type of work— especially for nurses who had just transferred from a hospital setting (which was a common situation in the northern RHA). They suggested that it was natural for these nurses to be more comfortable with the type of work that they were most familiar with— that is, working on a one-to-one basis with individuals and families. SCA work, on the other hand, was something new and perhaps frightening for many of these nurses. As one participant stated, “sometimes there's safety in just doing what you've been doing...you're a little bit more out there and in the public eye and vulnerable when you're doing some of the community development [work].”

Participants felt that, even when nurses see the value of doing more SCA work, there are differences of opinion regarding how much time to spend on that type of work versus individual-level work. Many frontline practitioners are reluctant to get involved in these initiatives because they have so many other responsibilities. Just as it was mentioned in the earlier discussion of resource barriers to HP in general, PHNs stated that they simply didn't have time for SCA work during the course of their usual work hours, and that it often involved a lot of time outside of regular work hours that they couldn't always take back. They also noted that their managers don't view this work as a top

priority when there is so much demand for mandatory program activities. One PHN stated, “what’s the point of putting any time into community development work if you won’t have the time to do it well?” Several PHNs pointed out that it isn’t just a matter of not having the time during the typical day. Sometimes staff commit wholeheartedly to a CD project, thinking that it may only be for a couple of months when, in fact, the project may go on for years. This type of work involves making a long-term commitment.

Two additional attitudinal barriers to the SCA strategy that related to personal comfort levels were identified. First, it was suggested that staff who live in the communities that they work in, especially in smaller communities, may not feel comfortable in the role of community developer or community mobilizer. Second, it was proposed that some staff may not be comfortable due to fear of a potential conflict of interest. One PHN described her experience with a particular CD initiative where she eventually had to ask herself where her obligations lay— with the community or with the RHA? She stated that she never really knew through this whole process if she was acting as a public health nurse or as an interested community member. The PHN eventually submitted a ‘potential conflict of interest’ letter to the RHA, informing her employer about the nature of her involvement with this CD initiative. She did not receive negative feedback from the RHA, but she never felt totally comfortable with her involvement.

There were some other attitudinal barriers to SCA, beyond personal comfort level with this strategy, that were mentioned. Several participants who had been involved in this type of activity spoke about the feelings of frustration and discouragement they felt when a specific initiative didn’t have a good level of community participation. This

sometimes led to an attitude of “why try again?” One nurse admitted that CD work can take its toll on a practitioner. “It takes a lot of energy sometimes....if something falls through you have to forge ahead and try something else and something falls through and you try again....After a while, you get tired.” Others acknowledged the difficulty of giving up control when involved in CD work. One individual admitted candidly that “the only way that you can empower is not to have power and just to encourage. And when you’re the expert, and we’ve all been trained to be that, giving it away isn’t easy.” Giving up control was viewed as especially difficult when no one from the community was perceived as being ready to take on a leadership role. As one PHN declared, “if you’re involved with a group who’s leadership you don’t find to be very effective, it’s difficult to sit back and let that group flounder when you have thoughts about how things could be improved upon.”

Other attitudinal barriers originating within the RHA that were identified by participants included a negative attitude among some staff toward working with certain populations, and the common (according to participants) situation of staff feeling that there’s a need for action or change, when the community actually isn’t ready for any change. It was also suggested that staff may have a different philosophy, either more or less conservative, than their community partners, or even colleagues, which makes engaging in SCA work much more challenging.

Perhaps the most interesting comment was made by an individual who suggested that agency staff, whether from the RHAs or any other organization, begin to think of community members in an “us versus them” way. As a result, they don’t include the

people who are impacted the most in their SCA work, and inter-agency meetings end up becoming the focus of their energies. This insight fits with the observation made earlier that most examples of SCA that were described by participants were focussed on inter-agency activities, rather than direct work with community members who would be impacted by the initiatives. It also brings to mind the comment made by one PHN in the northern region, who talked about the tendency of outside professionals to be very comfortable discussing the problems of a particular community endlessly, but less comfortable in actively strengthening the community's capacity to deal with the problem themselves.

6.13.2 - Attitudinal Barriers to SCA *Outside* of the RHA

One of the external attitudinal barriers to SCA identified by participants in all regions was the perception that the public doesn't accept the RHA's role as anything other than care providers. PHNs, in particular, felt that the public might have a hard time accepting their involvement in CD activities, given the narrow and very traditional understanding of their role as care providers. One PHN, who works in a small rural town, stated that many people in her community have difficulty understanding why she isn't available in the clinic at all times.

Another commonly expressed type of external attitudinal barrier to SCA related to the public's reluctance to participate in these kinds of initiatives. On the one hand, it was suggested that community members often defer to professionals. While this was mentioned in every region, the problem was most often identified by participants in the northern RHA in relation to their work with the aboriginal population. As one program

manager stated:

They think you're supposed to do it for them. I mean, you're both caught in the old cycle. They think, well, why do you want me to lead the group? That's what you're paid for, isn't it? So, it's getting them to buy into themselves, to trust that they have the skills to do this. It's their community, you know. So, on that side, there's some resistance.

A couple of frontline practitioners contended that the health system itself was to blame for creating passivity among this particular population group by treating them, historically, as submissive receivers of health and other human services. According to these individuals, it should not be surprising that people who are not used to being asked to participate in decision-making are reluctant to do so.

Lack of motivation/participation in SCA activities by the people who would benefit most was noted in all regions; not just in the north. A variety of explanations were offered for this phenomenon, including: these people are too busy struggling with their day-to-day needs and have no energy left over to be involved in these activities; they might not view the issue as a priority, or even a problem at all; they may have no sense that their actions could result in any meaningful change; they may not trust outsiders; they may not trust either the motivation or the competence of RHA staff; there may be racist views among community members towards RHA staff (mentioned in the northern context); and the small pool of volunteer community members may eventually burn out and be unable to participate any more.

Several participants in the northern RHA were particularly concerned that, in certain communities, people were simply not emotionally ready to engage in this type of activity. Noting that the assumption underlying CD work is the existence of one or more

individuals who are motivated to work for change in their community, they pointed out that there was such a low level of social cohesion in some communities that there was virtually no one willing, or able, to take on that challenge. As one participant stated, “communities that already have some resilience and capacity do really well when you try to develop it, but in communities that have almost none, it’s a very, very hard struggle for them to come together.” CHNs described their experience with a CD project that was unsuccessful because they failed to recognize that the community was not ready to mobilize for change. One participant described the situation this way:

The problem there was people didn’t want to come out. They were huddled in their little houses, they didn’t talk to their neighbours, there wasn’t a real good sense of community and they weren’t networking. So it was really difficult to penetrate that and to make anything happen...

In addition to attitudinal barriers at the individual level in the community, participants in all regions noted that these barriers sometimes come from community agencies who are potential partners in this type of work. For instance, it was suggested that some community agencies are reluctant to engage in SCA work because they feel threatened by RHA involvement, fearing that the RHA will take control of the process and that they will lose their autonomy. Resistance from other professionals outside of the RHA due to fear of giving up control was also noted. Another problem was that community partners may not share the RHA’s philosophy and goals and/or they may be reluctant to share limited resources. The difficulty of obtaining ‘buy in’ from all parties was remarked on by several participants. One individual spoke of her frustration with certain community partners who tend to spend a lot of time in philosophical debates,

rather than being action-oriented. Finally, the problem of community partners' demands being unrealistic (either unaffordable or too expansive) was noted.

6.14 - Resource Barriers to SCA

6.14.1 - Resource Barriers to SCA *Within* the RHA

With one exception, participants in every region stated that the main resource barrier to engaging in SCA activities was lack of time due to other priorities, limited staff, and the fact that a lot of this work occurs outside of regular work hours. They noted that their employers supported SCA work, in theory, but not in terms of dedicated resources. PHNs expressed great frustration about their time being taken up increasingly with mandatory programs responsibilities. As one PHN declared, "it's not possible to do it all and do the community development [work] too." Another PHN vented: "You're supposed to be able to take everything in, add it to what you do, and keep on going. But nobody took anything away from the bottom, and this job is much busier now that it was 10 years ago when I first started." One PHN described how she had become involved in a community action initiative and then had to spend a lot of her own time attending meetings in order to avoid feeling that she wasn't contributing as much as her community partners.

Only one individual mentioned an internal resource barrier that wasn't related to lack of time. A CHN who was involved in CD activities stated that she lacked information about other people's successes in the area of SCA— i.e., what worked, what didn't?

6.14.2 - Resource Barriers to SCA *Outside* of the RHA

Two main types of external resource barriers were identified. First, participants in all regions felt that many potential/actual community partners lacked the necessary resources (financial, human, time, even space) that they needed to engage in effective SCA activities. They noted that it was becoming increasingly difficult for non-profit community groups to access funding in order to undertake new initiatives, and they observed that there was only a small pool of active community members available, which frequently leads to burnout. In addition, the community members who would most likely benefit from this type of strategy often do not have the resources (time, transportation, day care) to become active participants.

The other external resource barrier relates to the RHA's ability to secure external funding. As one participant noted, government funding is based on caseload, not on CD work. The other challenge is that, with certain projects that are funded by the province or the federal government, the RHA must meet external funding criteria which may or may not allow for a CD approach.

6.15 - Organizational Barriers to SCA

6.15.1 - Organizational Barriers to SCA *Within* the RHA

Participants in all regions mentioned that there was a lack of a shared organizational vision related to SCA and few role models to provide leadership in this area. As a result, there was a lack of organizational policies outlining what the strategy entails, whose job it is to do this kind of work, and how much time should go into it. One participant questioned how much ownership the health sector should have in this type of

work. She acknowledged that, within the health system, community or public health staff should be involved in this area, but she wasn't sure what the most appropriate role would be for them. Relatively new employees in all regions stated that they did not know what was expected of them, in terms of engaging in this type of work. It was interesting to observe that, in the region where the Public Health manual of policies and procedures did contain a section on *Community Development*, none of the frontline practitioners mentioned its existence, including a PHN who stated that she was unsure of her role in this type of work. Frontline nurses in all regions noted that their managers did not have enough, if any, practical experience in doing this type of work to act as role models.

Although nurses in all regions felt that the resource barriers mentioned earlier (e.g., lack of time due to other workload responsibilities) were the overriding obstacle to engaging in SCA work, they did suggest that there were other organizational policies and processes that limited the flexibility to participate in this type of activity. For example, CHNs in the northern region pointed out that their old contract had allowed unlimited flex time and banking of hours, which made it easier to engage in this type of activity. Their new contract limited the number of hours that staff could bank. One participant commented on the lack of tangible organizational support for staff to engage in SCA work, such as providing transportation and/or child care costs for individuals who needed to do this work after regular work hours.

PHNs in all regions complained that the system of recording statistics related to their daily activities did not capture the complexity of HP processes such as CD. As a result, all of the nurses who were involved in CD types of activities stated that, because

their daily stats did not capture that part of their work properly, it made it seem as if they were doing less work than they actually were. One of the PHNs who had recently been involved in CD work explained how this ended up working against the best interests of PHNs in her region:

I always have enjoyed community development work. But, compared to the one-to-one type of involvement that we have with clients, it doesn't seem to have quite as much validity or something when you look at the time spent. And I say that because we realized that our ratio of nurses to population is one of the lowest in the province of all the health regions...we've been lobbying with our CEO and Board members, whoever we can, to try to improve upon that. But one of the things they looked at were our daily stats forms. And actually, over the past year, they came to realize that our number of [individual] patient contacts, based on these statistical forms, had dropped quite substantially because we're doing more community development. But that was seen as a negative.

Other participants, both frontline practitioners and program managers, talked about the lack of an adequate evaluation process for this type of work. One nurse, who was active in a CD initiative involving youth at risk, talked about the problem of trying capture CD outcomes using primarily quantitative indicators:

Mostly they want to know who you met with, the number of meetings that you have with them....What you don't get a good picture of is the outcomes of those things in the long run....What you see is a lot of 'I met with so-and-so on such-and- such a day. What was the accomplishment of that doesn't show anywhere...and that to me is a very big thing....What we're trying to do is to increase their self-esteem and their self-confidence and to empower them to go on and do other things....And that's something that you don't see counted anywhere.

A senior CH program manager in this region acknowledged the lack of appropriate indicators of SCA activity among practitioners. However, this individual noted that the organization lacked an adequate evaluation process for even the most basic program activities, let alone complex processes like CD work.

One final observation regarding internal organizational barriers to SCA is the fact that most frontline practitioners in all regions felt that there was a lack of dedicated HP staff whose role is SCA work. Nurses, in particular, stated that they simply didn't have time to do this type of work effectively. Yet, in the RHA where there had not historically been any dedicated HP staff, a senior Public Health official insisted that all PHNs were doing CD as part of their job on a regular basis, and that there was no need for any dedicated staff to be responsible for this type of work.

6.15.2 - Organizational Barriers to SCA *Outside* of the RHA

In relation to the above-mentioned concern, it was noted that, although there might be a desire within the RHA to increase their involvement in activities that strengthen community action for health, a large proportion of a PHN's work is mandated by the provincial Public Health Act— which does not include SCA activities as part of the PHN's responsibilities. Also relevant to the discussion about the difficulty of measuring CD work in concrete quantitative terms, it was pointed out that, unfortunately, government funding is based on concrete quantitative indicators.

As far as working with organizations outside of the RHA to strengthen community action is concerned, participants noted that rural areas don't have the number of agencies that can be found in urban areas, so there are a limited number of potential partners. Others suggested that, no matter where you are, different agencies have different agendas, and they often end up competing for the same funding for CD initiatives.

6.16 - Knowledge/Skills Barriers to SCA

6.16.1 - Knowledge/Skills Barriers to SCA *Within* the RHA

Participants from each of the regions suggested that, within their organizations, there were different levels of understanding of the SCA strategy. A few examples of descriptions of the CD approach to HP by participants tends to confirm this observation. For one program manager, a CD approach meant helping people identify their needs. A Health Promoter defined CD as involving the community in decisions related to their health. A Board member suggested that a CD approach to HP involved getting the community to 'run with' a program that was originally set up by PHNs. Another program manager equated CD with providing community members with an opportunity to take responsibility for their own health.

C/PHNs in all regions stated that they lacked knowledge and skills for SCA work, but PHNs in the northern region were more likely to express this sentiment than PHNs in other regions. Educational background may be a factor in this disparity.³² Over the past ten years, a nursing degree has become the standard requirement for most PHN positions in Canada. In the northern region, the difficulty in recruiting and retaining health professionals has led to a higher percentage of PHNs being hired without a nursing degree. There were also more PHNs who had only recently transferred to the community health sector from the hospital setting than in other regions. However, it is important to

³²Nursing degree programmes have traditionally included a community health component, including the theory of community health promotion and community development (although the clinical experience in these programs has varied). Diploma nursing education has traditionally focussed on institutional nursing knowledge and skills, with little or no community health nursing content in their programs.

note that, even among the majority of PHNs in all regions with a degree in nursing, there was general agreement that their nursing education had emphasized care-giving skills, not CD skills. A number of PHNs stated that, although they were familiar with the concept of CD in theory, they hadn't had enough experience actually doing this type of work, and they suggested that unless one uses these types of skills every day one loses them. A Public Health manager in one of the southern RHAs noted that the PHN who was most comfortable being involved in SCA activities did not have a university education, and stated: "You know, it does seem to depend more on the personality and their own life experience and how well they've adapted and learned from what they've been exposed to."

Many frontline practitioners, and a few program managers, felt that they required more formal education in the knowledge and skills related to SCA, and that this was far more preferable to having to learn through trial and error. One participant described her lack of confidence in engaging in this type of work:

...the group dynamic skills you need and the facilitation skills are really very important. And I don't know if we have those. We're learning. We've had our workshops and we've practised. But it's kind of a scary place out there. I mean, you are in a position that people look to for knowledge and information and leadership. And you're saying to them, well what would you like to do about that? How do you see that happening?...You have to be able to know how to work a group.

However, participants who had experience with this type of strategy were more likely to state that CD knowledge and skills aren't ones that you can necessarily learn from a book. As one PHN stated, "it's nothing so simple as talking about group dynamics...or any of those sort of easy pat things that you could do an in-service on. It's

getting the feel for the group and how it's functioning and knowing the community." A CHN who had attempted to read and learn as much as possible about CD as a strategy noted that it isn't something where there are clear-cut guidelines, compared to other skills in nursing. Participants with CD experience suggested that the first requirement for this work is a sound knowledge of the social, political, economic, and cultural dynamics, as well as the available resources, of the community.

One senior program manager expressed the belief that SCA involves a highly specialized set of skills that you can't expect all staff to have. This individual noted that many of her frontline staff had never done a presentation, let alone act as a facilitator or a community developer, and that they needed to develop basic skills before going on to the more complex ones like CD. A program manager in another region suggested that nurses who have good CD skills have a natural aptitude for this type of work— i.e., they have natural skills, not learned skills. Another senior program manager agreed that some people are going to be better at SCA work than others, and it's important for RHAs to match up people's skills or their interests in appropriate areas, such as CD.

Perhaps the most interesting comment came from a senior administrator, who questioned the use of the term, 'community development,' to describe the work that certain practitioners were involved in:

They [public health practitioners] use that label nowadays. What they seem to mean is that I'm skillful in knowing how to talk to a group of people. That's not community development work....You have to focus on the local infrastructure, on neighbourhoods. On how decisions get processed. On how allocations are made. But the [public] health nurses use these processes for a very particular kind of health related activity. I'm not negative on that, but that's just not community development.

6.16.2 - Knowledge/Skills Barriers to SCA *Outside* of the RHA

Although the vast majority of knowledge barriers to SCA related to the staff within the organization, participants did identify a few external barriers. They noted that community members who may be actual or potential partners in CD work often have a low level of formal education and lack advocacy and community-building skills. A program manager suggested that, without these skills, it can take a lot of time to build the confidence of people to even become involved in any type of activity at all. One frontline practitioner suggested that it was difficult to find community-based staff in any human service organization who had solid facilitation and community-building skills.

6.17 - Barriers to Effective Partnerships in ADHPP and SCA

Whether referring specifically to ADHPP or SCA, the concept of *partnership*—both inter- and intra-sectoral—was central to the discussion. It was noted by many participants that most of the broad determinants of health lie outside the scope of the health sector (“we don’t own health”) and that effective partnerships were, therefore, a necessary condition for population health. As one key informant explained:

If we’re talking about population health and needing to work on the underlying determinants of health, it’s self-evident that you have to get out of the health system. What I mean by that is that you can’t stay within your office, you have to get out and work with other partners. In a small community that might be working with the Friendship Centre, or working with the mayor....So it forces you to see about the partnerships that you need to create in order to be effective.

In general, participants felt that more partnerships were occurring in the community health sector than in the past, and some people suggested that partnerships have been encouraged much more since regionalization. Nevertheless, participants in all

regions expressed their opinion that the Health sector had to increase the quantity and quality of their partnerships with other sectors, with other agencies within the Health sector (including the First Nations and Inuit Health Branch), and with other key stakeholders (e.g., municipal politicians). Participants identified a number of barriers that needed to be overcome in order to build effective partnerships, both within the health sector and between the sectors.

The two most frequently mentioned barriers apply equally to intra- and inter-sectoral collaboration. The first one is the amount of time involved in this type of activity— from the logistical challenges of arranging meetings among busy people to the sometimes lengthy periods of time that it takes to build trust and effective working relationships between partners. The second barrier is the problem of territoriality and reluctance to give up ownership of certain issues— a phenomenon which manifests itself at the professional level and the broader sectoral level. Other barriers that apply equally to intra- and inter-sectoral partnerships included: staff turnover disrupting the process of making connections at the local level and/or lack of political continuity (either due to a change in government or a change at the Deputy Minister level); a clash of organizational cultures, language, and/or philosophy leading to differences in how a problem is defined, and to differing visions about how to take action on a particular issue; potential partners lacking support from their administrations; partners who are at the table only because they have been told to be there (their body language making it obvious that they don't want to be there), resulting in some partners doing more work than others; jurisdictional barriers when working on First Nations issues; working with a partner who isn't focussed

on HP; and the absence of a natural leader who can pull everything together and coordinate action.

Several barriers were identified that were unique to building inter-sectoral partnerships. These included: the continuing 'silo' structure between sectors which, ironically, participants suggested was worse now than it had been prior to regionalization (i.e., there was more integration within the health sector, but less inter-sectoral integration); reluctance of different sectors to put any of their resources into work that is considered to be the responsibility of another sector; mistrust on the part of certain organizations towards the health sector (e.g., fear of 'health imperialism'); resistance to change and lack of flexibility in certain bureaucracies (the education, business, and income security sectors were specifically singled out as posing a challenge to work with); difficulty getting the Health sector's priorities onto the agenda of other sectors; and not knowing who the right contacts are in other sectors. One participant suggested that, in her experience, small local-level partnerships were the ones that worked best. A senior administrator listed several reasons why a recent partnership-building process in his region had worked well. These included: thinking 'out of the box'; a willingness to accept and share responsibility and ownership (no room for 'turf protection'); maintaining professionalism; willingness to accept change; communication being encouraged; successes celebrated; and failures accepted.

PART III - FACTORS THAT WOULD FACILITATE HP ACTION IN THE RHAs

6.18 - Ranking Facilitators for HP (General)

After identifying the various barriers to increasing the emphasis on HP in the RHAs, participants were then asked to identify and rank the top three factors that could *facilitate* HP in their regions. It was hoped that rankings could then be compared, both within and between regions. However, the majority of participants (37 out of 60) were unable to single out one facilitator as being more important than any another. These participants identified two (and occasionally three) facilitators as being equally important. Of the 23 participants who did identify one facilitator as being more important than another, none of them were able to clearly rank a second and third facilitator. The following is a breakdown of the number of participants (out of those 23 individuals) who identified a specific item as the single most important facilitator:

RESOURCES (financial, human, time) = 11
ORGANIZATIONAL SUPPORT (philosophy, policies, leadership) = 5
KNOWLEDGE/SKILLS = 5
ATTITUDE (individual staff) = 2

The basic argument made by the eleven participants who ranked '*resources*' as the number one facilitator was that none of the other factors mattered if the RHA didn't have an adequate level of funding in order to have the flexibility to allocate adequate resources for HP. A true shift in government policy towards HP, in their view, needs to be backed up with appropriate dollars. One participant talked about the need for long-term investment in population-based HP. However, a senior administrator remarked, "...as much as their [the Department of Health's] planning framework speaks to furthering

health promotion, they don't put their money where their mouth is necessarily." A senior administrator in another region agreed, pointing out that they had "gone through enough years of tightening up and becoming more efficient" and that now it was time to put some money into HP. The number of participants who ranked 'resources' as the number one facilitator were fairly evenly distributed throughout the three regions.

The five participants who ranked '*organizational support*' as the number one facilitator argued that, even if they had all the funding that they needed, without the support and commitment of the RHA board and senior management to the importance of HP, an increased allocation of resources for HP was unlikely to occur. As one participant claimed, "with all the resources in the world, there'd probably be a CT scanner...and no enhancement of public health." A Board member in another region agreed:

If the Board makes no demands, if the Board makes no new initiative plans, if the Board cannot prove to government why they need 'x' number of dollars to do health promotion, they won't get it. So, unless you have a Board that has the will, the knowledge, and the drive to do health promotion, it's not going to happen.

One participant emphasized that this organizational support needs to filter down through all areas of the RHA. Another person stated that the RHAs had to get the administrative structures properly in place before they could adequately address HP. A third individual stressed that you had to build a vision among staff in order to effect organizational change. Organizational support was not only viewed as the responsibility of the RHA itself. It was pointed out that there needs to be organizational support from Manitoba Health as well. A senior program manager spoke of the need for an organizational or regional philosophy of HP, noting that the province lists HP as a core

service, but provides no additional philosophical direction or standards to guide HP work.

The five participants who ranked '*knowledge/skills*' as the number one facilitator claimed that, even with adequate financial resources and organizational support, if individual staff members didn't have a high level of HP knowledge and skills, then the work simply wouldn't get done. One senior administrator stated that, "even if you don't have enough resources, if those people who are here have a better understanding of promotion and prevention, we can still have an impact." Four of the five participants who ranked this as the number one facilitator were from the northern RHA.

Two participants ranked '*attitudes*' as the number one facilitator for HP (both were from the same region). One individual suggested that it is the personal beliefs, values, and overall commitment of individual staff to the importance of HP and the need for change that is the key to building capacity for HP. Another participant suggested that a change in attitude towards the importance of 'wellness' must occur both among staff of the RHA and among the public. She felt that this could only happen by starting education about healthy lifestyles with children as soon as they entered the school system and continuing this education throughout their primary and secondary school years, followed up by extensive and targeted 'wellness campaigns.' This individual did end by stating that it would probably take "a huge amount of money" to create the shift in attitude that is required— a statement that really highlights the whole "what came first, the chicken or the egg?" nature of the discussion.

The remaining 37 participants identified two or more factors (resources and/or organizational support and/or knowledge/skills and/or individual attitudes) that they felt

were the most important facilitators for HP, stating that they really couldn't rank one as more important than the other(s). The most common combination of facilitators was adequate resources plus organizational support. One participant identified individual attitudes of RHA staff combined with a HP team linked to a solid provincial HP infrastructure as the most important facilitators. Another participant suggested that adequate resources combined with a change in the mind-set and, therefore, the expectations of the public were the most important facilitators for HP. One individual argued that the RHAs needed to provide the public with enough information that they would support HP initiatives.

A unique comment was made by one individual, who stated that the geography of his RHA might be a natural facilitator— i.e., a small urban RHA with only one hospital might be at an advantage over RHAs covering larger geographic areas and having several hospitals. In the latter case, board members might view their main role as protecting the health services in their district, whereas board members in the former case might be more likely to look beyond hospital services to HP activities.

6.19 - Facilitators for Specific HP Strategies

When participants were asked to rank the top three facilitators for two specific HP strategies— advocacy for healthy public policy (ADHPP) and strengthening community action (SCA)— a similar trend emerged as in the case of HP facilitators in general. The majority of participants were unable to identify one facilitator as being more important than any other. Even in the cases where participants did identify one facilitator as being the most important, they were often unable to rank their second and third choices clearly.

6.19.1 - Facilitators for ADHPP

Organizational support was most commonly identified as the single most important facilitator for engaging in ADHPP. This support was defined as having Board 'ends' policies supporting ADHPP, organizational policies clarifying whose role it was to engage in ADHPP, training provided for staff to increase their ADHPP skills, support from management for staff engaging in this strategy, and an overall organization culture that values this type of work and encourages staff to 'think upstream.' One participant pointed out that being 'client-centred' should involve having some responsibility for the advocacy function. A high level of ADHPP *knowledge and skills* among staff was the second most commonly identified facilitator for this HP strategy. One participant viewed public opinion as the number one facilitator of ADHPP. Only one participant identified *resources* as the single most important facilitator of this strategy. The majority of participants identified combinations of facilitators that were most important for ADHPP—the most common combination being *organizational support and knowledge and skills*.

6.19.2 - Facilitators for SCA

Organizational support was also most commonly identified as the single most important facilitator for SCA. This support was defined similarly to the support for ADHPP described above. However, since a successful CD initiative often takes years of commitment and a common vision before positive outcomes are evident, there was even more emphasis on the need for an organizational culture that values SCA and validates the time and effort put into this type of work. One participant stated that the RHAs have to put more effort into orientation of new employees to a vision that includes recognition

of the value of SCA. Another individual went further, stating that the RHA needs to advise new community/public health staff at the orientation stage that, not only are they responsible for the clinical part of their job, but the expectation is that they will get out into their communities and find out who the key 'movers and shakers' are and then work with them on issues related to the health of the community.

One Health Promoter suggested that RHAs need to recognize that SCA work cannot be carried out effectively by all staff:

I feel that I am given a lot of free reign to move in my work. You can't be, like the public health nurses for example, mandated and put into such a box that you can't move, and then told to do community development. Community development is a work all to itself, and it needs to be recognized as that. Involving the community means that you need to be out there, hanging around with people and hearing what they have to say. And moving with their issues.

While most of the comments focussed on organizational support at the regional level, it was suggested that the leadership and direction for SCA/CD work must begin at Manitoba Health, filter down thru the Board, and then through all levels of management down to the frontline staff.

Adequate *resources* was the second most common factor to be identified as the most important facilitator for SCA. In this case, the most important direct resource was 'time.' Participants suggested that this type of work takes a lot of time commitment—something they simply couldn't afford given the current restraints on their work time. The third most common facilitator for SCA was *knowledge/skills*. Participants stated that they lacked comfort and confidence engaging in this type of work because they lacked adequate knowledge and/or skills in this strategy. Even those who had theoretical

knowledge of SCA felt that they needed more training and experience in the practical skills of SCA (e.g., community development skills). Facilitation skills were identified as the key to CD work. Increased knowledge about the dynamics of their communities was also viewed as important. A program manager concluded that “doing CD well should mean that nobody knows you’re doing it.”

One participant identified the capacity of the RHA for developing partnerships with other organizations as the number one facilitator for SCA. Another individual identified support and commitment from community partners as the single most important facilitator of SCA. An interesting observation was made by a participant who noted that Francophone communities in her region were quite proactive when it comes to CD initiatives. She attributed this phenomenon to strong local leadership for community economic development and pointed out that this gave the RHA a solid foundation to partner with. The rest of the participants identified two or more facilitators as being most important for SCA— the most common combination being *organizational support and resources*.

One potential facilitator was mentioned that was unique to the northern context, where CHNs and PHNs function in separate roles. It was suggested that better integration of the two roles might improve capacity for HP— i.e., that adding a more clinical role to the CHN’s work (such as doing home visits) could be a “great way into the door” of finding out what the issues are in the clients’ community. This might take the pressure off PHNs, who didn’t have time to do more community development work because of their client-based role.

Other important facilitators for SCA that were mentioned included: community partners feeling free to criticize the RHA; presence of an issue for the community to organize around; providing material support, incentives for community members to volunteer their time; community members feeling the potential for creating community within themselves; and CHNs/PHNs living in the community that they are working in. One individual pointed out that it is important for agencies to recognize that the resources are right there in the community, in the form of all kinds of people with talent that can be 'tapped.' A Health Promoter suggested that one way to encourage the participation of lay people in CD work at the committee level is to engage them in activities at the community level, and then get them interested in being involved at the planning level. Apparently this strategy, involving a community skate exchange, was used with some success in the northern region. One of the more interesting comments was also made in the northern region, where one participant spoke about a CD approach requiring a whole shift in health care providers' way of thinking:

It's more than just a 9 to 5 job. It's got to be an attitude. I'm looking for a quote here by Lilly Walker. She's an Australian aboriginal woman. And I think that this speaks to what we need to do here....And she said, "if you come here to help me then you're wasting your time. But if you come here because your liberation is bound up in mine, then let us begin. Because it involves everybody. And we have to struggle with certain people within our own [workplace] who have this attitude- we'll go to that place and help those people and aren't we wonderful and great, but let's get away from there as soon as we can. And they don't really understand this notion that their own issues are bound up with all the community's issues. And so, that shift in attitude needs to occur, and in a very big way.

6.20 - How Can the RHA Support its Staff to Build HP Capacity?

Finally, frontline practitioners and program managers were asked to summarize how the RHAs could support their staff to build capacity for HP within the organization. Most of these individuals (in all regions) stated that the RHA boards and senior management needed to value, encourage, and provide time for, HP work. Many frontline practitioners felt that they needed more in-servicing on CD and facilitation skills, and how to write a proposal. Participants in the northern region pointed out that these types of workshops need to happen on a continuing basis, because it isn't enough to have them only once every few years. However, a few frontline workers noted that, although workshops are good, it would be more helpful to have mentors in the workplace with experience in using these types of skills. In the northern region, several nurses commented that more management support and guidance for the transition from hospital nursing to public health nursing was necessary. Continuing to support nurses who want to upgrade in the BN program by allowing them to take some time from work to attend required courses was also viewed as extremely important by several participants in the northern region. More financial support for continuing education was raised by participants in all regions. One frontline practitioner noted that she hadn't had a paid educational opportunity in 17 years. A couple of program managers stated that they would like more training in management and supervisory skills.

In the RHA where there were no staff designated specifically as Health Promoters, several PHNs stated that they would like to see at least one such position created with the goal of becoming involved in ADHPP and CD work because the PHNs don't have the

time for those activities. Another participant in that region stated that frontline staff need more information about the overall strategic plan for the region. PHNs in all regions stated that they would like more opportunities to share their CD experiences with their colleagues, to network, and to discuss RHA initiatives with their colleagues. They also wanted to see greater access to computers and the Internet for all frontline staff.

6.21 - What Are the RHAs Doing to Build HP Capacity?

All three RHAs were still very much in the transition phase during the first round of interviews, focussed primarily on establishing the RHA infrastructure and developing regional policies and basic programs. However, during the course of the discussion about HP barriers and facilitators, a number of potential/actual strategies for building HP capacity were mentioned by participants.

In Region A, the CHNA had identified one particular district as having a high level of unmet needs. As a result, the RHA had just opened a Primary Health Care centre in the area, with the goal of preventing illness and hospitalization among the residents of this district. The RHA had also developed a proposal to establish an Early Childhood Development and Parent Education Centre in this district. In addition, a PHN in one of the outlying areas of this region planned to relocate her office to the local school, so that she could be more involved in HP/prevention activities.

In Region B, a senior administrator stated that the RHA wanted to move away from the idea of a HP 'specialist' to the idea of a HP 'facilitator,' and the role of the Health Promotion staff was expected to change to more of an emphasis on being a community developer and facilitator. The RHA was also in the process of forming a

partnership with the Alliance for the Prevention of Chronic Disease to look at educational needs of staff for health promotion work. Another initiative within this RHA involved setting up Continuous Quality Improvement (CQI) teams across the RHA that would help to spread the mission and vision of the RHA throughout the organization. It was suggested that this mechanism could be used to promote HP ideas among staff in other sectors of the health system and to provide an opportunity for all employees to be exposed to the work of someone at the other end of the health system spectrum. Noting that staff do not have time for extensive in-services, one participant suggested a possible strategy for staff education around HP concepts— the development of videos, or modules, that could be viewed in 20-minute chunks. Two additional initiatives were identified by participants as potentially increasing capacity for HP in this region. First, the RHA planned to relocate all of its senior management, community health, and mental health staff to a downtown mall, to improve accessibility and better integrate community health services. Second, the RHA planned to create a Population Health epidemiologist/research position to monitor population health status and HP needs.

Region C was the only RHA that specifically identified CD as a key approach to Public Health in the region. The year prior to the data collection phase for this study, consultants from an organization specializing in CD and group facilitation had been brought in to provide a week-long CD workshop for selected community health staff. There were no plans to repeat this workshop. However, the RHA was developing a new position for a Population Health Promotion facilitator, and there was some discussion about the development of a CD team. Saskatchewan's PHP framework document was

being discussed with community health staff, and a senior program manager felt that CD work should be viewed as the key to long-term community health needs assessment in the region. There was also a stated desire to increase the focus of mental health programs on resources for mental health promotion, and to use more of a CD approach. However, the program manager responsible for these programs felt that they needed to select two or three communities at first to focus their CD efforts in, and then monitor them over a ten-year period to see how much of a difference this type of initiative made. It was also pointed out that having a CD philosophy was a pre-requisite to being hired by the CNRP in the region, that they were developing a database to monitor their CD work, and that CNRP staff were encouraged to think in CD terms.

Aside from the strategies or tools that were being discussed in specific regions, a more general observation was made by a former Manitoba Health employee, who noted that some of the RHAs were hiring people outside of the formal health field to do HP (for example, individuals with a background in recreation) because their skills are viewed as being community-based and they are perceived as being more confident about engaging in community mobilization activities. This was the case in one of the RHAs in this study.

PART IV - SUMMARY OF FINDINGS

What can we conclude about the state of health promotion practice in Public Health in the selected RHAs during the study period? It is difficult to summarize such a vast body of information succinctly. However, there are two aspects of the discussion about HP practice in Manitoba's RHAs that stand out. Perhaps the overriding observation is that, in spite of three very different geographic and demographic contexts,

there were remarkable similarities in the climate for, content of, and barriers to HP practice between the three study sites. For example, there appeared to be total consensus among all participants across study sites that, although there was certainly some discussion about the need to increase the emphasis on health promotion within the RHAs, this discussion continued to be overshadowed by the priorities of the acute care system. There also appeared to be a high degree of consensus among frontline practitioners across study sites regarding the following aspects of their HP practice: (i) a strong focus on working at the individual/family level to develop personal skills; (ii) the belief that their educational background had prepared them primarily for this focus (especially among nurses); (iii) the belief that, although they might not have the time, knowledge/skills, resources, or support from management to be involved in the other *Ottawa Charter* HP strategies, it was not inappropriate for them to do so; (iv) the perception that, although senior managers would probably support their involvement in any of the HP strategies in theory, the emphasis on mandatory programs and evaluation based on the number of client contacts meant that, in practice, DPS was more likely to be supported by management than any of the other strategies; (v) the belief that personal health practices/coping and healthy child development were the two determinants of health that they were most likely to influence; (vi) the belief that income/social status and working conditions/employment were the two determinants of health that they were least likely to influence; and (vii) the belief that income/social status and personal health practices/coping were the two most important determinants of health for their most vulnerable clients.

It was also interesting to note the level of consensus across the three study sites regarding the barriers to building capacity for HP. For example, regarding barriers to increasing the emphasis on HP in general, areas of consensus included: (i) the perception among all types of participants of resistance to 'buying into' the HP philosophy by staff in the acute/long term care sectors; (ii) the perception among frontline staff and middle-level managers that HP was viewed by senior managers as an activity that one engages in only if there is time left over after the 'regular' work is done; (iii) the perception among all types of participants that the public's top priority is the availability of, or access to, acute care services— not HP services— and that the RHA needs to respond to public demand; (iv) concern among board members, senior administrators and senior program managers regarding (a) the degree to which demands for acute care services dominate the agenda, (b) the lack of funding from the province for HP initiatives originating in the RHAs, and (c) the resulting lack of flexibility that they have to allocate more funds to HP programs; (v) the concern expressed by frontline staff and program managers about a lack of human resources and time to engage in HP activities, with public health nurses and managers being particularly concerned about the increasing demands related to mandatory programs activities; (vi) the concern expressed by most participants (excluding Board and DHAC members) about the increased workload and organizational challenges related to the transition period following regionalization; (vii) the perceived challenge of finding the correct balance between the autonomy of RHAs and the need for support from the provincial health department (frontline practitioners and program managers in all regions complained about the lack of a strong, centralized HP infrastructure at the provincial

level, while senior administrators tended to complain about Manitoba Health continuing to 'micro-manage' the regions); and (viii) the belief among all types of participants that staff at all levels of the organization (including the board and advisory committees) required increased knowledge and skills in HP.

As far as barriers to specific HP strategies are concerned, there were also a number of areas of consensus across the study sites. For example, in relation to advocacy for healthy public policy (ADHPP), the vast majority of frontline staff and program managers stated that they saw an active role for the RHA in ADHPP, although the nature and degree of that involvement varied (the majority of these participants felt that there was more of an organizational role rather than an individual role). Interestingly, the negative responses to this question were all from Board members, senior administrators, and one senior program manager. However, the majority of participants in all regions stated that ADHPP was *not* happening on a *regular* basis at *any* level of their RHA during the time of the study. Other areas of consensus related to ADHPP included the belief that (i) lack of time is the main resource barrier to involvement in ADHPP; (ii) individual comfort level might be a major barrier to staff involvement in this type of activity; (iii) many RHA employees still have the view that ADHPP might be a conflict of interest due to their previous position as government employees or being in conflict with current organizational policy; (iv) the public doesn't view ADHPP as a legitimate part of the RHA's role; and (v) all levels of RHA staff, Board and DHAC members lack ADHPP knowledge/skills (something which was of considerable concern to C/PHNs).

Areas of consensus across study sites related to barriers to the HP strategy of

'strengthening community action' (SCA) were similar to those for ADHPP, for the most part. Concerns about the willingness and/or ability of community members and/or community agencies to participate in SCA initiatives, lack of a shared organizational vision of SCA and few role models to provide leadership in this area, and a lack of an appropriate system to record this type of activity were areas of consensus that were unique to this strategy. Unlike ADHPP, the majority of participants across the study sites felt that there were a number of examples of SCA occurring in their regions. However, it is interesting that involvement in inter-agency work— as opposed to working directly with community members— was the most frequently mentioned example of SCA in all regions. It should be noted that, whether referring to ADHPP or SCA, there was also consensus across the study sites about (a) the importance of effective partnerships being a necessary condition for population health; (b) the perception that there were more partnerships occurring in the Public Health sector in recent years; and (c) the belief that the health sector had to increase the quantity and quality of their partnerships with other sectors, with other agencies within the health sector, and with other key stakeholders.

The other area where there was a high degree of consensus across study sites related to the question of how the RHA could support their staff to build capacity for HP within the organization. Frontline practitioners and program managers in all regions stated that their Boards and senior managers needed to value, encourage, and provide time for HP work, and most frontline practitioners stated that they needed more knowledge/skills related to specific strategies such as SCA. Public health nurses in all regions stated that they would like more opportunities to share their CD experiences with

their colleagues, to network, to access the Internet, and to discuss RHA initiatives with colleagues.

A second, less overt, theme that emerged from the discussion relates to the conceptualization of HP and the nature of HP practice in the RHAs. It is apparent that the majority of participants viewed HP primarily from a biomedical or behavioural, rather than a socioenvironmental, perspective. That is to say, HP was discussed for the most part from the traditional perspective of prevention of disease/disability and promotion of a healthy lifestyle among individual clients. Although almost all frontline practitioners acknowledged the importance of the broad determinants of population health, their own health promotion practices was defined fairly narrowly in terms of assisting individual clients to develop personal coping skills and healthy preventive behaviours. Similarly, while the majority of participants acknowledged the importance of broader socioenvironmental HP strategies such as SCA and ADHPP, these strategies seemed to be viewed as activities beyond the usual scope of HP within the Public Health sector.

In the next chapter, health promotion 'champions within the Public Health sector across Manitoba provide their perspective on building capacity for HP.

**CHAPTER SEVEN:
BUILDING HEALTH PROMOTION CAPACITY IN MANITOBA:
THE PERSPECTIVE OF PROVINCIAL HEALTH PROMOTION ‘CHAMPIONS’**

7.1 - Introduction

The first round of interviews were conducted during the ‘transition phase’ to regionalized health systems when the focus of activity was on establishing the administrative infrastructure for the new RHAs. During that phase it became apparent that discussion regarding the RHAs’ vision and strategies for building health promotion capacity was premature. As a result, it was decided to carry out an additional phase of data collection, in the form of a one-day consultation– referred to hereafter as a ‘Think Tank.’ The choice of the ‘Think Tank’ format was a deliberate one; it was hoped that the consultation process could itself be a means of capacity-building. The complete set of objectives and the methodological approach used for this initiative are outlined in more detail in Chapter One. However, it is worth re-iterating that the individuals who were selected to be participants in the Think Tank were considered to be ‘champions’ or ‘exemplars’ of health promotion– that is to say, individuals who were viewed by their peers as having a strong commitment to, or passion for, health promotion. Twenty-two exemplars from eight (out of the ten) RHAs in Manitoba participated in the Think Tank. The topics/questions for discussion were:

1. What excites you about current health promotion activities in your region/workplace?
2. What is your vision of what a regional health authority would look like if it had the highest possible capacity for health promotion– i.e., what would the

characteristics of the RHA be?

3. Which of the challenges or barriers to building capacity for health promotion that were identified in Phase I are you currently experiencing in your regions? Are there any that are not relevant to your regions? Are there others that you are experiencing that aren't mentioned here?
4. What are the opportunities for overcoming some of these barriers and for building capacity for health promotion in your organization/region? Realistically, what can your peer group do in order to build health promotion capacity over the next three years?

In the following sections, the responses to each of these questions will be presented, followed by a discussion of the findings.

7.2 - Current HP Activities That Are Exciting Exemplars

At the beginning of the day, participants were asked to introduce themselves, and to share something that was exciting them about HP in their work or in their region. A salient feature of the responses was that, in spite of the many barriers existing both within and outside of their organizations, the exemplars felt that there were a number of positive developments related to HP in their regions. Several participants talked about a shift in perspective within their RHAs towards more of a focus on HP and prevention activities and a belief that their RHAs were supportive of their HP efforts. Representatives from two of the original study sites spoke about the adoption of a population health approach by their RHAs. One stated that the Board of Directors' priorities were now grouped according to the determinants of health, while the other pointed to the Board's

commitment to evidence-based decision-making. In the third study site, a 'Population Health Promotion' coordinator had recently been hired. An expansion of designated HP positions was noted by exemplars in two other regions as well. For example, a recent reorganization within one RHA had resulted in the development of a 'wellness facilitator' position within each district of the region, instead of only one HP coordinator for the whole region.

A few people spoke of specific HP initiatives that they were involved in directly or that were being developed in their region. These included: an 'early childhood' support initiative (in one of the original study sites); smoking reduction; community development in a 'stressed' urban neighbourhood; building capacity for seniors' health; and a 'Healthy Schools' initiative. A common theme related to these examples was an emphasis on the formation of successful partnerships as the key to effective HP action, and there seemed to be general agreement that there were an increasing number of inter-sectoral partnerships— although it wasn't clear if these initiatives had begun prior to, or following, the development of the RHAs. The examples also suggested that, for these exemplars, health promotion was conceptualized in its broadest socio-environmental sense, something which became even more evident during the next exercise.

Perhaps the most common remark related to participants' excitement about the increased discussion about the broad determinants of health and their optimism regarding the *potential* for building HP capacity in the RHAs. There appeared to be a consensus among participants that there was a window of opportunity for HP that hadn't been present for awhile, and that there was a need to take advantage of this situation while it

lasted. Having said this, many of the participants noted that, although there was much more talk about HP within the RHAs, there was still a long way to go in terms of integrating the philosophy of population health promotion into all of their work throughout the organization and translating the talk into HP action. The lack of a true shift in resources to support this shift in thinking, and the fact that RHAs are based on the traditional medical model were just two of the challenges to 'walking the talk' that were raised at this time.

7.3 - Vision of a RHA That is 'Rich' in Capacity for HP

For the first major task of the day, participants were asked to consider the question: "*What is your vision of what a regional health authority would look like if it had the highest possible capacity for health promotion— i.e., what would the characteristics of the RHA be?*" Each individual was asked to write down three to five ideas, each idea on a separate half sheet of paper. Ideas were then posted and clustered into categories, which were then further refined by the author. Since this was a brainstorming exercise, there was no discussion about the relative benefits/limitations of individual ideas. Therefore, it is not possible to say that there was consensus among all participants about each individual characteristic. With this in mind, an RHA with the highest possible capacity for health promotion was described as having characteristics which can be grouped into four broad categories: organizational culture; organizational (infra)structure and policies; organizational processes/practices; and extra-system characteristics.

7.3.1 - Organizational Culture

The characteristics in this category are all related to the values and philosophy of the RHA organization. In a RHA that is 'rich' in HP capacity, not only will there be commitment from management that HP is a priority, but there will be an organizational culture that understands, embraces, and demonstrates the underlying concepts and philosophy of HP— especially its focus on empowerment of individuals, groups and communities. The Board's mission, vision, values and strategic priorities will all reflect a commitment to HP. All staff – from Board level to frontline level– will be able to articulate what is meant by the term 'health promotion' and how the organization is accomplishing such an approach, and they will be working for the same collective goals. Although there may be dedicated HP positions, there will be an infusion of HP 'thinking' in all staff. Health promotion activities and staff dedicated to this work will not have to struggle for legitimation; their work will be valued. Lastly, there will be a 'healthy' workplace environment, with on-going efforts to empower employees within the RHA so that they are better able to empower communities. This includes recognition, acceptance and support by management that frontline staff need the freedom to do different things in different ways.

7.3.2 - Organizational (Infra)Structure, Policies

The characteristics in this category can be grouped into those that relate specifically to resource availability and those that don't.

7.3.2.1 Characteristics related to resources

In a RHA that is 'rich' in capacity for health promotion, HP will be legitimized

and validated by dedicated/committed resources, including sufficient funded positions for expert leadership, access to information, funded research, and program funding. A recommended minimum of 25% of RHA resources (fiscal and human) will be devoted to primary prevention/health promotion, and these resources will be allocated into appropriate HP activities. The ability to redirect money from facilities to community will be maintained. Adequate resources will also be allocated for HP program evaluation. There will be larger HP teams, and staffing will be flexible enough to meet local conditions and needs. A commitment of financial resources to develop and maintain staff, and to educate staff, partners, and community members about HP concepts and actions will be made. HP activities/programs will be occurring all year long, driven by the community, and supported/resourced/partnered by the RHA. There will also be support for the volunteer sector that contributes to HP at the community level. Finally, resources will be allocated to opportunities for development of healthy public policy at the level of governments and corporations.

7.3.2.2 Non-resource-related characteristics

In a RHA that is 'rich' in capacity for health promotion, the organizational structure will be reflective of medical, behavioural/lifestyle, *and* environmental approaches to health services delivery and partnerships. Organizational policy statements related to HP will be well articulated and mechanisms will be in place to ensure that they are adhered to. An RHA Health Promotion 'Action Plan/Framework' will be developed with input from all levels (Board, Management, and frontline staff), and there will be a Regional HP Steering Committee made up of community leaders (e.g., mayors, chiefs).

Strong inter-regional linkages will also be fostered and maintained. There will be a focus on making connections for HP action, rather than on specific HP programs. Lastly, HP will include mental health promotion and prevention of mental health problems.

7.3.3 - Organizational Processes/Practices

While processes and practices may be viewed as elements of an organization's overall infrastructure, there were several distinct themes that set these characteristics apart from the characteristics described above. They are presented in five sub-categories.

7.3.3.1 Population health/determinants of health approach

In a RHA that is 'rich' in HP capacity, the focus will be more on a population health approach, with increased work at the group/community level and action plans that address the determinants of health, rather than a focus on disease prevention. This means that HP staff will have the opportunity to work on initiatives that may not be seen as "health"—housing being one example. This also means that all RHA decisions will be previewed (vetted) from a 'healthy public policy' perspective, and RHAs will take an active role in influencing government policy development and be involved in social advocacy. In addition, the RHA will be a resource on health impact assessment—i.e., there will be a process to determine the impacts of government policy decisions on the health of the community at the regional level. One of the Board's strategic priorities will be 'Healthy Communities,' and there will be formal support and resources for community development targeting major determinants of health. There will be a focus on vulnerable populations, as well as healthy child development in the first five years of life.

7.3.3.2 Partnerships

In a RHA that is 'rich' in capacity for HP, there will be formal and informal partnerships with a variety of sectors and agencies at all levels– Board, Management, and field staff– in order to address healthy public policy and health determinants (including making changes at the political level). In particular, there will be a more integrated approach between Health, Education, and Family Services & Housing (or Child and Family Services). Partnerships will increase both in number and effectiveness; they will be maintained, nurtured, developed. Inter-sectoral partnerships will include the private sector. Working in an inter-sectoral manner will be 'the norm,' not the exception, and there will be a willingness and ability to participate in diverse agendas. Since communication is a key factor in successful partnerships, 'roundtables' will occur regularly with a host of community partners (e.g., police, CFS, education, etc.). There will be more partnerships *within* the health sector as well, including partnerships with provincial counterparts and with funding bodies. Within all partnerships, the RHA will be a catalyst/facilitator of the process versus controlling it. This means being willing to stay out of the limelight, not being concerned about who gets the credit, and letting the community take front stage.

7.3.3.3 Planning & Evaluation

In a RHA that is 'rich' in capacity for HP, there will be sufficient data to indicate health needs and evidence (including policy evidence) on how to effect change. There will be utilization of quality research and evaluation processes, an ability to assess the capacity for health at a local (neighbourhood) level, and all HP initiatives will be planned

based on the community health needs assessment. Planning processes will have more intentional focus on all three approaches to health promotion (medical, behavioural/lifestyle, socio-environmental), more community involvement, and both short-term and long-term planning will occur. There will be an appreciation of community assets and the intent/ability to mobilize them. Finally, all elements for evaluation will be in place: sufficient baseline data, realistic HP indicators, seamless sharing of regional/provincial stats.

7.3.3.4 Knowledge/Skills

In a RHA that is 'rich' in capacity for HP, capacity building/training will be provided for all RHA staff and Board members. There will be a solid understanding of the principles of health promotion throughout all levels of the organization, as well as Board 'Ends' policies relating to HP. Facilitation skills will be developed among staff in all areas, and all staff will actively participate in health promotion activities. There will be a process for acquiring and sharing information, best practices, literature, experiences, and materials— locally, provincially, and nationally— a process that goes beyond informal 'networking.'

7.3.3.5 Communication plan

In a RHA that is 'rich' in capacity for HP, there will be good communication to the public regarding the RHA's HP activities using accessible language, and there will be a major communication strategy to educate the public re: inputs (health determinants) and how they relate to health outcomes. Recognizing that health policy is often made by the front page of newspapers, which tend to focus on issues related to acute care services

(e.g., 'hallway medicine'), the RHA will use the media to expand the media focus from illness to 'wellness.'

7.3.4 - Extra-System Characteristics

Although the focus of the discussion was on the RHA's capacity as an *organization*, participants did identify a number of external characteristics. A region that is 'rich' in capacity for HP will have commitment from community partners that HP is a priority. It will also have widespread support from, trust in, and participation of community members in the RHA's HP initiatives. Community members will have a solid understanding of the principles of HP, and they will also understand that they have the ability to make changes in their lives— i.e., 'they can own their health.' There will be provincial/federal funding available for communities to access in order to implement their health promotion action plan, including capacity building/training for community committees. Finally, policy changes will occur at the municipal level to promote the health of the community.

7.3.5 - Discussion

Two aspects of the discussion about participants' vision of a RHA that is rich in capacity for health promotion stand out. The first is the degree to which their conceptualization of health promotion fits the broad socioenvironmental perspective outlined earlier. A capacity-rich RHA is clearly, from these exemplars' point of view, *not* limited to one that has the resources and ability to provide specific services or programs that are labelled 'health promotion.' Much of the discussion is focused on health promotion as an approach, a way of thinking that will permeate the organization from top

to bottom. Taking action on the broad determinants of health, engaging in partnerships and inter-sectoral collaboration, advocacy for healthy public policy development, community development, community participation, community capacity-building, and empowerment are all part of this approach and of their vision of an RHA that is rich in capacity for health promotion. Another interesting aspect of the discussion that stands out is that neither the availability of sufficient resources nor the presence of specific HP knowledge and skills dominate the list of characteristics. It is the integration of a broad HP perspective within organizational culture, policies, processes and practices (and, hopefully, outside of the RHA as well) that seems to be the predominant feature of the vision that the exemplars outline.

7.4 - Current Barriers to RHAs That are 'Rich' in Capacity for HP

This segment of the Think Tank began with the author presenting a summary of types of barriers to HP capacity that were identified in the first phase of the research project (see Appendix J)³³. Participants were then divided into four small groups, based on geography/demographics— i.e., northern, central, southern, and the Winnipeg Regional Health Authority (WRHA). The rationale for this organization of small groups was based on the assumption that different types of regions might have different/unique types of barriers (e.g., northern regions versus the WRHA). The small groups were asked to focus their discussion on the barriers that were still particularly relevant, to identify any new barriers that had not been mentioned and to identify any of the original barriers that were

³³Participants were provided with a written copy of this list of barriers to refer to during their small group discussions (see Appendix J).

no longer present.

7.4.1 - Key Themes of Discussion About Barriers

A salient feature of the participants' discussion was the extent to which they agreed that most of the barriers identified in the first phase were still relevant. Moreover, there was very little difference expressed between participants from the various geographic regions regarding major barriers. The obvious geographic, demographic, and jurisdictional issues associated with different regions were noted but other, more universal, themes tended to dominate the discussion. Many of these themes involve the tension between opposing forces. For example, there is the tension between the demands for acute care services and the desire to increase the emphasis on health promotion. On the surface, it appears to be a tension between the acute and Public Health sectors in the health system. However it also represents the tension between trying to respond to the expressed needs and priorities of the public when those needs and priorities may clash with those of the Public Health sector. Another of these themes is the tension *within* the Public Health sector between their legislated responsibilities (i.e., communicable disease control and health protection) and the desire to engage in population health promotion activities such as community development and advocacy for healthy public policy. A third theme is the tension between creating an organization where health promotion is an integral part of the thinking and activities of all staff, and the belief that there needs to be specific staff, even whole departments, with designated responsibility for health promotion. Finally, there is the tension between the desire for greater autonomy for RHAs from the provincial health department and the desire for greater support and

direction from the provincial health department in order to build capacity for HP.

Barriers related to resources and knowledge/skills were mentioned less frequently than those barriers that related to attitudes/philosophy and organizational structure, policies, processes and practices. Not surprisingly, in three out of the four categories of barriers, most of the barriers that were identified were perceived as originating *within* the organization— the exception being those barriers that fit in the *resources* category. Clearly, participants felt that the RHAs had little room for manoeuvre as long as the province holds the purse-strings.

7.4.2 - Barriers Unique to 'Think Tank' Participants

In spite of broad similarities between barriers identified by 'Think Tank' participants and those identified by participants in the first phase of the study, there were a number of barriers identified exclusively by the exemplars that are worth highlighting.

7.4.2.1 - Attitudes/Beliefs/Values

In the category of 'attitudes/ beliefs/values,' it was noted that RHAs' organizational culture or outlook doesn't necessarily allow for the kind of risk-taking and innovation that would be required to develop maximum HP capacity. The organizational culture also demands immediate response and action, a characteristic that conflicts with the HP process— involving networking, community development, partnerships, coalitions, and empowerment— all of which take considerable time to develop. Concern was also expressed that, although many RHAs are going through a paradigm shift— beginning the process towards a more socio-environmental approach to HP— there were only pockets of individuals who were thinking from that perspective and there was a long way to go to

develop a common philosophy and vision. Another barrier raised by exemplars related to staff attitudes towards embracing personal job changes necessary to achieve maximum HP capacity. It was suggested that staff may be supportive of HP in theory, but that this comfort level tends to disappear if implementation means personal job change. Finally, exemplars identified several attitudinal barriers related to partnerships. For example, it was suggested that it was becoming all too common for staff to start a partnership process, only to experience changes in the organizational structure that prevent them from participating in that process, leading to a loss of credibility and trust in the RHA on the part of the community. As a result, staff end up being afraid to start the process in the first place. It was also suggested that staff are beginning to experience 'partnership exhaustion.' Either way, the potential for growth of intra- and intra- sectoral partnerships is compromised.

Exemplars also identified several attitudinal barriers that originated outside of the RHAs. For example, they noted that, in rural areas, in addition to public *demand* for acute care services, there is the issue of public *support* for hospital services due to the employment impact of a potential hospital closure, since many farm families supplement income with hospital work. Regarding external government support for population health promotion, it was suggested by one exemplar that, when all is said and done, the health sector at both the federal and provincial levels sees its main responsibility as providing health 'care' services. According to this hypothesis, the population health approach was adopted by governments mainly to send a message to other sectors that health is everybody's responsibility, and that the other sectors need to "cough up the dollars."

7.4.2.2 - Funding/Resources

Exemplars raised a number of interesting points about resource barriers, mostly related to external funding issues. For example, they talked about how community based/driven HP efforts are knocked off course by strategic external government funding. They referred to this phenomenon as the 'dangling carrot' syndrome, which they described as follows: RHAs are supposed to be planning at the community level and assessing community needs, but they have very little money to do that. Along comes Health Canada, Justice, or the Community Mobilization Program saying, "here's some money, if you do this." So, instead of addressing your community's needs, which you don't have the money for, everybody switches gears to chase the dollars. This type of 'stovepipe' funding (a stand-alone program addressing a narrow segment of the population) has very limited time lines, so you then spend time trying to fit your community's objectives into their criteria or you change your objectives. This, according to the exemplars, is not the way to achieve community empowerment for health promotion. Exemplars noted that short-term funding of HP programs/ activities with short-term objectives means that sustainability and increased expectations may create future problems for RHAs, and also reduces the inclination to support HP ventures. They pointed out that the typical time line for funding is 18 months, whereas 3-5 year time lines are the minimum required for most HP initiatives. Exemplars also expressed concern that the inflexibility of provincial/RHA finance systems is severely restricting creative partnerships and intersectoral work— e.g., RHAs can't integrate funds earmarked for Diabetes Education Resource programmes or Healthy Seniors with general HP

programming. Other concerns about external funding barriers included the need for support for community groups to encourage horizontal integration so that you don't have three major fundraising initiatives all trying to tap into the same dollars, and a lack of seed money for local Healthy Communities projects. In fact, the lack of support from the province for Healthy Communities initiatives was very clear to many exemplars. They noted that designated HP staff in the RHAs are expected to go out and support these initiatives, but they are not given resources to do this.

In terms of internal barriers related to resources, the exemplars' focus was more on lack of information and other tools. For example, they noted that there was a lack of resources and therefore capacity for local analysis of data to approach HP strategies. In order to mobilize people around issues, they need data from all sectors, but haven't had a way to validate, integrate information into their everyday work. There was also a concern about lack of access to statistics that allow the RHA to identify specific needs of First Nations population.

7.4.2.3 - Organizational Structure/Policies/Processes

Exemplars identified a number of barriers to HP related to internal organizational structure/ policies/processes. For example, although there was acknowledgement that several RHAs had adopted Board 'Ends' policies that related to HP, these policy statements tended to reflect a medical and behaviour change perspective on HP (which, they felt, probably reflects the level of understanding of HP at the Board level, and other levels), rather than a broad socio-environmental perspective. Another barrier was the lack of a coordinated HP strategy at multiple levels, which the exemplars felt was due to a

lack of HP leadership. However, it was acknowledged that the individuals within the organization who could provide such leadership had to spend so much time working on Operational Plans and Regional Health Plans, that there was no time left to look at other things like a coordinated HP strategy. Regarding the RHAs' potential role in advocacy for healthy public policies, exemplars noted that there is no clear process regarding how the RHA can fulfill this advocacy role, or how front line staff can get input to the Board, which might be in a position to advocate. There was also concern expressed regarding barriers to partnerships. Participants felt that the health sector *should* be taking the lead in bringing people together for partnerships, but that, in reality, they weren't always playing this facilitative role. There were some conflicting ideas, however, about the effectiveness of some partnerships. For instance, the view was expressed that many inter-agency/inter-sectoral partnerships lacked 'clout' because decision-makers often were not at the table. This was in contrast to the view that the task of developing trusting and truly collaborative inter-sectoral partnerships was most difficult the further away from the community level you got.

As far as external organizational structure/policies/processes barriers to HP are concerned, exemplars had some interesting views regarding the role/influence of the provincial health department. They noted that the provincial diabetes program was an example of a move back to a more biomedical approach to HP— i.e., there was more discussion of the care component of diabetes than about the prevention aspect. They also felt that core services guidelines for HP were very behaviourally based. As a result, exemplars were reluctant to support the idea of provincial standards for HP unless they

are based on a broad (socio-environmental) understanding of HP, because the standards could get in the way of some community based initiatives. Exemplars also suggested that core services guidelines should apply to all government sectors, not just the health sector. Barriers to local inter-sectoral collaboration and partnerships include the fact that organizational structures at the provincial and federal levels are still very silo-based, and that potential partners in other sectors may not be regionalized as the RHAs are. It was noted that the 'Alliance for Prevention of Chronic Disease' (a formal alliance of six Manitoba non-governmental health organizations³⁴) has had a very large, positive impact on capacity-building in several RHAs; however, exemplars expressed concern about long-term sustainability of those initiatives and reliance on individuals from that organization.

Another external barrier related to funding policy frameworks that are not conducive to community-driven planning processes. Funding proposals require concrete statements of exactly what you are going to do but, if you are going to use a CD or capacity-building process, you can't prescribe the process without the input of the people in the community. Lastly, the network of health promoters/educators (HP/HE) in the province felt that they had not been given any real power. Noting that they were only allowed to meet a couple of times per year and that a document on HP produced by

³⁴The six member organizations of the 'Alliance' are: Canadian Cancer Society, Manitoba Division; Canadian Diabetes Association, Manitoba Division; Heart and Stroke Foundation of Manitoba; Manitoba Lung Association; The Kidney Foundation of Canada, Manitoba Branch; and the Manitoba Cancer Treatment and Research Foundation. The Alliance's mission is to strengthen health care for primary prevention of chronic disease and the enhancement of the quality of life for Manitobans.

HP/HE network had never been formally endorsed by either the RHAs or the province, it was suggested that there might be some concern about a HP/HE network recreating the old provincial structure. Participants felt that the HP/HE network required a mandate and legitimacy.

7.4.2.4 - Knowledge/Skills

The last category of HP barriers was knowledge/skills. Exemplars felt that there was still a lot of confusion between the concepts of 'population health' and 'health promotion,' and that all RHA staff needed a better understanding of the differences between the two terms, as well as how to combine the two perspectives to create a population health promotion (PHP) approach. For example, they suggested that there is a need to differentiate between a population health indicator, such as 'incidence of diabetes,' and a PHP indicator, such as 'developing new partnerships to deal with the determinants of health.' There was also concern about the low level of capacity for evaluating health promotion at all levels, from community up to provincial and federal levels, and some participants pointed out that it is very difficult to evaluate PHP when indicators remain more medically focussed (e.g., decreased incidence of diabetes). The need for more knowledge of 'best practices' in HP (both at the regional and provincial level) was also identified. However, it was also suggested that, while 'best practices' may be useful when using a biomedical approach to HP, and perhaps a lifestyle approach, they won't necessarily work when you try and apply them to the socioenvironmental approach— at least, not the way that they are currently conceptualized.

7.5 - Building Capacity for HP

In the third and final exercise of the day, participants were asked to address the following questions: *“What are the opportunities for overcoming some of these barriers and for building capacity for health promotion in your organization/region? Realistically, what can your peer group do in order to build health promotion capacity over the next 3 years?”* Participants were divided into three small groups for discussion, based on position/type of work within the organization— (i) senior administrators, Board members; (ii) community health programme managers/ directors; (iii) frontline staff.

It was originally hoped that there would be a sufficient number of Public Health Nurses (PHNs) to form their own group of frontline staff— separate from the individuals in positions designated for Health Promoter/Educator. Due to the very small number of PHNs who were able to participate in the Think Tank, the decision was made to combine the PHNs and Health Promoters/Educators into one ‘frontline staff’ group. It was assumed that when it came time for specific suggestions about strategies that peer groups could engage in over the next three years, that the PHNs would raise ideas specific to their peer group. Unfortunately, the discussion about specific opportunities tended to be dominated by the Health Promoters/Educators, and the ‘voice’ of the PHNs was not heard.

It should also be noted that the intention was for participants to divide their discussion between general opportunities for capacity-building and more specific strategies that their peer group might engage in over the next three years. This did not happen uniformly, with a lot of the discussion integrating the two tasks— i.e., there was

not always a distinction between ‘opportunities’ (situations, contextual circumstances) which could be taken advantage of, and ‘opportunities’ that could be created (i.e., strategies)— either generally, or specific to a particular peer group. Also, mixed in with the discussion of opportunities, participants identified progress made in building HP capacity. As a result, the information gathered during this session is presented in three categories: (i) opportunities that have been or could be taken advantage of (including examples of progress toward building HP capacity); (ii) general strategies for building HP capacity within or across RHAs; and (iii) specific strategies that can be carried out realistically by peer groups over the next three years.

7.5.1 - Opportunities for Building HP Capacity

Recognition of, and support for, HP by senior management (ranging from “a good beginning level of support” to more active levels) was noted by frontline practitioners in several RHAs. In two RHAs, the leadership of key individuals in the organizations was identified as a crucial opportunity for capacity-building. One exemplar described it this way: “Because this individual shows leadership [moving the RHA forward in the area of HP], then others know that it’s o.k. to step outside of the box.” Exemplars from one RHA noted that a prominent local government department had adopted a broad HP approach, and this was providing a model for other sectors, including the health sector. They also felt that their RHA was in an ideal situation to build HP capacity in that it is small, geographically contained, but large enough that they have a number of community partners with dedicated resources that they could work with easily, which other rural/northern RHAs don’t have.

The Achieving Improved Measurement (AIM) accreditation process was identified by all groups as a good opportunity for HP capacity building. The AIM process provided an opportunity to examine the RHAs' actions in addressing population health, allocation of appropriate resources, involving the community in planning, and generally discussing organizational values. Noting that the term, 'population health,' had been introduced into the new AIM standards, exemplars felt that this provided the opportunity to talk about the concept and to incorporate a HP perspective into all of the teams during the accreditation process. Strategic planning processes were identified as good opportunities for capacity-building for the same reasons. Another opportunity that was raised by all groups was the acknowledgement that there were many networks/coalitions in their communities that RHAs could engage with, and that the number of partnerships was definitely increasing. It was noted that one of the RHAs had recently had the opportunity to partner with the Alliance for Prevention of Chronic Disease to hold HP capacity-building workshops for staff.

The group consisting of senior administrators and board members focussed much of their discussion on the opportunity to build on the population health promotion (PHP) approach, which they viewed as broadening the perspective on HP from a focus on individual behaviours to a multi-dimensional perspective looking at causes and the health of populations. These exemplars noted that a key feature of this PHP approach was working with other partners who may not have traditionally been in the health field, which could enable access to funds and support for health goals from other sources than a health care budget (this could include other government departments, or other agency or

community sources). They suggested that the use of population health promoters, wellness coordinators, etc., could expand the focus of RHA planning. Some health educators pointed out that a number of strategic policy position papers had been developed by the Council of RHA Chairpersons for the provincial government. They felt that, if they were available and relevant to HP, then they could be discussed and supported by the HP network. Program managers suggested that there were always leftover dollars, which could be used for small-scale community initiatives. This group also mentioned that the 'Think Tank' itself was a good opportunity to discuss the issues with colleagues across the province.

An additional opportunity related to the role of the advisory bodies within the RHAs. The group of frontline practitioners noted that the Provider Advisory Councils (PACs) had a direct link to the Boards and, therefore, they could— in theory— have some influence on the Board regarding advocacy for healthy public policies. Similarly, there was an opportunity for District Health Advisory Committees, representing the voice of the population served by the RHA, to influence their Boards in this regard.

Finally, exemplars described a few initiatives that they felt could increase capacity for HP indirectly. For example, one RHA had recently moved its offices out of a government building into a downtown shopping mall. This was viewed as a major step; getting out of fortresses that don't invite people in and being closer to where people are in the community. Exemplars from this RHA stated that staff feel better about where they work, and clients were being given the respect that they deserved. In another example, it was noted that one RHA had consciously taken on its deficit to supplement community

health programs, which allowed it to hire two additional PHNs. Since inadequate human resources, combined with increased demands for mandatory programmes, was identified as decreasing the time available for staff to be involved in HP activities, this was viewed as contributing to the HP capacity of this RHA.

7.5.2 - General Strategies for Building HP Capacity

Frontline practitioners mentioned a number of general strategies for building HP capacity in the regions. A couple of ideas related specifically to their own work. For example, they suggested that, in HP, one can't always wait for permission to get involved; sometimes it's necessary to just jump in and see where you land. They also suggested that there needs to be a mechanism for frontline people to give input to the Board or other advocacy body through line management. The other strategies had broader relevance, including: being mindful of, and getting involved in, HP work going on outside of the RHAs in other sectors; having a central HP directorate with links to the regions; building HP capacity among Board members (possibly through workshops), because the Boards have a lot of potential influence on local policymakers; but also recognizing that the RHAs' role may be, most appropriately, educating/facilitating public awareness about their power to advocate for healthy public policy (i.e., not necessarily doing it *for* the public).

Community health programme managers also identified a number of general HP capacity building strategies. They included: using a wide variety of means (mass media, internet, etc.) to inform the public, other agencies and stakeholders about what contributes to population health; developing better marketing strategies to convince

political decision-makers that prevention and HP can save money; providing orientation for all levels of RHA staff re: the meaning of HP, examples of how it can be carried out at the individual level, and examples of processes that can be engaged in at the community level; making an effort to get HP issues *first* on the agenda at all levels, then going on to a discussion of acute care/facility issues; developing ethically based policies to guide decisions re: allocation of resources for HP; and applying the “Seven Habits of Highly Effective People” (based on using a proactive approach at all times) to the entire organization. Like the frontline practitioners, the programme managers suggested that the RHA doesn’t necessarily need to take the lead in, but can facilitate, healthy public policy advocacy (and they used the example of advocating for an increase in the minimum wage). It should be noted that the group representative who reported back to the large group in this exercise ended her report by stating, “Notice that we didn’t talk about standards and benchmarking.”

The group of senior administrators and Board members did not specifically identify general strategies for building capacity.

7.5.3 - What Can Peer Group Do In Next Three Years To Build HP Capacity?

Most of the specific activities identified by the frontline practitioners reflected the voice of staff designated as health promoters/educators. These included: keeping each other informed of the community organizations, professional associations, etc., that have the ear of government and that would be good to partner with in order to advocate healthy public policy; supporting the VP network and Board Chairs to raise healthy public policy issues at an inter-RHA level; advocating partnerships with universities to do research

related to HP; bringing individuals from the Winnipeg Regional Health Authority into the provincial HP network; getting HP staff onto PACs (which have a direct link to the Boards); and recommending a common name/role for designated HP staff across RHAs in order to give clarity to the community and to co-workers. Frontline practitioners also suggested devoting a health planning day to HP, which would involve community partners in addition to RHA staff.

Community health programme managers identified a number of activities, including: creating the freedom and the environment for staff to take risks in the area of HP (especially related to the socioeconomic approach); creating a framework of HP principles for people to work within and a HP strategic plan to guide and direct practice; working harder and more effectively to get senior managers, board members, and peers to value HP; and modelling HP values within the organization (“we need to learn from the Baha’i– they don’t preach, they model the way, they ‘walk the talk’”). These exemplars also discussed the need to focus on creating better partnerships, suggesting that it’s better to be involved in a smaller number of initiatives characterized by strong partnerships, rather than a greater number of initiatives with weaker partnerships. Finally, the programme managers talked about exploring and utilizing what’s out there in terms of models/tools for HP. For example, they noted that the Institute for Cultural Affairs (ICA) has developed frameworks and tools for community and organizational development.

Senior administrators/board members identified a number of activities that they could be involved in over the next three years. These included: accessing federal monies; redirecting unused dollars to support community initiatives (e.g., one RHA had deleted 2

administrative positions and re-directed funds to community positions); working more with other sectors (recreation/fitness, housing, transportation, etc.) that the traditional health care system has ignored in the past; promoting PHP activities with all partners (CEOs were identified as having a major role to play as champions of HP with community partners, businesses, and schools by showing the RHAs' commitment to HP); using the Board, Council of Chairs to identify high-priority issues in the regions; and adding a HP specialist to promote HP activities within school settings.

7.5.4 - Additional Opportunities/Strategies Raised

During the various large-group discussions that occurred during the day, additional opportunities/strategies were also raised by exemplars. It was suggested that provincial support for 'Healthy Communities' initiatives is less important than a growing regional support for 'Healthy Communities.' In fact, it was noted that 'Healthy Communities' has been a leader in some areas. Some participants emphasized the need to recognize, and take advantage of the fact, that the front page of the newspaper drives policy. There was also discussion about the need for the health sector to spread the message of population health promotion in a more formal way to Family Services, Education, Housing. Noting that this isn't happening on a provincial level, exemplars wondered how they could facilitate this happening on a regional level. They pointed out that, while this task might be part of the RHA's mandate, for other governmental agencies that aren't regionalized this may not be the mandate coming from the top. As a result, the definition of population health promotion needs to be communicated to all these other sectors, and then people need to start coming together and having a coordinated, inter-agency plan,

above the regional level.

7.5.5. - Discussion

It is difficult to select common themes regarding building capacity for HP since the different groups of exemplars did not take exactly the same approach in answering this set of questions and did so from different perspectives. One salient feature of the discussion is that the tendency (which was evident in earlier exercises) to focus on strategies that involve changing attitudes and philosophy and creating supportive organizational structures, policies, processes and practices seems to outweigh strategies which focus on funding and knowledge/skill development. Similarly, the need to take advantage of opportunities and develop strategies for building effective partnerships is evident in each of the three groups' remarks.

An interesting observation was made by one participant, who acted as a recorder for the senior administrator and Board member group. He noted: "the more senior group here, we finished first, we exhausted what we knew, and that was it. The middle management group finished next. The group that stayed here and that would have still been working for another couple of hours are the people who are at the community level, and that's where the strength is in this area right now." The question, of course, is the degree to which these frontline health promotion champions can influence the thinking of their organizations, from the bottom up.

7.6 - Conclusion

At the end of the day, a round table discussion was held, where participants were asked for any insights, inspirations, and ideas from the discussions that they would take

back to their work. There was one overall impression from the discussion that stands out. In spite of the success stories and perceptions of potential opportunities for building HP capacity that were shared by the participants, these health promotion exemplars clearly felt isolated (both within and across regions) and were often exhausted in their efforts to build that capacity. Having the opportunity to discuss these issues with individuals who 'spoke the same language' and shared the same vision of health promotion was mentioned by many people as one of the highlights of the day. As one person commented, "perhaps through this process there's the beginning to find a collective voice for health promotion because I think that's what has always been missing in Manitoba."

CHAPTER EIGHT: WHAT WAS LEARNED?

8.1 - Introduction

The objective of this dissertation was to investigate the issue of capacity for health promotion (HP) in the Public Health sector in Manitoba, particularly within the context of a regionalized health system based on a population health approach to planning. The study was *not* intended to be a cross-sectional evaluation of HP capacity in Manitoba, but rather, it was intended to document the *discourse* on HP capacity within the formal health care system. The largest phase of this exploratory, descriptive study focussed on the experience of three RHAs selected to represent the diversity of Manitoba, both geographically and demographically.³⁵ Key informants included Board members, senior administrators (CEOs and Vice-Presidents), and citizen advisory committee members. However, the vast majority of participants were frontline providers and programme managers within the Community/Public Health sector of the health system, and a large percentage of these individuals had a nursing background. Later phases of the study expanded the focus to include the perspective of current/former Manitoba Health employees and ‘champions’ of HP from other RHAs. In addition to documenting the views of key informants, the literature on organizational capacity for HP, the discourse on ‘population health,’ health system restructuring in Canada, and the role of HP in Public Health was reviewed. Part 1 below presents a summary of key findings from all phases of

³⁵Winnipeg was excluded from the first phase of the study because, at the time that data collection began, there were separate health authorities for acute care institutions and community/long term care services. This was an anomaly at the time compared to the fully integrated delivery systems in the rest of the province.

the study. Part 2 will explore the policy implications and theoretical gaps that arise from the study, and questions for further research.

PART 1: SUMMARY OF FINDINGS

8.2 - Regionalization: Will it Help or Hinder Capacity for HP in Manitoba?

The literature on health system restructuring in Canada suggested that this phenomenon could be viewed either as an opportunity for building capacity for HP or as a potential threat to that goal. If accompanied by a true shift in perspective and commitment (both philosophically and materially) to 'investing in health,' then health system restructuring might be a great opportunity. If, on the other hand, it is primarily viewed as an administrative realignment designed to improve efficiency and accountability, without any shift in perspective and commitment to 'investing in health,' then health system restructuring could make the task of building capacity for HP even harder. In Manitoba, there were at least three features of the Health Reform plan articulated in key Manitoba Health documents prior to the establishment of the RHAs that suggested a potential opportunity for building HP capacity: (i) a philosophical shift in perspective to 'investing in health'; (ii) the identification of HP as a 'core service' that had to be provided within the regions; and (iii) a conceptualization of 'health promotion' that reflects a broad socioenvironmental perspective. However, at the time that this study was initiated there were no first-hand accounts regarding how the process of health system regionalization was evolving in Manitoba or how the three above-mentioned features were being integrated into regional health system planning and action.

Interviews revealed that, while most benefits of the regionalization process

identified by key informants related to increased administrative efficiency and sense of local control, two of them— an increased Public Health profile within the RHA and increased involvement of Public Health in organizational planning— suggested that there was at least the *potential* for expanding the emphasis on HP within the RHAs. However, there were also indications that the regionalization process had created certain conditions that could act as barriers to building HP capacity in the regions. Four of these conditions stand out. First, the continued demands for acute care services in an environment of fiscal restraint indicate that the concerns of the institutional sector are likely to continue to dominate the RHAs' agenda. Second, it was noted that the demands placed on health systems during the transition period following regionalization (when new administrative structures were being established) had led to a state of 'burnout' at all levels of the RHA organizations. There was concern that, even if the 'burnout' factor was a temporary one, unless there was a large infusion of resources into the Community/Public Health sector, then the ability to move in new directions with an increased focus on HP would be thwarted. Third, the formal severing of links between the Health and Child & Family Services sectors through the integration of health services into regional systems had, ironically, *decreased* the potential for inter-sectoral collaboration at the local level— one of the crucial elements of a socioenvironmental approach to HP. Lastly, the loss of a strong, centralized provincial HP infrastructure meant that RHAs had become very isolated in their HP efforts. In fact, the question of the ideal role of the provincial health department in a regionalized health system— especially in relation to the task of building capacity for HP— was a recurring theme in discussions with participants. Overall,

although there appears to have been increased discussion about HP following regionalization at the Board and management levels, the consensus among key informants was that there was far more ‘talk’ about HP than ‘action.’

8.3 - Population Health: Will it Help or Hinder Capacity for HP in Manitoba RHAs?

In the months leading up to the establishment of the RHAs in Manitoba the provincial health department produced a framework document to guide health planning in the regions. This document outlined a vision for health reform in Manitoba that was reflected in a set of goals, including: reducing inequalities in health status, establishing public policy that promotes health, and fostering environments that promote health. In order to achieve these goals, the planning framework emphasized the adoption of a ‘population health’ approach that would, among other things, focus on the broad determinants of health of communities and populations, equity of health, an intersectoral approach, and investment in health promotion and disease prevention. This raised several questions: What is the discourse on ‘population health’ in the RHAs? How are RHAs integrating this approach into health planning? What are the implications of this approach for HP capacity?

The review of the literature on population health revealed a number of key themes. First, it was noted that there was no universally accepted definition of the population health perspective (although several assumptions about the perspective appeared to be generally accepted), and very little information regarding how the concept of population health was understood by those on the ground who have to put it into practice— especially at the level of the RHAs. A second, related observation was that, although the population

health perspective had clearly influenced health policy at all levels of government— at least, in theory— preliminary evidence suggested that knowledge about the broad determinants of health was not necessarily influencing Canadian health policy or program decisions in practice. Whether or not RHAs in Manitoba were integrating this perspective into their program planning, as well as the barriers that they might be facing in attempting to do so, was unknown prior to undertaking this study. Third, there have been only very preliminary attempts to outline a population health approach to public health practice at the level of frontline practitioners, and the degree to which these practitioners were using such an approach was unknown. Fourth, while it may seem that there has been little opposition to the adoption of a population health perspective within government, criticism of this phenomenon was evident in the literature. These critiques have come primarily from academic circles. Whether or not individuals within the RHA had any concerns about the population health perspective was unknown. Fifth, the specific relationship between a population health perspective and health promotion has not always been clear. The origins of these two perspectives are different, with the former developing out of the field of epidemiological research, while the latter grew out of Public Health/Community Health practice. As a result, in spite of the mutual agreement that the health of the population depends upon taking action on a broad range of health determinants beyond the health care system, the implications of a population health perspective for HP practice are very broad. There has been some effort to link the population health and health promotion perspectives into a PHP approach that identifies specific strategies for taking action on the determinants of health. However, at the time

that this study was undertaken, there was no information regarding the application of this framework in practice in Manitoba (or elsewhere), either at the provincial or regional level, and the author wondered how the individuals within Manitoba's health system viewed HP within the context of a population health approach and what role they saw for the RHA in putting it into practice. Lastly, the discussion about the relationship between population health and health promotion raised the possibility that, depending on how one defines the two concepts, building capacity for one may not be the same thing as building capacity for the other.

One of the most striking observations regarding key informants' perceptions of the population health perspective is that, although there had obviously been considerable discussion of the concept (and related ones) within the RHAs— particularly within the Public Health sector— there was considerable variation in participants' interpretation of the concept, some acknowledged confusion about what it meant, and a perception of a lack of understanding of the population health perspective in the acute care sector of the health system. Perhaps most significant, for the purposes of this study, is the observation that the majority of participants didn't automatically associate the population health perspective with a focus on health promotion *action*. Certainly, recognition of the broad determinants of population health appeared to be widespread among participants, but only a relatively small number of them included taking action on the determinants of health as a key element of a population health perspective. Significantly, only two participants focused on the need to reduce inequalities in health status. A large percentage of key informants associated this perspective with an approach to using either traditional

epidemiological evidence or evidence from population-wide surveys or consultations to better plan services for the entire population or sub-populations within their region. This perspective was particularly predominant in one RHA, where the influence of the Medical Officer of Health during the Community Health Needs Assessment and subsequent health planning processes appeared to have been a major catalyst for discussion of the population health perspective and the shaping of 'public' opinion within the region.

In spite of the fact that most participants did not automatically associate a population health perspective with a focus on HP, when they were asked how they viewed HP within a population health perspective as compared to more traditional approaches to HP, the vast majority did identify differences between the two. A focus on larger groups, on positive concepts of health, on determinants of health, on community participation, and on evidence-based planning were the five distinguishing features of a population health approach to HP. Most key informants associated the traditional approach to HP with a focus on lifestyle change to prevent disease.

Regarding the question of whether or not RHAs were utilizing a population health perspective, most participants could give examples of planning or program activities within the organization that were influenced by a population health perspective, but it seems safe to conclude that a comprehensive population health approach was not operating in any of the RHAs. Significantly, in the RHA where the population health discourse seemed to be most deeply embedded, a senior administrator was adamant that they were only implementing a population health approach in the most sporadic sense. It is also important to note that, in all RHAs, the majority of programs that were identified

as examples of a population health approach were federally- or provincially-funded initiatives which did not originate within the RHAs. Many frontline practitioners spoke about how they were trying to use a population health perspective in their day-to-day work, however they noted that there were many barriers to actually implementing this approach.

Concerns were expressed about the population health perspective at all levels in all RHAs. Not surprisingly, the concerns raised by participants were more practical in nature than those offered by academics in the literature. The challenges of operationalizing the concept and the implications for professional practice were the most frequently mentioned. For many people, the complexity of the task made it seem overwhelming, while others were concerned about the radical implications of the population health perspective. However, only one key informant expressed strong doubts that this kind of perspective could be effectively implemented at a regional level. A salient feature of the discussion was the concern expressed by nurses regarding the implications of a population health perspective on their workload (which they felt had increased dramatically from the implementation of population health programs) and on the nature of their professional practice in general. Public Health Nurses (PHNs) in particular commonly associated the population health perspective with working at a group or population level, and they worried that their work with individuals and families might suffer. They also expressed concern that they did not have the necessary skills to engage in a population health approach.

An overall impression upon analysis of key informants' perceptions *within* the

RHAs about the population health perspective is that, for the majority of them, this concept remained very much at an abstract level. The need for political will and leadership both within and outside of the RHA in order to integrate a population health perspective into the philosophy of the organization at all levels was a notable concern of several key informants who suggested that, without this happening, the perspective would remain an abstract concept. It is also apparent that, although recognition of the broad determinants of population health status was widespread among participants, individuals within the RHAs were clearly struggling to clarify what the organization's role was (and what their own individual roles were) in addressing these determinants of health in their own populations. Lastly, it is clear that, for many of the participants, the conceptualization of a population health perspective did not automatically include some of the key elements of a socioenvironmental perspective on HP such as a focus on reducing inequity and the use of specific *Ottawa Charter* strategies for HP. The criticisms by those individuals in the literature who argue that the dominant population health discourse lacks the focus on strategies for change and the values of social justice of the socioenvironmental approach to HP appears to be germane to these findings. Therefore, it seems safe to suggest that the discourse on population health does not contribute to HP capacity in Manitoba RHAs.

There are two salient features of the discussion by Manitoba Health employees regarding the discourse on the population health perspective that are worth highlighting. Although this was a very small sample and cannot be considered representative of the views of the entire department, it is nonetheless significant that the two individuals

employed by Manitoba Health (including a very senior official) felt that, at the time of the study, there was no integrated PHP perspective operating at the provincial level and no real policy mechanism for implementing such a perspective. At best, they saw only isolated examples of a population health approach operating at the provincial level. In addition, the failure to proceed with the development of a central Population Health Promotion Unit that could provide support and guidance to the RHAs indicates a lack of political will to implement a PHP perspective. It seems safe to suggest that, without the commitment to an integrated PHP perspective at the provincial level, clarity regarding the RHAs' role in PHP will be difficult to achieve.

8.4 - The Nature of HP Practice in Public Health: Key Characteristics, Barriers,

Facilitators

After exploring the broader contextual factors influencing HP capacity in the RHAs, key informants were asked to talk more specifically about various facets of HP practice in their region. Overall, two aspects of the discussion stand out. Perhaps the overriding observation is that, in spite of three very different geographic and demographic contexts, there were remarkable similarities in the climate for, content of, and barriers to HP practice between the three study sites. For example, there appeared to be consensus among all participants across study sites that, although there was certainly some discussion about the need to increase the emphasis on health promotion within the RHAs, this discussion continued to be overshadowed by the priorities of the acute care system. There also appeared to be a high degree of consensus among frontline practitioners across study sites regarding the following aspects of their HP practice: (i) a strong focus on

working at the individual/family level to develop personal skills; (ii) the belief that their educational background had prepared them primarily for this individual/family level focus (especially among nurses); (iii) the belief that, although they might not have the time, knowledge/skills, resources, or support from management to be involved in other population-focused *Ottawa Charter* HP strategies, it was not inappropriate for them to do so; (iv) the perception that, although senior managers would probably support their involvement in any of the HP strategies in theory, the emphasis on mandatory programs and evaluation based on the number of client contacts meant that, in practice, developing personal skills at the individual level was more likely to be supported by management than any of the other strategies; (v) the belief that personal health practices/coping and healthy child development were the two determinants of health that they were most likely to influence; (vi) the belief that income/social status and working conditions/employment were the two determinants of health that they were least likely to influence; and (vii) the belief that income/social status and personal health practices/coping were the two most important determinants of health for their most vulnerable clients.

It was also interesting to note the level of consensus across the three study sites regarding the barriers to building capacity for HP. For example, regarding barriers to increasing the emphasis on HP in general, areas of consensus included: (i) the perception among all types of participants of resistance to 'buying into' the HP philosophy by staff in the acute/long term care sectors; (ii) the perception among frontline staff and middle-level managers that HP was viewed by senior managers as an activity that one engages in only if there is time left over after the 'regular' work is done; (iii) the perception among all

types of participants that the public's top priority is the availability of, or access to, acute care services— not HP services— and that the RHA needs to respond to public demand;

(iv) concern among board members, senior administrators and senior program managers regarding (a) the degree to which demands for acute care services dominate the agenda, (b) the lack of funding from the province for HP initiatives originating in the RHAs, and (c) the resulting lack of flexibility that they have to allocate more funds to HP programs;

(v) the concern expressed by frontline staff and program managers about a lack of human resources and time to engage in HP activities, with PHNs and managers being particularly concerned about the increasing demands related to mandatory programs activities; (vi) the concern expressed by most participants (excluding Board and DHAC members) about the increased workload and organizational challenges related to the transition period following regionalization; (vii) the perceived challenge of finding the correct balance between the autonomy of RHAs and the need for support from the provincial health department (frontline practitioners and program managers in all regions complained about the lack of a strong, centralized HP infrastructure at the provincial level, while senior administrators tended to complain about Manitoba Health continuing to 'micro-manage' the regions); and (viii) the belief among all types of participants that staff at all levels of the organization (including the board and advisory committees) required increased knowledge and skills in HP.

As far as barriers to *specific* HP strategies are concerned, there were also a number of areas of consensus across the study sites. For example, in relation to advocacy for healthy public policy (ADHPP), the vast majority of frontline staff and program managers

stated that they saw an active role for the RHA in ADHPP, although the nature and degree of that involvement varied (the majority of these participants felt that there was more of an organizational role rather than an individual role). Interestingly, the negative responses to this question were all from Board members, senior administrators, and one senior program manager. Perhaps most importantly, the majority of participants in all regions stated that ADHPP was *not* happening on a *regular* basis at *any* level of their RHA during the time of the study. Other areas of consensus related to ADHPP included the belief that (i) lack of time is the main resource barrier to involvement in ADHPP; (ii) individual comfort level might be a major barrier to staff involvement in this type of activity; (iii) many RHA employees still have the view that ADHPP might be a conflict of interest due to their previous position as government employees or being in conflict with current organizational policy; (iv) the public doesn't view ADHPP as a legitimate part of the RHA's role; and (v) all levels of RHA staff, Board and DHAC members lack ADHPP knowledge/skills (something which was of considerable concern to C/PHNs).

Areas of consensus across study sites related to barriers to the HP strategy of 'strengthening community action' (SCA) were similar to those for ADHPP, for the most part. Concerns about the willingness and/or ability of community members and/or community agencies to participate in SCA initiatives, lack of a shared organizational vision of SCA and few role models to provide leadership in this area, and a lack of an appropriate system to record this type of activity were areas of consensus that were unique to this strategy. Unlike ADHPP, the majority of participants across the study sites felt that there were a number of examples of SCA occurring in their regions. However, it

is interesting that involvement in inter-agency work— as opposed to working directly with community members— was the most frequently mentioned example of SCA in all regions. It should be noted that, whether referring to ADHPP or SCA, there was also consensus across the study sites about (a) the importance of effective partnerships being a necessary condition for population health; (b) the perception that there were more partnerships occurring in the Public Health sector in recent years; and (c) the belief that the health sector had to increase the quantity and quality of their partnerships with other sectors, with other agencies within the health sector, and with other key stakeholders.

The other area where there was a high degree of consensus across study sites related to the question of how the RHA could support their staff to build capacity for HP within the organization. Frontline practitioners and program managers in all regions stated that their Boards and senior managers needed to value, encourage, and provide time for HP work, and most frontline practitioners stated that they needed more knowledge/skills related to specific strategies such as community development. PHNs in all regions stated that they would like more opportunities to share their community development experiences with their colleagues, to network, to access the Internet, and to discuss RHA initiatives with colleagues.

A second, less overt, theme that emerged from the discussion relates to the conceptualization of HP and the nature of HP practice in the RHAs. It is apparent that the majority of participants viewed HP primarily from a biomedical or behavioural, rather than a socioenvironmental, perspective. That is to say, HP was discussed for the most part from the traditional perspective of prevention of disease/disability and promotion of

a healthy lifestyle among individual clients. Although almost all frontline practitioners acknowledged the importance of the broad determinants of population health, their own health promotion practices were defined fairly narrowly in terms of assisting individual clients to develop personal coping skills and healthy preventive behaviours. Similarly, while the majority of participants acknowledged the importance of broader socioenvironmental HP strategies such as SCA and ADHPP, these strategies seemed to be viewed as activities beyond the usual scope of HP within the Public Health sector.

8.5 - The View of Manitoba's Health Promotion 'Champions'

In the final phase of the study, a one-day consultation—referred to as a 'Think Tank'—was held with individuals from across the province who had been identified as 'champions' or 'exemplars' of HP.³⁶ The objectives of this 'Think Tank' were: (i) to bring together the 'champions' or exemplars of health promotion in Manitoba's RHAs for a day of focussed, facilitated consultation and discussion related to building capacity for health promotion, and to provide the opportunity for these exemplars to share ideas with each other, and to identify common issues/ concerns; (ii) to share and discuss some of the findings from the first two phases of the study—specifically, barriers to HP capacity—beyond the original three RHAs; (iii) to identify characteristics of a region that is rich in capacity for HP— as well as identifying possible opportunities/strategies for capacity-building; and (iv) to stimulate on-going interest in building capacity for HP in Manitoba's

³⁶ Between the time of the first phase of interviews in the three study sites and the time that the Think Tank took place, the two separate health authorities in Winnipeg were amalgamated into the Winnipeg Regional Health Authority (WRHA). As a result, HP champions from the WRHA were included in the one-day consultation process.

RHAs.

The day began with participants describing current HP activities in their regions and what, if anything, was exciting them about this work. There appeared to be a consensus among these exemplars of HP that there was a window of opportunity for HP that hadn't been present for awhile, and that there was a need to take advantage of this situation while it lasted. Having said this, many of the participants noted that, although there was much more talk about HP within the RHAs, there was still a long way to go in terms of integrating the philosophy of population health promotion into all of their work throughout the organization and translating the talk into HP action. The lack of a true shift in resources to support this shift in thinking, and the fact that RHAs are based on the traditional medical model were just two of the challenges to 'walking the talk' that were raised at this time.

The first major task of the day was a visioning exercise where participants were asked to identify characteristics of a region that was 'rich' in capacity for HP. The characteristics can be grouped into four broad categories: organizational culture; organizational (infra)structure and policies; organizational processes/practices; and extra-system characteristics. Two aspects of the discussion about participants' vision of a RHA that is rich in capacity for health promotion stand out. The first is the degree to which their conceptualization of health promotion fits the broad socioenvironmental perspective outlined earlier. A capacity-rich RHA is clearly, from these exemplars' point of view, *not* limited to one that has the resources and ability to provide specific services or programs that are labelled 'health promotion.' Much of the discussion was focused on health

promotion as an approach, a way of thinking that will permeate the organization from top to bottom. Taking action on the broad determinants of health, engaging in partnerships and inter-sectoral collaboration, advocacy for healthy public policy development, community development, community participation, community capacity-building, and empowerment are all part of this approach and of their vision of an RHA that is rich in capacity for health promotion. Another interesting aspect of the discussion that stands out is that neither the availability of sufficient resources nor the presence of specific HP knowledge and skills dominate the list of characteristics. It is the integration of a broad HP perspective within organizational culture, policies, processes and practices (and, hopefully, outside of the RHA as well) that seems to be the predominant feature of the vision that the exemplars outline.

The participants were then asked to discuss the barriers to achieving the vision of a capacity-rich HP that they had outlined. A summary of major barriers identified in the first phase of the study was provided, and exemplars were asked to discuss which of these barriers were still of particular concern, which barriers were not a problem any more, and any barriers that were missing. A salient feature of the participants' discussion was the extent to which they agreed that most of the barriers identified in the first phase were still relevant. Moreover, there was very little difference expressed between participants from the various geographic regions regarding major barriers. The obvious geographic, demographic, and jurisdictional issues associated with different regions were noted but other, more universal, themes tended to dominate the discussion. Many of these themes involve the tension between opposing forces. For example, there is the tension between

the demands for acute care services and the desire to increase the emphasis on health promotion. On the surface, it appears to be a tension between the acute and Public Health sectors in the health system. However it also represents the tension between trying to respond to the expressed needs and priorities of the public when those needs and priorities may clash with those of the Public Health sector. Another of these themes is the tension *within* the Public Health sector between their legislated responsibilities (i.e., communicable disease control and health protection) and the desire to engage in population health promotion activities such as community development and advocacy for healthy public policy. A third theme is the tension between creating an organization where health promotion is an integral part of the thinking and activities of all staff, and the belief that there needs to be specific staff, even whole departments, with designated responsibility for health promotion. Finally, there is the tension between the desire for greater autonomy for RHAs from the provincial health department and the desire for greater support and direction from the provincial health department in order to build capacity for HP.

Barriers related to resources and knowledge/skills were mentioned less frequently than those barriers that related to attitudes/philosophy and organizational structure, policies, processes and practices. Not surprisingly, in three out of the four categories of barriers, most of the barriers that were identified were perceived as originating *within* the organization— the exception being those barriers that fit in the *resources* category. Clearly, participants felt that the RHAs had little room for manouevre as long as the province holds the purse-strings.

For the last exercise of the day, exemplars were asked to identify the opportunities for overcoming barriers and for building capacity for health promotion in their organization/region, and what their peer group could realistically do in order to build health promotion capacity over the next three years. It is difficult to select common themes regarding building capacity for HP since the different groups of exemplar discussed this topic separately, didn't take exactly the same approach in answering this set of questions, and did so from different perspectives. However, a conspicuous feature of the discussion was that the tendency (evident in earlier exercises) to focus on strategies that would create supportive organizational structures, policies, processes and practices outweighed strategies focussed on funding and knowledge/skill development. Similarly, the need to take advantage of opportunities and to develop strategies for building effective partnerships was preeminent in each of the three groups' remarks.

At the end of the day, a round table discussion was held, where participants were asked for any insights, inspirations, and ideas from the discussions that they would take back to their work. There was one overall impression from the discussion that stands out. In spite of the success stories and perceptions of potential opportunities for building HP capacity that were shared by the participants, these health promotion exemplars clearly felt isolated (both within and across regions) and were often exhausted in their efforts to build that capacity. Having the opportunity to discuss these issues with individuals who 'spoke the same language' and shared the same vision of health promotion was mentioned by many people as one of the highlights of the day. As one person commented, "perhaps through this process there's the beginning to find a collective voice

for health promotion because I think that's what has always been missing in Manitoba."

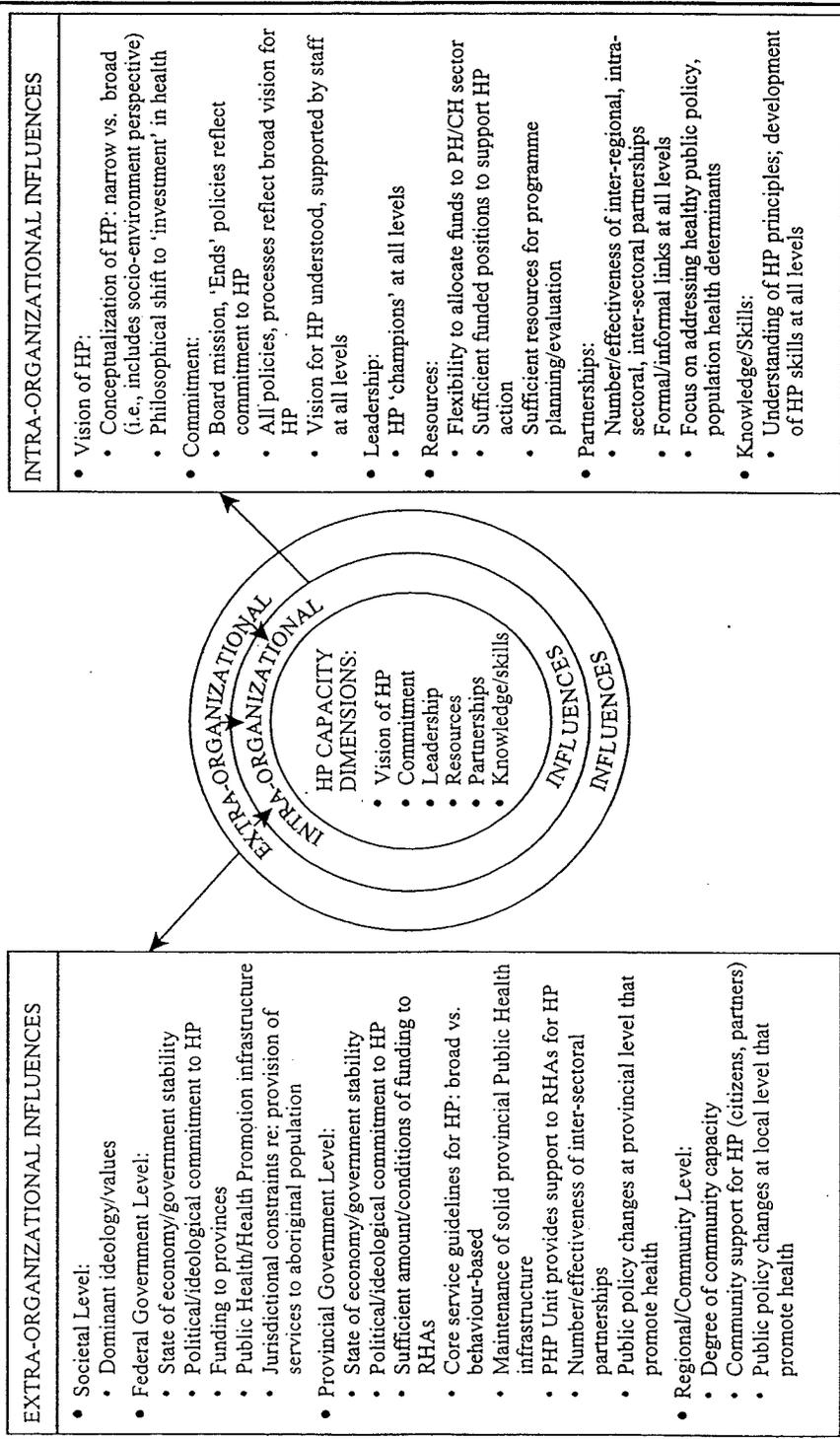
PART 2 - IMPLICATIONS OF FINDINGS

8.6 - A Conceptual Model of Organizational Capacity for HP

What can we conclude about building organizational capacity for HP in general?

First, there is a need to expand the basic conceptualization of organizational capacity for HP that is prevalent in most of the literature. While there are a number of variations on the theme, the two fundamental dimensions of capacity for HP that appear in all conceptualizations are (i) infrastructure, and (ii) will or commitment. There is, however, also a need to (a) better situate the concept of an organization's capacity for HP within the broader context of social, political and economic influences, and (b) place a greater emphasis on the vision and goals of health promotion that must guide the process. Figure 8-1 presents a conceptual model of capacity for HP within the context of Manitoba's regionalized health system that reflects these concerns. It suggests that the core capacity for HP of an organization consists of several dimensions: vision of HP, commitment, leadership, resources, partnerships, knowledge and skills. These capacity dimensions are not necessarily distinct from each other; they may overlap or influence each other. The model indicates that organizational capacity for HP will be influenced by a number of factors within and external to the RHA. These factors (influences) may be categorized according to the capacity dimensions themselves (see section 8.6.1) or they may be categorized according to the level at which the factor originates (see section 8.6.2).

FIGURE 8.1 - HEALTH PROMOTION (HP) CAPACITY IN MANITOBA RHAs:
INTRA- AND EXTRA-ORGANIZATIONAL INFLUENCES



8.6.1 - Intra-Organizational Influences on HP Capacity

Beginning with the influences that originate from within the organization, capacity for HP depends, perhaps first and foremost, on the *vision* for HP that is adopted by a regional health authority— that is to say, whether or not HP is conceptualized from a narrow biomedical or lifestyle perspective that focuses primarily on disease prevention and behaviour change, or from a broader socioenvironmental perspective that includes a focus on reducing inequalities in health and influencing public policies that impact on population health. It is assumed that the latter perspective is a necessary condition for HP capacity, although the biomedical and lifestyle approach to HP may be appropriate in certain situations. The vision of HP also includes a philosophical shift in thinking from a focus on provision of health services to a focus on ‘investing in health’ and the determinants of health.

Commitment to HP depends primarily on the extent to which a broad HP perspective is incorporated into all aspects of the organization, from the mission and Board ‘Ends’ policies to organizational policies and processes related to the planning and delivery of health programs. The goal should be the creation of a ‘health-promoting’ organization, and this would include a health-promoting workplace environment.

Commitment to HP also depends on the extent to which all staff, Board members, and citizen advisory committee members understand and actively support the organization’s vision for HP. As we have seen, there are a number of individual-level factors that may influence this capacity dimension, including educational background, personality and political/ideological beliefs.

The degree of commitment to HP may also be influenced by the presence of another capacity dimension— *leadership*. This dimension of HP capacity refers to the presence of HP ‘champions’— i.e., individuals at all levels of the organization (Board members, senior administrators, program managers, frontline staff) who not only ‘buy into’ the vision for HP, but who are willing to take a lead role in acting on this vision whenever possible. The presence of these HP champions may influence the degree of commitment to HP within an organization.

The ‘*resources*’ dimension of capacity within the health organization refers to human, fiscal, or other material resources (such as time, information). Flexibility of the RHA to allocate funds to the Public Health sector, sufficiently funded positions to support HP action, and sufficient resources for program planning and evaluation (including appropriate process indicators and workload indicators that reflect a broad socioenvironmental approach to HP) are all essential elements of resource capacity.

Intra-sectoral, inter-regional and inter-sectoral *partnerships* are another essential element in capacity for HP, particularly if the organization has adopted a ‘population health’ and/or socio- environmental approach to health enhancement. Both the number and effectiveness of these partnerships are critical, and should include both formal and informal links at all levels of the organization with a focus on addressing healthy public policy and population health determinants. Partnerships should include research links with universities, in addition to policy/advocacy and practice links.

Lastly, *knowledge/skills* refers to the necessity for a solid understanding of HP principles and the development of HP skills at all levels of the organization (including the

board level and citizen advisory committees). HP skills include facilitation and advocacy, effective partnership building, community health assessment (including assessment of community assets, not just deficits and needs); program planning and evaluation, as well as the more traditional health communication and health education. Knowledge and skills in the area of provision of culturally appropriate HP programs is also essential.

8.6.2 - Extra-Organizational Influences on HP Capacity

Using this conceptual model, extra-organizational influences on HP capacity could also be categorized using the six capacity dimensions. However, an additional factor to consider here is the level at which the influences originate outside the organization. Rather than analyzing the six capacity dimensions operating at each of the four levels of extra-organizational influences— society, federal government, provincial government, community (which would take up too much space in a diagram to be practical)— key factors at each of these four levels are identified.

Beginning at the level of the *society* as a whole, the dominant ideology and values at any particular point in time will have a major influence on both government and public perceptions of the importance of HP. For example, a society where social justice and the ‘common good’ are the most highly valued characteristics will have a very different perspective on HP than a society which places greatest value on ‘market justice’ and the rights of the individual. Capacity for HP from a socio-environmental perspective depends more on the former ideology than the latter.

Influences at the *federal* government level include the dominant ideology of the

party in power, the state of the economy, and the degree of government stability— all of which will influence the level of political commitment to HP. This, in turn, may influence the level of federal funding in the form of transfer payments to the provinces. The existence (or lack of existence) of a strong Public Health/Health Promotion infrastructure at the federal level will have a major impact on HP capacity at provincial/regional levels. Lastly, it should be noted that jurisdictional barriers related to the historic fiduciary responsibility of the federal government for provision of services (including health services) to aboriginal peoples is also a factor that influences HP capacity at the provincial/regional levels.

At the *provincial* government level, the dominant ideology of the party in power, the state of the economy, and the degree of government stability are factors that will influence the level of political commitment to HP (just as they are at the federal level). The nature of funding provided by the province to the RHAs is also a key factor influencing HP capacity in the regions. Funding issues include: sufficient amount based on population health needs; conditions of funding that allow maximum flexibility for resource allocation at the regional level; sufficient time lines conducive to community driven planning processes; and a focus on developing partnerships versus health (read illness) outcomes. Core service guidelines for HP and population health (outcome) indicators should reflect a broad conceptualization of HP— i.e., the former should not be limited to disease prevention and behaviour change, while the latter should not be limited to indicators of morbidity and mortality and use of health services. The presence of a strong provincial Public Health infrastructure, including a Population Health Promotion

Unit to provide support for HP within the RHAs, is essential in order that HP promotion efforts in the RHAs do not become isolated. This Unit should also provide support for capacity-building and training for community stakeholders. Lastly, since many of the public policies that influence population health are determined at the provincial level, it is essential that inter-sectoral partnerships between the health sector and other government sectors increase, both in number and effectiveness.

At the *regional/community* level, the extent of community capacity is both influenced by, and will itself influence, the RHA's capacity for HP. In the latter case, the state of the local economy, and the stability and ideological bent of local government will influence commitment to HP, just as it does at the provincial and federal levels. Public policy changes at the local level that promote health are essential. An additional factor to consider here is the level of social cohesion in a particular community or region. If it is low, then the RHA's capacity for HP may be limited. Community support for HP, both from citizens and from potential community partner organizations, is essential. All community stakeholders need to be committed philosophically to the vision of HP presented by the RHA. In addition, the degree of leadership, knowledge, skills, and resources of community partners will influence the RHA's capacity for HP.

With this broad conceptual model of capacity for HP in mind, we can now look at specific recommendations for building HP capacity in Manitoba RHAs. Before doing that, however, it's important to situate any recommendations that come out of this study within the broader policy context for HP that is currently present in this country.

8.7 - The Federal Health Policy Context for Building HP Capacity

Three major Canadian health policy statements have been released in the past year that have important implications for HP at national, provincial and local levels. In spite of certain weaknesses or omissions, each one of these documents addresses the issue that lies at the heart of any discussion about building capacity for HP in Manitoba's RHAs— which is, that the ability to build capacity for HP at the regional level will depend entirely on the capacity for HP at the provincial and national levels.

The document that has received the most attention is the Romanow Commission's *Building on Values: The Future of Health Care in Canada* (Romanow, 2002)— commonly referred to as the 'Romanow Report.' Significantly, out of 47 recommendations, only one specifically refers to health promotion: "Prevention of illness and injury, and promotion of good health should be strengthened with the initial objective of making Canada a world leader in reducing tobacco use and obesity" (p.250). However, perhaps a dozen other recommendations have indirect implications for health promotion, in terms of developing adequate national structures to support local HP initiatives. For example, the report calls for the establishment of a national Health Council which would, among other things, provide ongoing coordination and support for implementing primary health care (PHC) across the country. In fact, a significant number of recommendations relate to the need for increased funding and implementation of local health systems based on the PHC principles of increased accessibility of services, use of appropriate technology, community participation in decision-making related to health and increased emphasis on disease prevention and health promotion. However, the Romanow Report does not

provide a clear distinction between the concepts of disease prevention and health promotion (the two appear to be used synonymously) and there is no mention of the fact that PHC calls for intersectoral collaboration for health and social development (World Health Organization, 1978) (the report waters this principle down to ‘*interdisciplinary*’ collaboration). In fact, in the Romanow Report there is no mention of the need to address the social determinants of health at all.

In contrast, *The Health of Canadians-The Federal Role* (Kirby, 2002)– the final report of the Senate sub-committee exploring the state of the health care system in Canada, which was released a couple of months earlier than the Romanow Report but received relatively little public attention– devoted an entire chapter to health promotion and disease prevention, with a strong emphasis on the need to address the non-medical determinants of health through healthy public policies and other population health strategies. Healthy public policy, according to the report, “requires an intersectoral approach– one that engages the several sectors that are responsible for, or affect, each of the determinants of health” (Chapter 13). Population health strategies include “a wide range of government policies and programs that can influence income redistribution, access to education, housing, water quality, workplace safety, and so on– all major determinants of the health of a population” (Chapter 13). The Kirby report (as this Senate sub-committee report is commonly referred to) notes that the Public Health infrastructure in Canada is fragmented and under stress, and that this has resulted in a poorly integrated health promotion infrastructure with no health goals set nationally for health promotion. It recommends that the federal government ensure strong leadership and provide

additional funding to sustain, better coordinate and integrate the Public Health infrastructure in Canada as well as relevant health promotion efforts. However, the recommended amount of additional federal funding— \$200 million— seems grossly inadequate (considering that the Romanow report proposed a Primary Health Care transfer to the provinces of \$1 billion), and there is no further elaboration on specific structures, processes, or policies that might help to build capacity for HP.

The third Canadian health policy document that has relevance to HP capacity was unveiled by the Canadian Medical Association early in 2003 amidst virtually no fanfare whatsoever. *Answering the Wake-Up Call: CMA's Public Health Action Plan* (Canadian Medical Association, 2003) makes a number of recommendations aimed at strengthening the Public Health infrastructure in Canada. These include the creation of a Canadian Office for Disease Surveillance and Control, the appointment of a Chief Public Health Officer of Canada, the creation of a Canadian Centre of Excellence for Public Health to invest in multidisciplinary training programs in public health, funding of \$1 billion over five years to build capacity among federal, provincial/territorial and municipal authorities to fulfill essential public health functions, and special funding to enhance research on public health. While all of these recommendations are very important, they do not go far enough, in terms of building capacity for HP at the regional level. This is because the CMA report never clearly defines what Public Health is and the role of HP within that system.

In the following sections, recommendations for HP capacity-building at federal, provincial, and regional levels will be discussed. It is important to note that (i) these

recommendations are based on a synthesis of the evidence found in the literature *and* the evidence from the empirical data collected during field work, and (ii) these recommendations represent the *ideal* vision for building HP capacity in Manitoba RHAs. It is not suggested here that organizational capacity for HP at the regional level is impossible to achieve without the changes identified at the provincial and national levels. Rather, it is suggested that maximum organizational capacity for HP– and sustainability of that capacity– *ideally* requires supports (such as the ones proposed) from higher levels of society.

8.8 - Recommendations for Building HP Capacity at the Federal Level

1. *Legislative reform at the federal level.* The reforms recommended by the CMA report, while necessary, focus only on disease surveillance and control. The Romanow report does recommend a number of important amendments to the *Canada Health Act*, including the need to confirm its underlying principles of public administration, universality, accessibility, portability and comprehensiveness, and to add a new principle of accountability. However, the Canadian Public Health Association (CPHA) noted several years ago that the ‘comprehensiveness’ criterion has been compromised as many of the provinces and territories have redefined “medically necessary” services in order to cut costs– i.e., “delisting insured services which may be, in fact, “health necessary” (Canadian Public Health Association, 1996, p.I-14). As a result, the CPHA called for a review of the interpretation of the ‘comprehensiveness’ criterion to ensure a greater focus on funding of a range of core health services that produce healthy outcomes. The redefinition of “medically

necessary services” to “core *health* services” that will be publicly funded is a minimum requirement of any legislative reform strategy.

2. *Endorsement of a set of guiding principles that reflect the underlying assumptions, values and vision for Public Health in Canada.* Rather than reinventing the wheel, it is suggested that a Centre of Excellence for Public Health (or similar agency) endorse, with some modifications, the guiding principles proposed in a discussion paper from the board of directors of the Canadian Public Health Association (2001). These include: concern with the root causes affecting health; a focus on the ‘public good’; a focus on equity/diversity/social justice; commitment to building intersectoral alliances/partnerships at the national, regional and community level to address health concerns; and programme planning/resourcing founded on a base of public input and accountability, sustainability, and continual improvement. In addition, the CPHA identified the need for Public Health services that are ‘science-based’ and efficient/cost-effective. Some clarification of these two principles is required. For instance, it should be acknowledged that a population health promotion approach to ‘evidence-based’ decision-making is based on the assumption that both traditional research and experiential learning are valid forms of ‘evidence,’ and that the use of qualitative methods to explore the processes involved in health promotion is just as ‘scientific’ as traditional epidemiological approaches (Hamilton & Bhatti, 1996). More problematic is the potential clash between principles of efficiency/cost-effectiveness and the principle of promoting the ‘public or common good.’ It is difficult to argue against the notion that the

benefits of any particular program or service must outweigh the costs. However, in order to uphold the principle of the 'public good,' any discussion of the 'costs' should include those of *not* taking action on a particular issue, and these costs should take precedence over the costs of providing the service/intervention. Some clarification regarding the principle of 'efficiency' is also required. The CPHA uses the term synonymously with cost-effectiveness. However, Janice Stein (Stein, 2001) argues that efficiency, when it is understood correctly, is "the best possible use of scarce resources to achieved a valued end" (p.6). This is certainly important, but/and it is more than a matter of cost effectiveness alone.

3. *Identification of 'essential Public Health functions.'* After the principles of Public Health are adopted, there must be a consultative process to clearly define the concept of 'essential Public Health functions' in Canada— including those that are specific to a socioenvironmental approach to health promotion. It is not enough to describe Public Health functions simply as prevention, protection and promotion— which is the usual approach. As Turnock (2000) noted, these aren't functions; they are outcomes. The functions of Public Health refer to processes required in order to achieve those outcomes. For example, one of the essential Public Health functions could be, advocacy for healthy public policies related to the social, economic and environmental determinants of health. Another essential Public Health function could be, acting as a resource on health impact assessment of government policies. Other essential public health functions could relate to building community capacity and strengthening community action for health. Without this type of definition of

Public Health functions, the concept of HP will remain primarily biomedical and behavioural in nature (as it is treated in the Romanow Report).

4. *Development of HP Infrastructure.* Once the principles, functions and legislative parameters of Public Health are established, then attention can be paid to the development of HP infrastructure. Lopez-Acuna et al. (2000) identified a number of potential dedicated institutions that could catalyze national, provincial and local HP action, including a Public Health Research Council, intersectoral organizations for HP, independent HP institutions (publicly and privately funded), and associations and networks of HP professionals. These dedicated institutions at the national level are required in order to monitor and provide support for the HP functions within the overall Public Health mandate at all levels of government. This is essential in order that the HP functions are not overlooked due to ever-present demands for health protection and disease prevention services such as immunization, communicable disease control and environmental health hazard reduction. It is even more important in provinces/territories that have devolved authority to regional health authorities, where a supportive HP infrastructure may not be maintained.
5. *Development of Professional Principles of Practice for Health Promotion.* One of the tasks of a federal agency responsible for establishing the essential Public Health functions related to HP should be the development of professional principles of practice for HP. Providers need to be recognized and supported with HP principles of practice and policies to guide their work and ensure a shared vision and values

for HP (Department of Human Services, 1998). An excellent model for this type of initiative was developed by Ewles and Simnett (cited in Department of Human Services, 1998), who proposed thirteen principles divided into three categories: (i) those that relate to the relationship between providers and recipients; (ii) those that relate to the social and environmental influences on health; and (iii) those that relate to health promotion practice. This model could be adopted as is, or it could be adapted to harmonize with the guiding principles of Public Health in Canada.

8.9 - Recommendations for Building HP Capacity at the Provincial Level

Even without the national level initiatives that are required in the long-term to support regional/local HP initiatives, there are certain actions/strategies that could be adopted at the provincial level in order to strengthen that capacity. HP capacity depends on the strengthening of the Public Health system at the provincial level. To a certain extent, most of the national level initiatives mentioned above could be replicated at the provincial level— such as the development of guiding principles and essential functions of Public Health that clearly support a socioenvironmental approach to HP and the adoption of a policy for professional principles of practice for HP. However, there are several specific recommendations that come out of the findings of this study that will be addressed here.

1. *Establishment of a Population Health Promotion Directorate within the Public Health Branch of Manitoba Health with the specific mandate of building capacity for HP in the RHAs.* Currently, there is ‘ad hoc’ provincial support to the regions in the form of epidemiologists, medical officers of health, and health policy

consultants. However, there is a need for a Directorate that specifically coordinates population health promotion strategies within and across RHAs, including: providing support to a team of HP facilitators based in each RHA; providing training in a wide variety of population-based HP skills (e.g., advocacy, community development) to RHA staff; providing support for program planning; and providing funding and logistical support for population health promotion research and evaluation within and across RHAs. One of the key tasks of such a Directorate— via its regional HP facilitators— would be to facilitate the process of defining the role that each of the key stakeholders within the health system (from the RHA Boards down to the frontline practitioners) could play in particular population health promotion initiatives, as well as facilitating the sharing of information and lessons learned across the RHAs. Another key task of the Directorate would be to facilitate the development of partnerships between the health sector and other sectors— something that is essential in order to take action on the determinants of health that lie beyond the scope of the health system. This should include provision of training for regional staff in the development of effective partnerships. It is suggested that the establishment of such a Directorate would not diminish the degree of local control of programs at the regional level, but rather, it would support and enhance regional capacity.

2. *Clarification and expansion of the definition of 'Core Health Services' related to health promotion.* Manitoba Health has stated that “health promotion/education will be required in every region” (Manitoba Health, 1997, p.6). The problem with

this statement is that it is open to interpretation, in that RHAs may choose to focus on health education related to lifestyle change and disregard other aspects of health promotion. The requirement should be revised to state that “health promotion will be required in every region” and then expanded to indicate that education may be one of several possible HP strategies utilized.

3. *Addition of ‘advocacy for healthy public policy to address the social and environmental determinants of health’ to the list of mandatory Public Health programmes under the provincial Public Health Act.* Further efforts should be made to consider revision of the *Act* to include a mandatory requirement for healthy public policy advocacy, in order that this function receives the same attention and legitimacy as other mandatory disease prevention and health protection programmes. Without this attention and legitimacy, it is unlikely that RHAs will be able to influence any of the broad socioenvironmental determinants of health affecting their populations.
4. *Reform of the Provincial/RHA funding system to allow maximum flexibility at the regional level.* Essential changes would include: replacing requirement for an annual health plan with a minimum of a 3-year plan; expansion of time lines for funded HP projects to a minimum of 3 years; block funding that allows RHAs the freedom to integrate funds from various dedicated programs (e.g., Diabetes Education Resource, Healthy Seniors) with HP programming; and priority funding of projects that focus on developing local intersectoral partnerships, community empowerment, and influencing the determinants of health, rather than a focus on

traditional 'health' outcomes. A method of global funding to the RHAs based on population health 'needs' (using both sociodemographic and population health indicators) would be desirable.

8.10 - Recommendations for Building HP Capacity at the Regional Level

1. *Development of a mission statement and 'Ends' policies at the Board level that emphasize HP goals, values.* It has been suggested that the foundation for any system (health or otherwise) is not a question of its structure or its function of governance, but the mission and culture of that system (Birse, 1998). In order to create a health-promoting organizational culture, at the very least the RHA's mission statement and Board 'Ends' policies should clearly articulate HP values and goals. Core HP values include *empowerment, public participation, influencing the broad determinants of health, equity and social justice, inter-sectoral collaboration, sustainability, and effectiveness* (Birse, 1998; Lopez-Acuna et al, 2000).
2. *Communication of HP mission statement and 'Ends' policies within and outside of the health sector.* The best mission and 'Ends' policies statements will be irrelevant if they are not actively disseminated among all levels of RHA staff and to the broader community that the RHA serves. Internal newsletters, posters, use of local media are all possible tools for communicating these messages.
3. *Development of policies and processes at the organizational level that support health promotion activities.* Policies and processes within the organization that support HP activities should follow from the HP values and goals articulated in the board's mission statement and 'Ends' policies. Examples could include: an

intentional focus of planning processes on all three approaches to HP (biomedical, behavioural/lifestyle, and socio- environmental), with a commitment to taking action on the determinants of health whenever possible; establishment of a process whereby the RHA can be a resource on health impact assessment– i.e., a process to determine the impacts of government policy decisions on the health of the community; commitment to creation of a workplace environment that empowers employees so that they are better able to empower communities; development of program planning, evaluation and workload measurement tools that acknowledge the *process* dimension of HP through the use of qualitative indicators of empowerment, participation, and staff involvement in capacity building activities; development of a HP ‘Action Plan/Framework with input from all levels; and priority support and resources for the development of partnerships within the health sector and with other sectors. It has been noted that, although a skilled workforce is essential for HP, so is the context in which people work, and this means that opportunities to promote health must be created by management through appropriate policies and support (Department of Human Services, 1998).

3. *Adoption of a policy for professional principles of practice for health promotion.* It is important that health promotion providers follow common principles of practice. The RHA should be able to adopt a standard set of principles developed at the national/provincial level. In the absence of such an initiative, the RHA should develop its own policy.
4. *Dedicated resources to advance the HP knowledge and skills of the RHA workforce,*

especially in the Public/Community Health sector. While all of the RHA workforce could benefit from increased HP knowledge and skills, it is essential that both managers and frontline practitioners in the Public/Community Health sector have access to continuing education opportunities. Ideally, this activity would be supported by a provincial HP Directorate. In the absence of supportive structures at the provincial level, the RHA must ensure that there are at least a few key individuals from all levels of the workforce who have received up-to-date education in HP knowledge and skills— especially related to advocacy and community development work, building effective partnerships, and program planning and evaluation. The development of strong links between RHAs and universities in order to take advantage of opportunities for research related to HP capacity-building should be encouraged.

8.11 - Recommendations for Further Research

This study raises a wide variety of issues/questions that warrant further investigation. For example, at the level of the individual practitioner, a number of questions have been raised related to the gap between the theory and reality of HP practice in Public Health. This is especially true in the case of Public Health Nurses (PHNs), where the following questions come to mind: Is it realistic to expect PHNs to engage in HP beyond the individual/family level? If so, what is the realistic contribution that PHNs can make toward goals of reducing inequalities in health status, establishing public policy that promotes health and fostering environments that promote health? What are the specific skills that PHNs require to engage in community- or population-level HP

strategies? How are they best learned? How can we improve the way that we teach community health nursing content to undergraduate and graduate students? Lastly, how can we develop better inter-disciplinary and inter-sectoral collaboration between PHNs and other health and human service providers? At the RHA organizational level, potential areas for further study include: exploring the feasibility of developing *process* indicators for each of the HP capacity dimensions that RHAs could use to keep track of their HP capacity development over time; exploring in more depth the potential role (including specific contributions at every level) that the RHA can play in reducing socioeconomic inequalities in health status; exploring the feasibility of establishing a process whereby the RHA can be a resource on health impact assessment; and exploring opportunities for inter-sectoral collaboration that address broad health determinants. At the provincial government level, it is imperative to explore creative ways that the provincial Health Department can provide support for HP in the regions while respecting the autonomy of the RHAs. In addition, much more work needs to be done to monitor the degree to which provincial policies impact on the health of Manitobans— with particular attention to the impact of public policies on inequalities in health status and environments that promote health. Lastly, at the national level, there is a need to explore the many issues and challenges related to building a strong Public Health and Health Promotion infrastructure within the context of current federal-provincial relations. At all levels, there is a need to further explore the way that the public, politicians and key stakeholders view health promotion and its role in the Public Health system.

The study also raises several theoretical questions. First, there are a number of

contradictions and weaknesses in the current Population Health Promotion model that require further exploration. How useful is this model? Can it be modified or is something else needed to illustrate the connection between the determinants of population health and the HP strategies required to address them? What are some of the concrete indicators or elements of each of the PHP strategies that can guide practitioners' practice? Another question that comes to mind is: how useful is the term *health promotion*? Should the health system be using another term, such as *quality of life*? Finally, and perhaps most important of all: is it possible to achieve the goals of health promotion in a society where the values of social justice and the 'common good' are absent? The work of Beauchamp (1976) on the relationship between social justice and Public Health needs to be revisited and discussed within the current Canadian context.

8.12 - Conclusion

Although the purpose of the study was not to evaluate the level of current capacity for HP in Manitoba's RHAs, the discourse on the subject suggests that the early transitional years following the establishment of RHAs in Manitoba have been characterized by a fairly low capacity for HP (no matter which definition of the term one uses). The will or commitment— and, therefore, the potential— for HP is apparent in certain key documents and is articulated by certain leaders or 'champions' both within and outside of the RHAs. However, there is a huge gap between the vision of health promotion outlined by Manitoba Health and proposed by provincial health promotion 'champions' and the reality of health promotion capacity in the Regional Health Authorities. Multiple barriers exist at all levels, both within and outside of the RHA

organization, which impede significant movement towards the transformation of the health system into one that 'invests in health' and that is characterized by the integration of a population health promotion perspective throughout all levels of the organization. There are a number of actions/activities at the national, provincial and regional levels that may increase the potential for building HP capacity in Manitoba RHAs. However, without a broader social, political and economic policy context at the regional, provincial and national levels that is committed to supporting the transformation of society as a whole to one that 'invests in health,' the ability of any single RHA to build a high degree of capacity for HP will be compromised. In particular, in the absence of a society that values social justice and the common good above all else, and that is committed to taking active steps to address the socio-environmental determinants of health— especially, reducing the social and economic inequities between populations— then the broad goals for transforming the health system outlined in Manitoba's policy statements for 'health reform' may be unattainable.

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APPENDIX A**DISCLAIMER FORM FOR ALL PARTICIPANTS**

I am conducting a research study that will explore how Manitoba's Regional Health Authorities can build capacity for population health promotion. Approval for this project has been obtained from Dr. John O'Neil, my Supervisor in the Department of Community Health Sciences, and from the Ethics Committee in the Faculty of Medicine, University of Manitoba.

I would like to interview you about your views on issues related to population health promotion. Participation in the interview is entirely voluntary, and there are no direct benefits to you personally for participating. The interview will only commence after you have had a chance to read this disclaimer, after you have had any questions about the project answered to your satisfaction, and after you have given verbal agreement to proceed. The interview will take approximately one hour and would be conducted at a time and place that is most convenient for you. You may refuse to answer any question in the interview without penalty, and you may feel free to terminate the interview at any time by simply informing me that you wish to do so.

I would like to tape-record the interview in order that I can listen more carefully to what you are saying without having to take detailed notes. The tape will then be transcribed and the information analyzed along with the information from all of the other participants. When the project is written up, the information will be presented in such a way that it will not be possible to identify any individual.

If you would like any additional information about the project, please feel free to contact me at (204) 474-9936. If you leave your name and a number where I can reach you in my voice mailbox, I will return your call as soon as possible. I can also be reached by e-mail at <bcohen@cc.umanitoba.ca>.

Thank you for your interest in this project.

Benita Cohen, R.N, M.Sc, PhD candidate

University of Manitoba

Faculty of Nursing and Department of Community Health Sciences

APPENDIX B

INTERVIEW GUIDE FOR PUBLIC HEALTH PROGRAM MANAGERS

1. Can you give me a brief summary of your position within [name] Regional Health Authority....

Roughly how long have you been in this position?

2. Over the past few years, almost every province and territory in Canada has embarked on some form of health system restructuring and there is much discussion about the future of the health care system.... One of the things that I have noticed about a lot of the discussion surrounding Health Reform is that phrases such as, '*population health*' and the '*determinants of population health*' appear again and again. In fact, some government strategic plans for Health Reform recommend that a *population health perspective* be incorporated into health planning and action at the regional level....

- A) Has there been any discussion about these concepts within this RHA?'

[If 'yes'] What type of discussion?

At what level of the organization?

Has this discussion included how to incorporate this type of perspective into health planning at the regional level?

[If 'no,' go to #2B]

- B) I think that there are probably many different interpretations of concepts such as 'population health' and 'the determinants of population health,' so there is no right or wrong answer to this next question....If someone from the local newspaper approached you and asked you, "What are some of the key elements of a population health approach to health planning?," how would you answer that (in just a few sentences)?
- C) What source(s) of information have most influenced your understanding of this 'population health' perspective?
- D) Is there any difference between a 'population health' approach to health promotion and traditional approaches to health promotion?

[If 'yes'] How would you summarize the difference?

[If 'no', go on to #3]

3. I want to go on now to discuss some of the broad strategies that have been recommended by the World Health Organization for promoting population health.....First, it is suggested that health systems need to *increase the emphasis on health promotion and disease prevention...*

A) Has there been any discussion within this RHA about the need to increase the emphasis on health promotion and disease prevention?

[If 'yes'] What type of discussion? At what level has this discussion taken place?

[If 'no,' go on to #3B]

B) I'd like to focus now on some of the factors that might make it difficult to increase the emphasis on health promotion and illness prevention in this region. In order to assist you in thinking about this next set of questions, I sent you a list of types of factors, and you may want to refer to that sheet as we go along (see handout #1). These factors could be material barriers (related to financial resources, information, organizational structure or supports), or they might be non-material barriers (attitudes, knowledge, etc.). In addition, these factors may either originate within the RHA organization or they may originate outside the RHA at the community or government level.

(i) From your perspective, are there any factors making it difficult to increase the emphasis on health promotion and illness prevention that originate *outside* of the RHA organization?

For example, at the level of the provincial government?

What about at the level of the communities in your region— e.g., would local politicians, or community members support this strategy?

(ii) What about *within* the RHA organization? Are there any factors *within* the organization that might be acting as barriers to increasing the emphasis on health promotion?

For example; related to resource allocation?

Do organizational structures or policies support this strategy?

Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of putting more emphasis on health promotion?

Do individuals within the organization have the skills that they need to focus on health promotion? If not, what types of skills do you feel are required?

- (iii) If you had to choose 3 factors that would be most critical in allowing you to place greater emphasis on health promotion, what would they be? Which factor would be #1 in importance?
4. I'd like to turn now to another strategy that has been suggested for promoting population health...this is the strategy of *advocating for public policies that create healthy living conditions and that reduce social inequalities in health*— e.g., non-smoking policy in public places, child welfare and income support policies, and so on....
- A) Do you feel that there is a role for [name] RHA to play in advocacy of healthy public policies like these?
- [If 'yes'] What is the role?
- [If 'no'] Why not? [then go on to #5]
- B) I'd like to focus now on some of the factors that might limit your ability to engage in this type of strategy....
- (i) From your perspective, are there any factors originating *outside* of the RHA organization that limit your ability to advocate for healthy public policies?
- For example, at the level of the provincial government?
- What about at the level of the communities in your region— e.g., would local politicians, or community members support this strategy?
- (ii) What about *within* the RHA? Are there any factors *within* the organization that might limit your ability to advocate for healthy public policies?
- For example; do organizational structures or policies support this type of activity?
- Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of advocating for healthy public policy?
- Do individuals within the organization have the skills that they need to engage in this strategy? If not, what types of skills do you feel are required?
- (iii) If you had to choose 3 factors that would be most critical in helping you to advocate for healthy public policies, what would they be? Which factor would be #1 in importance?
5. Let's go on now to another PHP strategy— *strengthening local community action for health*....[give examples of this type of strategy]

- A) [Are you currently engaged/ Does your program currently engage] in any of these activities?

[If 'yes'] From your perspective, are any of these activities inappropriate for a RHA to be involved in?

[If 'no'] Why not?

- B) I'd like to focus now on some of the factors that might limit your ability to engage in this type of strategy....

- (i) From your perspective, are there any factors originating *outside* of the RHA organization that limit your ability to engage in these types of activities?

For example, at the community level?

- (ii) What about *within* the RHA? Are there any factors *within* the RHA that might limit your ability to engage in these types of community capacity-building activities?

For example; do organizational structures or policies support this type of activity?

Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of strengthening community action through things like community development work?

Do individuals within the organization have the skills that they need to engage in this strategy?

- (iii) If you had to choose 3 factors that would be most critical in helping you to strengthen community action for health, what would they be? Which factor would be #1 in importance?

6. Both of the above-mentioned strategies— advocating for healthy public policy and strengthening community action for health— require collaboration with other sectors beyond the health sector (e.g., education, social services, housing, justice).

- A) Let's begin by discussing some of the barriers to engaging in this type of strategy....

- (i) From your perspective, what are some of the factors *outside* of the RHA organization that limit your ability to engage in intersectoral collaboration?

For example, do you think that other sectors are amenable to working collaboratively with the health sector?

- (ii) What about *within* the RHA? Are there any factors limiting your ability to engage in intersectoral collaboration?

For example; do organizational structures or policies support this type of activity?

Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of intersectoral collaboration?

Do individuals within the organization have the skills that they need to engage in this strategy?

- (iii) If you had to choose 3 factors that would be most critical in facilitating intersectoral collaboration, what would they be? Which factor would be #1 in importance?

7. A) From your perspective, what is the main effect that regionalization and integration of health services has had on the organization and delivery of Public Health programs to date?
- B) What long-term effect(s) do you foresee in the future?
8. Do you have any other comments that you would like to make before we end this interview?

HANDOUT #1 FOR PARTICIPANTS

“What are some of the things that would make it difficult for [you/your staff/the RHA] to effectively engage in [type of strategy]?”

Potential/Actual Barrier ▼	Source of Potential/Actual Barrier	
	Within RHA Organization	Outside RHA Organization (e.g., at level of community or at level of government)
Resource Availability: Financial Human Information		
Organizational structure/ policies		
Attitudes/Philosophy		
Knowledge/Skills		
Other....?		

APPENDIX C

INTERVIEW GUIDE FOR COMMUNITY/PUBLIC HEALTH NURSES (IN NON-SUPERVISORY POSITIONS)

1. Can you give me a brief description of your position within [name] Regional Health Authority....

Roughly how long have you been in this position?

2. Over the past few years, almost every province and territory in Canada has embarked on some form of health system restructuring and there is much discussion about the future of the health care system.... One of the things that I have noticed about a lot of the discussion surrounding Health Reform is that phrases such as, '*population health*' and the '*determinants of population health*' appear again and again. In fact, some government strategic plans for Health Reform recommend that a *population health perspective* be incorporated into health planning and action at the regional level....

- A) Has there been any discussion about these concepts within this RHA?

[If 'yes'] What type of discussion?

At what level of the organization?

Has this discussion included how to incorporate this type of perspective into health planning at the regional level?

[If 'no,' go to #2B]

- B) I think that there are probably many different interpretations of concepts such as 'population health' and 'the determinants of population health,' so there is no right or wrong answer to this next question....If someone from the local newspaper approached you and asked you, "What are some of the key elements of a population health approach to health planning?," how would you answer that (in just a few sentences)?
- C) What source(s) of information have most influenced your understanding of this 'population health' perspective?
- D) Is there any difference between a 'population health' approach to health promotion and traditional approaches to health promotion?

[If 'yes'] How would you summarize the difference?

[If 'no', go on to #3]

- E) Do you feel that you are moving towards using a 'population health' approach in your daily nursing practice?

[If 'yes'] Can you give any examples?

[If 'no'] What is stopping you from doing so?

- F) Do you have any concerns about the shift toward a 'population health' approach, and the implications for your nursing practice?

3. There is currently a model, or framework, for population health promotion that is receiving a lot of attention by policymakers and health promoters. This Population Health Promotion framework was developed in Canada, and it has been adopted (in whole or in part) by several provinces as part of their Health Reform initiatives.

[Show diagram and briefly explain PHP framework]

There are many aspects of this framework that could be discussed, but what I want to focus on here are the strategies for population health promotion that are listed on the right side..... [read them]

In order to assist you in thinking about the next set of questions, I sent you a handout with a short description of each of these strategies on one side....[see handout #2, page 2]

I would like to focus now on this first strategy— *strengthening community action*. Sometimes you will see this described simply as *strengthening communities*, whereas others use the term *strengthening community capacity*....

No matter what you call it....the central goal of this strategy is to strengthen a community's capacity for health....

- A) Are you currently involved in any of these types of activities aimed at strengthening local community action for health?

[If 'yes']: Can you describe one (or more) of these activities?

From your perspective, are any of these activities inappropriate for a PHN to be involved in?

[If 'no,' go to #3B]

B) I'd like to focus now on the types of things that might make it difficult as a PHN to engage in activities like those on this list....In order to help you think about the next set of questions, I sent you a handout that lists types of factors (see handout #1), and you may want to refer to that list as we go along....These factors could be material barriers (e.g., related to availability of financial resources, information, organizational structures or policies, etc.), or they may be non-material in nature (e.g., philosophical beliefs and attitudes)....In addition, these factors may either originate within the RHA organization or they may originate outside of the RHA at the community or government level....

- (i) Are there any factors that originate *outside* of the RHA organization-- i.e., at the community level-- that limit your ability to engage in these types of activities effectively?

For example, would all community members be willing or able to participate in these activities?

- (ii) What about factors *within* the RHA? What types of things might limit your ability to engage in this type of activity effectively?"

Is there anything at the organizational level that might be acting as a barrier to engaging in this type of activity (eg., related to resource allocation, the structure of the organization, supports, etc.)?

Do you feel comfortable with the idea of engaging in this type of activity to strengthen community action?

Do you feel that you have the skills that you need to engage in this type of activity?

C) If you had to choose 3 factors overall that would be most critical in helping you to strengthen community action and capacity for health, what would they be? Which factor would be #1 in importance?

D) How could the RHA support you in developing the skills that you require to effectively strengthen community action and capacity for health?

4. Now I would like you to go back to the original list of PHP strategies [see handout #2, page 2] and take a few minutes to read through the next three strategies— building healthy public policy, creating supportive environments, and developing personal skills.....

A) Which of these three strategies would you say that....

(i) you utilize the most in your daily practice? Why?

(ii) you utilize the least in your daily practice? Why?

Is your educational preparation a factor that influences which strategies you utilize most or least?

Does the organizational philosophy, structure, or nursing practice policies of the RHA support your involvement in any one of these strategies more than another?

Are there any of these strategies that you feel are *not* appropriate for a PHN to be involved in? If yes, why?

- B) How could the RHA support you in increasing your skills in these PHP strategies?
5. A) How has regionalization impacted on your practice as a PHN *to date*?
B) What long-term effect(s) of regionalization on your PHN practice do you foresee in the *future*?
6. Do you have any other comments that you would like to make before we end this interview?

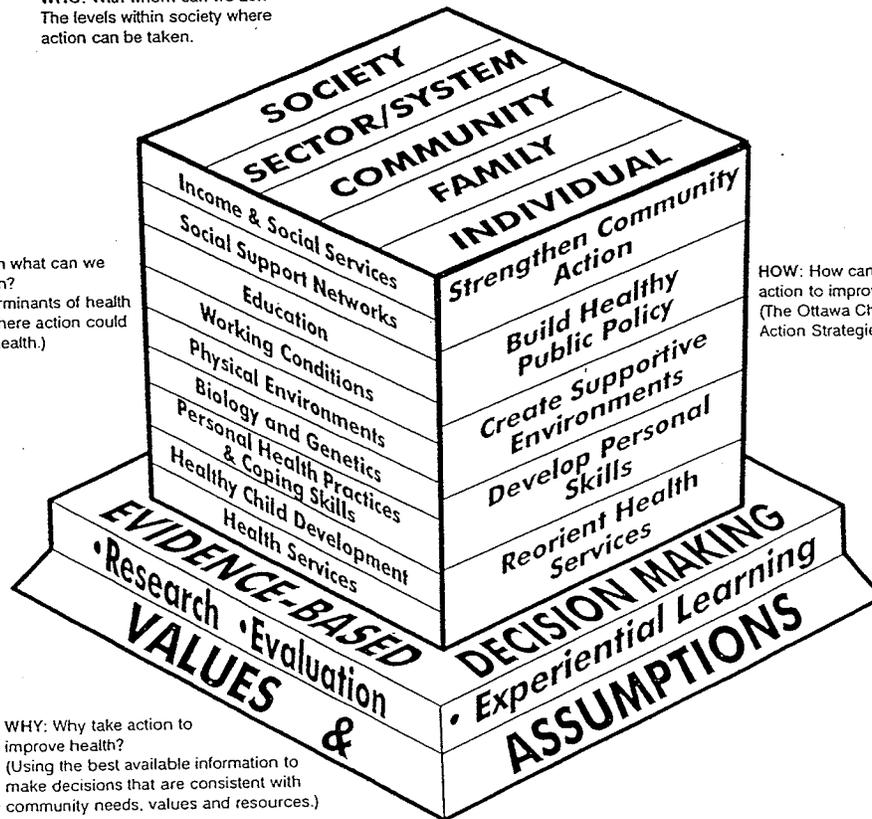
FIGURE 1 - POPULATION HEALTH PROMOTION MODEL

[page 1 of handout #2]

WHO: With whom can we act?
The levels within society where action can be taken.

WHAT: On what can we take action?
(The determinants of health - areas where action could improve health.)

HOW: How can we take action to improve health?
(The Ottawa Charter Action Strategies)



WHY: Why take action to improve health?
(Using the best available information to make decisions that are consistent with community needs, values and resources.)

[page 2 of handout #2- on reverse side of PHP model]

POPULATION HEALTH PROMOTION STRATEGIES

Strengthening Community Action

...involves supporting those activities that encourage individuals and communities to participate in, and take action on, issues that affect their health and the health of others. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavors and destinies (see attached list of activities that can strengthen community action)

Building Healthy Public Policy

...involves advocacy of any public policy that creates a setting for health (e.g., non-smoking policy in public buildings or seatbelt legislation). Advocacy involves working with others to identify most important areas where policy can make a difference, finding partners with whom to develop policy options, encouraging public dialogue on policy options, persuading decision-makers to adopt the healthiest policy option, and following up to make sure the policy is implemented.

Creating Supportive Environments

...involves generating living, working and playing conditions that are safe, stimulating, satisfying and enjoyable (e.g, infant care centres for mothers at school, workplace health and safety programs, teen drop-in centres).

Developing Personal Skills

...involves supporting personal and social development by providing information, education for health and enhancing life skills (e.g., problem-solving, parenting). By so doing, it increases the options available to people and the likelihood that they will make choices conducive to health. It is essential to enable people to learn throughout life, to prepare themselves for all of its stages and to cope with illness and injuries.

Reorienting Health Services

...involves, among other things, increasing the emphasis on health promotion and illness prevention. It is suggested that this is the only long-term way to achieve better population health and reduce the ever-increasing demand for medical and social services.

APPENDIX D

INTERVIEW GUIDE FOR C/PHNS (SUPERVISORY)

(E.G., TEAM LEADERS, BUT EXCLUDING SENIOR NURSING MANAGERS)

1. Can you give me a brief description of your position within [name] Regional Health Authority....

And how long have you been in this position?

2. Over the past few years we have been hearing more and more about the concepts of 'population health' and the 'determinants of population health.' In fact, Manitoba Health has recommended that a *population health* perspective be incorporated into health planning and action at the regional level.

- A) Has there been any discussion within the [name] RHA about 'population health' or the 'determinants of health'?

[If 'yes'] What type of discussion?

[If 'no,' go on to #2B]

- B) Very briefly, what would you say are the key features of a 'population health' perspective?

- C) How does a population, or population-based, health promotion approach differ from traditional approaches to health promotion?

- D) What source(s) of information have most influenced your understanding of this 'population health' perspective?

- E) Do you feel that PHNs in this region are moving towards using a 'population health' approach in their daily nursing practice?

[If 'yes'] Can you give any examples?

[If 'no'] What is stopping them from doing so?

- F) Do you have any concerns about the shift towards a 'population health' approach, and its implications for public health nursing practice?

3. There is currently a model, or framework, for population health promotion that is receiving a lot of attention by policymakers and health promoters. This Population Health Promotion framework was developed in Canada, and it has been adopted (in whole or in part) by several provinces as part of their Health Reform initiatives.

Here is a handout [see page 1 of handout #2] with a copy of this framework on one side, and I would like you to take a look at it now....

Very briefly, what this framework suggests is that practitioners can use one or more of the health promotion strategies listed along the right side of the model, at one or more of the levels listed along the top of the model, in order to influence one or more of the determinants of population health listed along the left side of the model....

There are many aspects of this framework that could be discussed, but what I want to focus on here are the strategies for population health promotion that are listed on the right side..... [read them]

On the reverse side of the handout there is a short description of each of these strategies...[see page 2 of handout #2]

I would like to focus now on this first strategy— *strengthening community action*. Sometimes you will see this described simply as *strengthening communities*, whereas others use the term *strengthening community capacity*...

No matter what you call it...the central goal of this strategy is to strengthen a community's capacity for health...

Are C/PHNs currently involved in any activities aimed at strengthening local community action for health?

[If 'yes'] Can you describe one (or more) of these activities?

[If 'no,' go to #2B]

- A) I'd like to focus now on the types of things that might make it difficult for C/PHNs to engage in these types of activities. In order to organize the discussion most effectively, let's look at each type of activity individually and talk about barriers to strengthening local community capacity for health that originate both within and outside of the RHA...

These barriers might be material in nature (e.g., related to availability of financial resources, information, organizational structures or policies, etc.)...Or they may be non-material in nature (e.g., philosophical beliefs and attitudes)...

- (i) Are there any factors *outside* of the RHA— i.e., at the community level—that limit your ability to engage in this activity effectively?

For example, would community members be willing to participate in this type of activity?

- (ii) What about factors *within* the RHA? What types of things might limit the ability of C/PHNs to engage in this type of activity effectively?

Is there anything at the organizational level that might be acting as a barrier to engaging in this type of activity (e.g., related to resource allocation, the structure of the organization, supports, etc.)?

Do you think that C/PHNs feel comfortable with the idea of engaging in this type of activity to strengthen community action?

Do C/PHNs have the skills that they need to engage in this type of activity?

- C) If you had to choose 3 factors overall that would be most critical in helping C/PHNs to strengthen community action and capacity for health, what would they be? Which factor would be #1 in importance?
- D) How could the RHA support C/PHNs in developing the skills that they require to effectively strengthen community action and capacity for health?

4. Now, I would like you to go back to the original list of PHP strategies [see handout #2] and take a few minutes to read through the next three strategies—building healthy public policy, creating supportive environments, and developing personal skills...

- A) Which of these three strategies would you say that....

(i) ...C/PHNs utilize the most in their daily practice? Why?

(ii)...C/PHNs utilize the least in their daily practice? Why?

Is your educational preparation a factor that influences which strategies you utilize most or least?

Does the organizational philosophy, structure, or nursing practice policies of the RHA support the involvement of C/PHNs in any one of these strategies more than another?

Are there any of these strategies that you feel are *not* appropriate for a C/PHN to be involved in?

[If yes] Why?

- B) How could the RHA support C/PHNs in increasing their skills in these PHP strategies?

5.
 - A) How has regionalization impacted on C/PHNs' practice *to date*?
 - B) What long-term effect(s) of regionalization on C/PHNs' practice do you foresee in the *future*?
6. Are there any other comments that you would like to make before we end this interview?

APPENDIX E

INTERVIEW GUIDE FOR SENIOR MANAGERS (C.E.O., V-Ps) & BOARD MEMBERS

1. Can you give me a brief description of your position within [name] Regional Health Authority....

Roughly how long have you been in this position?

2. Over the past few years, almost every province and territory in Canada has embarked on some form of health system restructuring and there is much discussion about the future of the health care system.... One of the things that I have noticed about a lot of the discussion surrounding Health Reform is that phrases such as, '*population health*' and the '*determinants of population health*' appear again and again. In fact, some government strategic plans for Health Reform recommend that a *population health perspective* be incorporated into health planning and action at the regional level.

- A) Has there been any discussion at the [Board level/senior management level] about concepts such as 'population health,' or the 'determinants of population health?'

[If 'yes'] What type of discussion? Has this discussion included how to incorporate this type of perspective into health planning at the regional level?

[If 'no,' go to #2B]

- B) I think that there are probably many different interpretations of concepts such as 'population health' and 'the determinants of population health,' so there is no right or wrong answer to this next question....If someone from the local newspaper approached you and asked you, "What are some of the key elements of a population health approach to health planning?," how would you answer that (in just a few sentences)?
- C) What source(s) of information have most influenced your understanding of this 'population health' perspective?

3. Several strategies have been recommended for promoting the health of populations. I would like to spend a little time now talking about two of those strategies.... First, it is suggested that health systems need to *increase the emphasis on health promotion and disease prevention*...

- A) Has there been any discussion at the [Board level/senior management level] about increasing the emphasis on health promotion and disease prevention?

[If 'yes'] What type of discussion?

[If 'no,' go on to #3B]

B) I'd like to focus now on some of the factors that might make it difficult to increase the emphasis on health promotion and illness prevention in [name] RHA. In order to assist you in thinking about this next set of questions, I sent you a list of types of factors, and you may want to refer to that sheet as we go along. These factors could be material barriers (e.g., related to financial resources, information, organizational structure or supports), or they might be non-material barriers (e.g., attitudes, knowledge, etc.). In addition, these factors may either originate within the RHA organization or they may originate outside the RHA— e.g., at the level of citizens in your communities or at the level of government....

(i) From your perspective, are there any factors making it difficult to increase the emphasis on health promotion that originate *outside* of the RHA organization?

For example, at the level of the provincial government? (e.g., funding)

What about at the level of the communities in your region— e.g., would local politicians, or community members support this strategy?

(ii) What about *within* the RHA organization? Are there any factors *within* the RHA that might be acting as barriers to increasing the emphasis on health promotion?

Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of putting more emphasis on health promotion?

Do individuals within the organization— e.g., Board members— have the knowledge and/or skills that they need to make decisions regarding increased emphasis on health promotion and illness prevention? If not, what types of knowledge/skills would they need?

(iii) If you had to choose 3 of these factors that would be most critical in allowing you to place greater emphasis on health promotion, what would they be? Which factor would be #1 in importance?

4. I'd like to turn now to another strategy that has been suggested for promoting population health. This is a strategy that recognizes that many of the determinants of population health lie outside of the traditional health care system....and it involves *advocating for public policies that create healthy living conditions and that reduce social inequalities in health*— e.g., non-smoking policy in public places, child welfare and income support policies, and so on....

- A) Do you feel that there is a role for [name] RHA to play in advocacy of healthy public policies like these?

[If 'yes'] What is the role?

[If 'no'] Why not? [then go on to #5]

- B) I'd like to focus now on some of the factors that might limit your ability to engage in this type of strategy....

- (i) From your perspective, are there any factors originating *outside* of the RHA organization that limit your ability to advocate for healthy public policies?

How much influence do you think that you can have at the regional level regarding policies that are set at the provincial or national level (e.g., income security)?

- (ii) What about *within* the RHA? Are there any factors *within* this organization that might limit your ability to advocate for healthy public policies?

Do you feel that individuals within the organization— including yourself— feel comfortable with the idea of advocating for healthy public policy?

Do individuals within the organization have the skills that they need to engage in this strategy?

- (iii) If you had to choose 3 factors that would be most critical in helping you to advocate for healthy public policies, what would they be? Which factor would be #1 in importance?

5. Has there been any discussion at the [Board level/senior management level] regarding changes in the organization and delivery of Public Health programs as a result of the regionalization and integration of health services in [name] RHA?

[If 'yes,'] What type of discussion?

[If 'no,' go on to #6]

6. Do you have any other comments that you would like to make before we end this interview?

APPENDIX F

INTERVIEW GUIDE FOR DISTRICT ADVISORY COMMITTEE MEMBERS

1. I wonder if you would start by describing the purpose of the District Advisory Committee (DAC)...

How did you come to be a member of the DAC? How long have you been a DAC member?

2. Over the past few years the terms, 'population health' and the 'determinants of population health', have become increasingly common among people who talk and write about the health care system.

- A) Has there been any discussion on the DAC about 'population health' or the 'determinants of population health'?

[If 'yes'] What type of discussion?

[If 'no,'] Have you ever heard of these phrases? [If 'yes,' go on to #2B][If 'no,' go on to #3]

- B) I think that there are probably many different interpretations of concepts such as 'population health' and the 'determinants of population health,' so there is no right or wrong answer to this next question.....If someone said to you: We need to use a 'population health' approach in [name] RHA, what would that mean to you?

- C) What source(s) of information have most influenced your understanding of terms such as 'population health' and the 'determinants of population health'?

3. It has been suggested that, in order to promote population health, the health services system needs to start putting much more emphasis on health promotion and illness prevention.

- A) Has there been any discussion about this in the DAC?

[If 'yes'] What type of discussion?

[If 'no'] Why do you think that there hasn't been any discussion of this issue?

- B) What is your feeling about how much importance citizens in your region place on health promotion and illness prevention?

Why do you think the public feels that way about HP/DP?

- C) Are there any issues in particular that you think should be a priority for health promotion efforts in your region?
4. Do you have any other comments that you would like to make before we end this interview?

APPENDIX G:

INTERVIEW GUIDE FOR CURRENT MANITOBA HEALTH EMPLOYEES

- “I’d like to ask you to start by giving me a brief summary of your current role within Manitoba Health, and how long you have been in this position?”

- “Many of the documents that have been produced by Manitoba Health over the past five years or so refer to the concept of ‘population health,’ and it is suggested that the health care system needs to adopt a ‘population health approach’....

“My experience so far is that, if you put 5 people in a room and ask them to define a ‘population health approach’, you may get 5 different answers....

“So there is no right or wrong answer to my first question...I’m just interested in your perspective..... The question is.....

“If you had to define the concept of using a *population health approach* in just a few sentences, how would you describe it?”

- “In what ways would you say that Manitoba Health is currently integrating a *population health approach* into its program planning?”
- “Is health promotion within a population health approach any different from traditional approaches to health promotion?”
- “I’m interested in how to build capacity for population health promotion in Manitoba’s RHAs....

“By capacity, I am referring to both the will or intention to focus on health promotion, and the infrastructure to carry out health promotion activities (e.g., policies, funding, human resources)....

“What is the role– in an ideal world– that Manitoba Health should take in building capacity for population health promotion in Manitoba’s RHAs?”

“What are the barriers to achieving that ideal role?”

“What is Manitoba Health currently doing, or planning to do, to build capacity for population health promotion?”

- “Health Canada has developed a *Population Health Promotion Framework* which looks like this [show framework]....Basically, this framework suggests that [describe model briefly]....

“As far as the broad determinants of health are concerned, there seems to be growing evidence that social and economic inequalities are probably the most important determinant of the health of any population.....

“Do you believe that Manitoba Health has a role to play in taking action on social and economic inequalities? If so, what would that role be?”

APPENDIX H:

INTERVIEW GUIDE FOR FORMER MANITOBA HEALTH EMPLOYEES

- “I’d like to ask you to start by giving me a brief summary of your former employment within Manitoba Health, and how long you were in that position?”

- “Many of the documents that have been produced by Manitoba Health over the past five years or so refer to the concepts of ‘population health’ and the ‘determinants of health’
 “When you were working with Manitoba Health, was there any discussion of these concepts? If so, what was the nature of the discussion?”

- “My experience so far is that, if you put 5 people in a room and ask them to define a ‘population health approach’, you may get 5 different answers....
 “So there is no right or wrong answer to my first question...I’m just interested in your perspective...
 “If you had to define the concept of using a *population health approach* in just a few sentences, how would you describe it?”

- “Do you see health promotion within a population health approach as being any different from traditional approaches to health promotion?”

- “I’m interested in how to build capacity for population health promotion in Manitoba’s RHAs....
 “By capacity, I am referring to both the will or intention to promote health, and the infrastructure to carry out health promotion activities (e.g., policies, funding, human resources)....
 “During your period of employment with Manitoba Health, what was your sense of Manitoba Health’s capacity for health promotion– in terms of (i) will or intention; and (ii) infrastructure (funding, human resources, policy)?”

- “Health Canada has developed a *Population Health Promotion Framework* which looks like this [show framework]....Basically, this framework suggests that [describe model briefly]....

“As far as the broad determinants of health are concerned, there seems to be a growing body of evidence that social and economic inequalities are probably the most important determinant of the health of any population.....

“Do you believe that Manitoba Health has a role to play in taking action on social and economic inequalities? If so, what would that role be?”

APPENDIX I**DISCLAIMER FOR PARTICIPANTS OF 'THINK TANK'**

DISCLAIMER FOR PARTICIPANTS

This 'Think Tank' represents the final stage of a research project that I am undertaking as part of my Doctoral programme in Community Health Sciences at the University of Manitoba. Approval for this project has been obtained from Dr. John O'Neil, my supervisor in the Department of Community Health Sciences, and from the Ethics Review Committee of the Faculty of Medicine.

The 'Think Tank' will provide an opportunity for individuals who have been recognized by their peers as having a strong commitment to health promotion to discuss issues related to building capacity for health promotion in Manitoba's Regional Health Authorities.

Discussion, both in large and small groups, will be tape-recorded, as well as recorded in writing through various methods (notes, flip charts, overheads, etc.). The purpose of tape-recording is to allow me to capture the details and contextual dimensions of the discussions that will not be evident from information recorded in writing (point form).

When the analysis of the 'Think Tank' is produced, all comments made during the discussions will be reported anonymously— i.e., in a way that it will not be possible to identify any individual. The list of participants will not be published.

A short report on the 'Think Tank' will be disseminated to all participants as soon as possible after the event. A more detailed analysis will be included in the PhD dissertation (which will, unfortunately, take longer to produce).

Your presence at the meeting on April 30th will indicate that you agree with these conditions of participation.

If you would like any additional information about the project, please feel free to contact me at (204) 474-9936. If you leave your name and a number where I can reach you in my voice mailbox, I will return your call as soon as possible. I can also be reached by e-mail at:

Benita_Cohen@umanitoba.ca

Thank you for your interest in participating in this event. I look forward to seeing you on April 30th!

Benita Cohen, RN, PhD(c)

Faculty of Nursing and Department of Community Health Sciences

University of Manitoba

APPENDIX J - 'THINK TANK' HANDOUT:
SUMMARY OF BARRIERS TO HP CAPACITY IDENTIFIED IN PHASE 1
(See following tables)

FACTOR	INTRA-SYSTEM	EXTRA-SYSTEM
<p>ATTITUDES/BELIEFS</p> <p>Political ideology</p> <p>Personal beliefs</p> <p>[Organizational philosophy/vision]</p>	<p>❖ <i>Valuing of HP</i></p> <ul style="list-style-type: none"> ➡ Perception that health practitioners in the acute care sector do not value HP in general. ➡ Perception that some DHAC/Board members, Senior Administrators may not value HP as much as acute/rehab care (e.g. "there is much talk about the need to increase HP, but no action") <p>❖ <i>Philosophy/Definition of HP</i></p> <ul style="list-style-type: none"> ➡ Lack of shared philosophy/definition of HP as an approach throughout RHA (i.e., many see it primarily as disease prevention through behaviour change - as opposed to a broader 'health-focused' socio-environmental perspective) ➡ Conflicting views of role of RHA in advocacy for healthy public policy - everyone agrees that there is a role, but disagreement about who should do what (frontline staff worried about going against RHA policy; senior administrators worried about 'biting the hand that feeds'; concern about alienating potential community partners, etc.) ➡ HP viewed as domain of the CH/PH sector rather than all sectors 	<p>❖ <i>Valuing of HP</i></p> <ul style="list-style-type: none"> ➡ Perception that public is most concerned with availability of/access to acute care services (HP viewed primarily as an individual responsibility, not the health care system's responsibility) ➡ Media focuses on acute care issues, not on HP issues. ➡ Ministry of Health's public statements focus primarily on acute care issues, not on HP issues <p>❖ <i>Philosophy/Definition of HP</i></p> <ul style="list-style-type: none"> ➡ Lack of clearly articulated philosophy/definition of HP in Ministry of Health documents; more emphasis on 'population health' and the 'determinants of health' - but without link to HP strategies ➡ Lack of public understanding of broad definition of HP, 'population health,' etc., and lack of acceptance that CD work and advocacy for healthy public policy is the responsibility of health care

FACTOR	INTRA-SYSTEM	EXTRA-SYSTEM
RESOURCES	<p>❖ <i>Funding:</i></p> <ul style="list-style-type: none"> ➡ Pressure to meet acute care service demands first means that Board, senior management have little flexibility to allocate resources to HP/IP ➡ If RHA's requests for funding of new initiatives aren't granted from Manitoba Health, then little flexibility to allocate resources to HP/IP <p>❖ <i>Human Resources:</i></p> <ul style="list-style-type: none"> ➡ May be influenced by lack of funding or by other demands on staff. For example: ➡ Early d/c of newborns/moms means that caseload of PHNs has increased and become more clinical, leaving less time for HP/IP (esp. CD work) <p>❖ <i>Information/Technology</i></p> <ul style="list-style-type: none"> ➡ Staff not always able to access Internet resources ➡ Staff no longer can access Manitoba Health as information clearinghouse and source of other resources 	<p>❖ <i>Funding:</i></p> <ul style="list-style-type: none"> ➡ No targeted funding for HP from Manitoba Health -- RHAs 'inherited' pre-RHA baseline funding (which was decreased prior to regionalization) and must request funds for new initiatives on 'ad hoc' basis. <p>❖ <i>Human Resources:</i></p> <ul style="list-style-type: none"> ➡ as above <p>❖ <i>Information/Technology</i></p> <ul style="list-style-type: none"> ➡ Manitoba Health has dismantled its resource library

FACTOR	INTRA-SYSTEM	EXTRA-SYSTEM
<p>ORGANIZATIONAL STRUCTURE/ CULTURE/ POLICIES/ PRACTICES/ SUPPORT</p> <p>Policies/Programs</p> <p>Management (leadership, mentoring)</p> <p>Communication</p> <p>Evaluation/Research</p> <p>[Organizational philosophy/vision]</p>	<p>❖ <i>Policies</i></p> <ul style="list-style-type: none"> ➡ RHAs must now develop own HP policies/programs/process and outcome indicators (may take years) ➡ RHAs' mission/values statements or other policy/planning documents don't necessarily define approach to HP and establish specific HP goals/priorities ➡ Lack of regional policy re: professional practice principles for HP <p>❖ <i>Organizational Culture/Structure</i></p> <ul style="list-style-type: none"> ➡ Question raised: "How to make RHAs 'health promoting organizations'?" ➡ Within CH/PH sector, lack of clear direction re: responsibility for HP - i.e., is this a specialized role or should everyone be promoting health? (if the latter, to what extent?) ➡ Some concern that RHA culture does not necessarily reflect HP values of equity/justice, empowerment, public 	<p>❖ <i>Policies</i></p> <ul style="list-style-type: none"> ➡ Provincial goals for population health outlined in policy documents (such as <i>Action Plan for Manitobans (1992)</i>, <i>Quality Health for Manitobans (1999)</i>) - are very broad (e.g., "foster environments that support health," "promoting disease prevention and wellness") - lack of specific goals for health promotion. ➡ Lack of provincial HP program/ directorate with designated HP personnel ➡ Lack of provincial standards for health promotion programs and practice. ➡ Lack of visible support by province for 'Healthy Communities' network

FACTOR	INTRA-SYSTEM	EXTRA-SYSTEM
	<p>participation (e.g., employees not always encouraged to participate in decision-making; inequities in the workplace still exist (lack of parity in compensation between employees working in institutional settings and those working in community settings</p> <p>❖ <i>Research/Evaluation</i></p> <ul style="list-style-type: none"> ➤ Lack of research capability within RHAs— i.e., each RHA must develop their own capability and, therefore, this may leave some RHAs at a disadvantage ➤ Lack of workload indicators that capture the scope of HP activity (e.g., CD work not captured in stats) ➤ Lack of process indicators that monitor HP capacity ➤ Lack of outcome indicators that capture goals of HP (e.g., empowerment, effective partnerships, etc.) 	<p>❖ <i>Research/Evaluation</i></p> <ul style="list-style-type: none"> ➤ No clear strategy by Manitoba Health re: research program to support RHAs (ad hoc support at present, mostly related to providing info re: population 'health' status indicators) ➤ Inadequate provincial funding for community health promotion research (tends to be more federal monies)

FACTOR	INTRA-SYSTEM	EXTRA-SYSTEM
<p>KNOWLEDGE/SKILLS</p> <p>Frontline staff</p> <p>Management/Board</p>	<p>➡ Knowledge of HP theory, strategies among RHA employees and Board members, is very uneven and may be narrow in scope (individuals at all levels particularly unconfident about abilities r/t advocating for healthy public policy and community development work)</p> <p>➡ R.N.s with diploma education have very little background in HP theory/practice compared to degree-prepared nurses</p> <p>➡ Many PHNs state that they feel most competent/comfortable doing one-on-one counselling/teaching</p> <p>➡ Program managers may have little experience with HP theory/practice (esp. related to CD)</p> <p>➡ Lack of opportunities for in-servicing or continuing education in specific HP knowledge/skills</p>	<p>➡ Knowledge/skills of potential partners (in other agencies, sectors, community organizations) is uneven and may be narrow in scope</p>