Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Registered Nurses' Association of Ontario (RNAO)

Feedback on revised Standards for Public Health Programs and Services

Written Submission to the Ministry of Health and Long-Term Care

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Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP), and nursing students in all roles and sectors across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contributions to shaping the health system, and influenced decisions that affect nurses and the public they serve.

RNAO appreciates the opportunity to provide feedback to the Ministry of Health and Long-Term Care (MOHLTC), Population and Public Health Division, on the *Standards for Public Health Programs and Services Consultation Document*.[1] This submission has been informed by our expert members working in public health through the Community Health Nurses' Initiatives Group (CHNIG), public health nurses working specifically to advance health equity through action on the social determinants of health, and ongoing research to support population health and health equity by RNAO staff.

RNAO appreciates the importance of modernizing the *Ontario Public Health Standards* (OPHS) since its last iteration in 2008 in order to advance the province's Patients First Strategy.[2] RNAO has been actively engaged in providing evidence-informed solutions to health system transformation[3] [4] [5] [6] to support the "structural changes that are necessary to achieve an improved, integrated, and efficient health system in Ontario that moves to one that is more person centred."[7]

Improving Population Health and Decreasing Health Inequities Through the *Ontario Public Health Standards*

The overarching goal of public health programs and services is "to improve and protect the health and well-being of the population of Ontario and reduce health inequities."[8] RNAO endorses this goal as it is consistent with international,[9] [10] [11] national,[12] [13] [14] and provincial[15] [16] [17] [18] evidence-informed public policy and is congruent with RNAO's organizational values.[19]

Organizational standards, including the 2008 version of the *Ontario Public Health Standards*, have been identified as one of ten promising practices to reduce social inequities in health at the local public health level.[20] OPHS 2008 has been recognized as providing "a theoretical framework to address health inequities" as well as a "mechanism by which local public health can work to reduce them."[21] RNAO appreciates the opportunity that the MOHLTC is taking to build on content that supports health equity in the 2008 OPHS[22] through the 2017 OPHS revision process. In particular, the MOHLTC is to be commended for strengthening opportunities to address health inequities by embedding it into all public health work through the introduction of a new Health Equity Foundational Standard.

A substantive concern that RNAO has with draft 2017 OPHS is that the critical goal of improving population health and decreasing health inequities is undermined by a lack of coherence in the policy framework for public health programs and services (figure 2, p. 5).

There is a well-established body of literature on population health,[23] [24] [25]social determinants of health,[26] [27] social determinants of health inequities,[28] [29] and opportunities for public health to reduce health inequities[30] [31] [32] that contradicts this policy framework's focus on healthy behaviours as a domain/objective. If the actual intention is to focus on upstream approaches[33] to decrease health inequities then it is logically inconsistent to spotlight healthy behaviours framed as choices made by individuals. Too often attributing "poor choices" to knowledge deficits, moral failings, or lack of personal responsibility leads to blaming people who are already marginalized. This is not helpful for people who experience discrimination attributed to behaviour, limits the reduction of health inequities and may even make some health inequities worse.[34] [35] Evidence overwhelmingly shows that a lifestyle approach in the absence of robust upstream social determinants of health policy does not lead to health equity and/or improved outcomes in population health.

"Lifestyle drift" has been described as the "tendency to recognize the need to act on the more structural determinants of health inequalities but to instead develop interventions targeting the more behavioural determinants of health."[36] OPHS language of "upstream efforts" (p. 3) but operationalizing behavioral health fits perfectly with the metaphor of policy that starts by "recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors."[37]

RNAO urges that instead of exacerbating lifestyle drift in the OPHS, the MOHLTC must utilize the World Health Organization's conceptual framework on the social determinants of health (as intermediary determinants of health) and social determinants of health inequities (or the structural determinants of health inequities). Appendix 1 of this document includes figures and references for this conceptual framework, a framework for tackling social determinants of health inequities, a priority public health conditions analytic framework, and an application of priority public health conditions analytic framework to alcohol-attributable harm. Alcohol was chosen as a timely example since the province currently has a "healthy behaviours" approach with a focus on Canada's Low-Risk Alcohol Drinking Guidelines and encouragement to "drink responsibly."[38] While these measures might assist some individuals, the bigger threat to population health and health equity is the province's expansion of the physical availability of alcohol and lack of a public health evidence-informed provincial alcohol strategy.[39]

Just as there is an expectation that current theory and evidence will inform public health practice for safe water, rabies control, and reduced transmission of tuberculosis, so too must the OPHS use the same rigorous approach to advance population and health equity. Lessons can be learned from the NHS Health Scotland's analysis of

epidemiological data to address the question: "what would it take to eradicate health inequalities?"

Evidence that all-cause socio-economic inequalities in mortality persist despite reductions for some specific causes, and that inequalities are greater with increasing preventability, suggest that focusing on reducing individual risk and increasing individual assets will ultimately be fruitless in reducing inequalities and may even increase them. Elimination and prevention of inequalities in all-cause mortality will only be achieved if the underlying differences in income, wealth and power across society are reduced.[40]

RNAO Feedback, Questions, and Recommendations

RNAO's specific feedback, questions and recommendations linked to the draft 2017 OPHS document have been organized below in a table format.

OPHS Document	RNAO Feedback, Questions, and Recommendations
Figure 1: What is Public Health? Population health approach circle shown in Figure 1 shows four segments: population health assessment; social determinants of health; healthy behaviours; and healthy communities. Text for healthy behaviours reads: "supporting people to make the healthiest choices possible." p. 3	Please see previous substantive feedback on the imperative to incorporate current theories and evidence as current framing works against population health and health equity goal. According to the Ontario's Public Health Sector Strategic Plan, "public health is the organized efforts of society to prevent illness, disease and injury through a sustained combination of approaches, including one-on-one health services, health promotion, health protection and healthy public policies."[41] Or, as the Public Health Agency of Canada defines public health: "an organized activity of society to promote, protect, improve, and when necessary, restore the health of individuals, specified groups, or the entire population. It is a combination of sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all people."[42] These definitions are helpful in their recognition of public health as a societal activity with opportunities to impact the health outcomes of individuals, families, groups, and population. The later definition is helpful in recognition of "sciences, skills, and values."
Figure 2: Policy Framework Domains and objectives for social determinants of health and healthy behaviours p. 4-5	Please see previous substantive feedback on the imperative to incorporate current theories and evidence as current framing works against population health and health equity goal. The explicit focus on assessing health status that extends beyond traditional health indicators to social factors and beyond traditional morbidity/disease to mental and social well-being is welcome.
Public health transformation is triggered by a series of drivers. p. 6	RNAO asks that our analysis of elements to be considered in public health alignment within the LHIN mandate -- found in ECCO 2.0[43] and in submission on *Bill 41: Patients First Act, 2016*[44] be referenced on this.

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	Global movement to advance health equity as discussed above should be included as a driver. Truth and Reconciliation Commission[45] and Ontario's *The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples*[46] should also be listed as triggers for transformative change.
Boards of health delegate authority for the day-to-day management and administrative tasks to the Medical Officer of Health (MOH) (and CEO or other executive officers) p. 7	The roles, functions, and competencies of Medical Officers of Health and Chief Executive Officer are distinctly different. Given the necessary content expertise and the heavy demands of these two distinct roles (MOH and CEO), RNAO urges in the strongest possible way, to separate the role of MOH and that of CEO. Indeed, this is the case in all other sectors. The role of CEO should be open to any health professional that meets the necessary requirement of management and administrative oversight.
Partnership, collaboration and engagement, including with "priority populations" p. 10	An identified concern with the term "priority populations" is that "without specific inclusion of social justice values, the term can be interpreted too broadly, and be used to identify populations not experiencing disadvantages."[47] High risk, vulnerable, marginalized, and equity-seeking groups are among the many terms often used but every label needs unpacking in each context to address power dynamics influenced by language.[48] Consistent with the health equity evidence, care must also be taken to focus on the broader conditions that create inequities rather than the groups. "For example, 'the homeless' may be viewed as a group of people without housing in need of individual-level intervention, as opposed to recognizing the effect of structural conditions that affect homelessness such as an inadequate supply of affordable housing or the history of colonization. We need to think about 'what are the structural conditions in which vulnerabilities are created?,' instead of only the groups we see being affected and at risk."[49] Resources for unpacking and operationalizing these concepts may be found at websites linked to the World Health Organization,[50] and the National Collaborating Centres funded by the Public Health Agency of Canada, including the National Collaborating Centre for Determinants of Health,[51] National Collaborating Centre for Healthy Public Policy,[52] and the National Collaborating Centre for Aboriginal Health.[53]
Population Health Assessment Foundational Standard, p. 12-13	The technical briefing noted the removal of the Nutritious Food Basket Protocol from the 2008 OPHS version under Chronic Disease Prevention. This MOHLTC briefing said "collecting data on the cost of a nutritious food basket remains in the Population Health Assessment and Surveillance Protocol."[54] RNAO affirms how critical the data from the Nutritious Food Basket Protocol is to research on health and social policy related to the social determinants of health inequities. This protocol is a structure-based intervention[55] as well as a tool that compares income levels for people receiving social assistance or minimum wage with the actual cost of

OPHS Document	RNAO Feedback, Questions, and Recommendations
	food and shelter. It is imperative that this information still be collected across the province and be readily available to help track progress on the province's poverty reduction plan. Ensure that priority populations/ equity-seeking groups/ people with lived experience of being marginalized are consulted and engaged in a meaningful way as part of the population health assessment. It would be helpful to provide guidance and share best practices on respectful, inclusive processes, including the need for adequate time and resources to build authentic relationships.
Health Equity Foundational Standard, p. 15-16	The stronger mandate to engage, build, and/or develop relationships with Indigenous communities and organizations is essential and fills a foundational gap. The goal of this standard is consistent with the WHO conceptual frameworks. "Public health practice aims to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances." This framing better serves the overarching goal of reducing health inequities compared with the downstream objective of "reducing the negative impact of social determinants of health that contribute to health inequities" p. 5. Suggest revising second bullet on p. 16 to read: "Community partners and the public are aware ***and engaged*** in local strategies to address health inequities and their causes through ***policy development and policy advocacy."*** Suggest revising number 4, requirements, on p. 16 to read: "The board of health shall lead, support, and participate with other stakeholders in policy development, ***policy advocacy***, health equity analysis, and promoting decreases in health inequities." Advocacy is not mentioned in the OPHS although it is "a critical population health strategy that emphasizes collective action to effect systemic change."[56] Advocacy is a critical means of improving health equity[5758] and is a core competency of public health professionals.[59]
Effective Public Health Practice Foundational Standard, 17-18	Concerns were raised about continuity of services and continuity of care for vulnerable clients who might fall through the cracks during system transformation. Please see discussion on sexual health clinical services and harm reduction services. Evidence-informed decision-making when starting, stopping, and changing programs and policies will require utilization of tools such as the Health Equity Impact Assessment[60] informed by collaborating with equity-seeking groups.
Chronic Diseases and Injury Prevention, Wellness and Substance Misuse Standard, 22-24	There is a concern that a lack of overall minimum standards in the effort to allow for increased flexibility may allow for too much interpretation and so increase variability among health units. The Children Count report[61] identified a need for a more coordinated and consistent surveillance approach across the province. The risk is that

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	current gaps in surveillance data will worsen and the province will lack comparable health status information. Consistent with clearly described public health roles and evidence-based interventions, more language is needed on comprehensive health promotion strategies (capacity building, supportive environments, skill development, policy development) as was in the previous standards. Cannabis is not specifically named as a requirement. In the context of pending legalization, this is an important public health issue. There is a need for a provincial strategy on cannabis and youth. There is a need for a public health evidence-informed provincial alcohol strategy.[62]
Healthy Environments Program Standard, 27-28	RNAO commends the expansion of the goal of this standard to include the promotion of "the development of healthy natural and built environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate." Consistent with RNAO's ongoing health equity feedback, it is also critical to address environmental challenges such as climate change, extreme weather, pollution, etc. through context specific strategies that tackle both structural and intermediary elements as shown in the Appendix. Structural determinants of health inequities lead to stratification with differential exposure, vulnerabilities, and consequences for disadvantaged groups. Public health units should be developing healthy public policy and developing community partnerships to support mitigation, preparedness, and building resiliency within municipal governments and in the community related to extreme weather, especially for marginalized and vulnerable populations. The Chicago heat wave of 1995 with its high mortality of racialized people living in poverty and isolation is a cautionary case study to illustrate this argument.[63]
Healthy Growth and Development Program Standard, 29-30.	As population health encompasses populations from preconception to death, RNAO recommends changing the title and focus of this standard to "Healthy Growth, Development and Aging." The draft OPHS do not mention "seniors" or "aging." Considering the growth of this demographic in our population[64] and the intention that public health play a role in health system planning, this is a serious omission. Where in the standards will the needs of children and youth who are not in school be addressed? Missing elements include: • Baby-Friendly Initiative (BFI) • direction to increase rates of breastfeeding to six months

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	• nutrition, including food insecurity • sleep A protocol for post-partum depression screening is required.
Infectious and Communicable Diseases Prevention and Control Program Standard, p. 36	RNAO is concerned about the implications for clients and the community of replacing language around "provision" to "promoting access" to sexual health clinical services, and harm reduction programs and services. **Sexual health clinical services:** Continued access to specialized STI testing and treatment, low cost contraception, and Pap testing for populations at risk is a crucial service. A review of sexual health clinical services in Toronto indicated that current providers, such as community health centres, do not have the capacity to provide this service to more clients. Additionally, this change could limit access to confidential services for youth and stigmatized populations that do not feel comfortable accessing their health care provider. It would also compromise access for people without a health care provider, including people without OHIP. **Harm reduction programs and services**: RNAO is deeply concerned that this change seems to be a weakening of public health's role in harm reduction and the importance of these services. This is alarming in light of recent opioid overdoses and deaths across the province[65] and the need for increased harm reduction including supervised injection services.[66]
School Health Program Standard, p. 42-43	Consistent with the evidence on the contribution of public health nursing in school settings to improve health,[67] [68] [69] RNAO applauds the new School Health Program Standard. Public health nurses are ideally situated to make a difference in the lives of children, families, and school communities by providing direct services, and engaging in health promotion, and disease prevention. RNAO looks forward to working with the MOHLTC on operational issues related to moving this important opportunity forward. Additional areas of health promotion we identified include: • cancer prevention • diabetes prevention • injury prevention • supporting newcomers • supporting children and youth through the education system As older adolescents continue to need public health nursing support while they individuate from their families in the sometimes unfamiliar new surroundings of a college or university, RNAO recommend that this School Health Standard include post-secondary students. Vision screening is included but there is conflicting evidence about the effectiveness of this type of program. It is difficult to get buy-in

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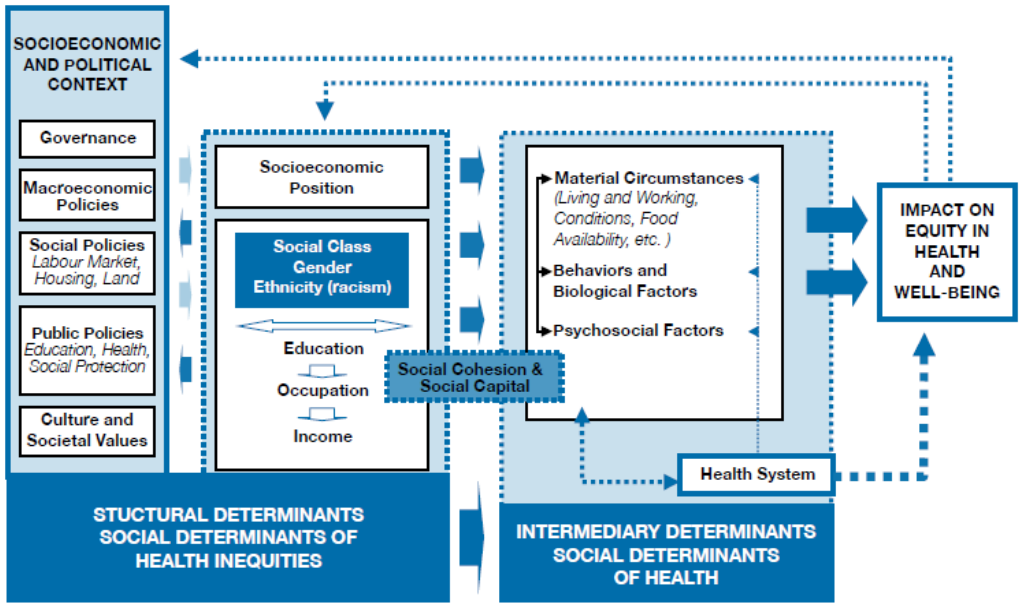
	when the evidence is weak. More specific information about what interventions are expected and a protocol will be required before being able to assess the implications for health units. RNAO recommends that vision screening be integrated into the other public health screening programs in consultation with the Ministry of Children and Youth Services and a similar model be applied. This comment crosses both the Immunization and School Health standards. Greater clarification is required about expectations related to children in schools, school-aged children and working with schools, and the rationale for including immunization in the School Health Standard.
For all program standards	Some health units may not view foundational standards as needing to be met by individual programs so long as they are met by centralized support services. As a result, RNAO recommends that all program standards include outcomes related to social determinants of health and social determinants of health inequities. As written now, program outcomes have a lifestyle and behavioural focus that does not advance the goal of improving health equity. All programs need to engage in meaningful ways with those with lived experience/priority populations/equity-seeking groups to help inform work. Policy advocacy and policy development should be built into all program standards as upstream interventions to impact health equity.
Implementation considerations	Time and resources are required to build capacity to implement the standards utilizing best practices in leadership and change management. This could involve: • restructuring within public health units? • development and implementation of new policies and procedures? • changing of staff roles? hiring? labour relations? • education and training, including cultural safety, cultural sensitivity, meaningful engagement with people with lived experience? • prevention of unintended impacts such as possible re-allocation of health unit resources to centralized, internal positions thereby impacting staff ability to work directly with priority populations on health inequities? • access to data and analysis support for health units where capacity is limited?

Thank you for considering this feedback in support of the critical goal of improving population health and decreasing health inequities. Please do not hesitate to be in touch if additional information would be helpful.

Appendix 1

Frameworks from the Commission on the Social Determinants of Health

Figure A. Final form of the CSDH conceptual framework



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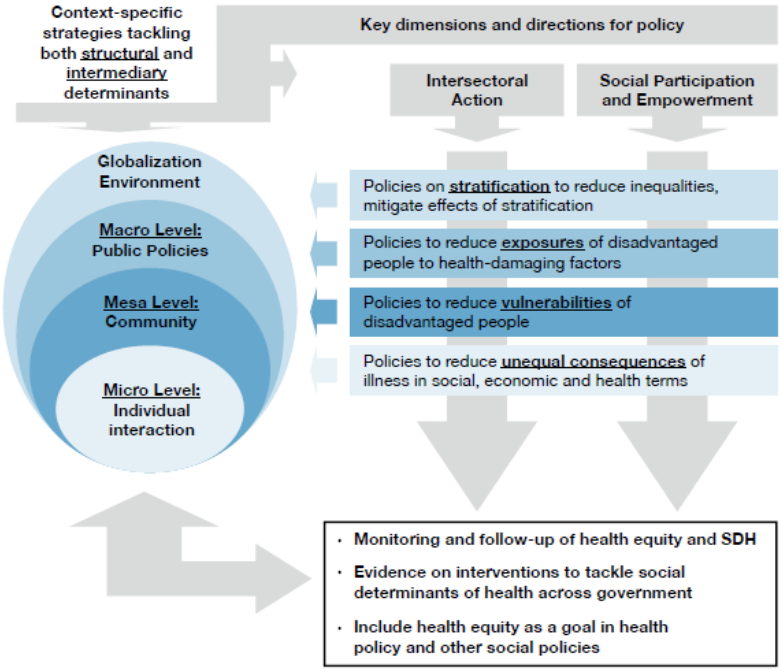
Solar & Irwin (2010).*A Conceptual Framework for Action on the Social Determinants of health.* Social Determinants of Health Discussion Paper 2, Geneva: World Health Organization, 6.

Figure 7. Framework for tackling SDH inequities



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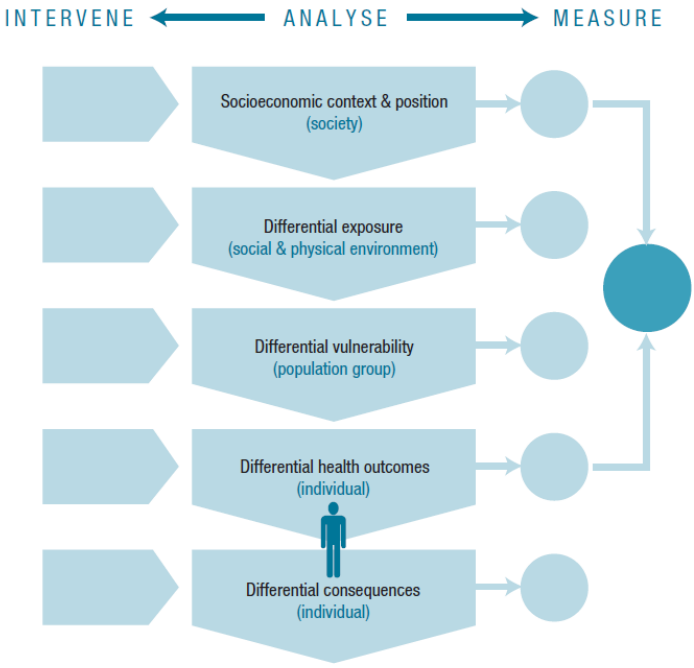
Solar & Irwin (2010).*A Conceptual Framework for Action on the Social Determinants of health.* Social Determinants of Health Discussion Paper 2, Geneva: World Health Organization, 60.

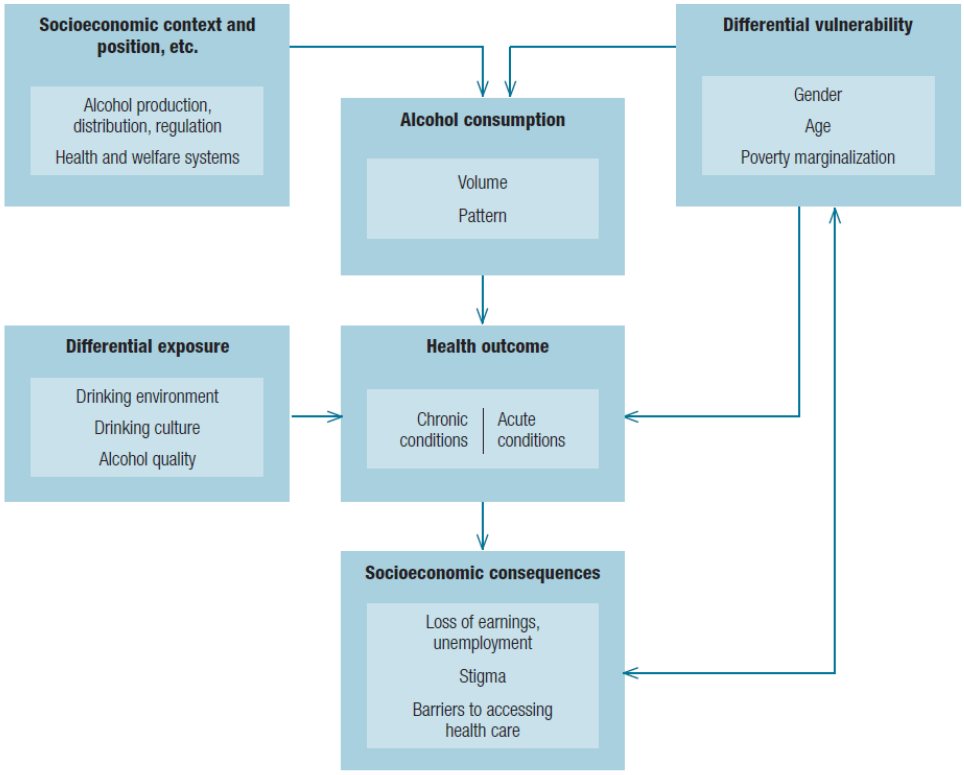
Priority public health conditions analytical framework

FIGURE 1.1 Priority public health conditions analytical framework



Blas, E. & Kurup, A. (eds). (2010). *Equity, social determinants and public health programmes*. Geneva: World Health Organization, 7.

FIGURE 2.1 Application of priority public health conditions analytical framework to alcohol-attributable harm



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