Revitalizing Ontario's Public Health Capacity: A Nursing Response

Submission to the Capacity Review Committee

Community Health Nurses' Initiatives Group/Registered Nurses' Association of Ontario

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Summary of Key Messages/Recommendations

1. Five essential functions make up the public health system: population health assessment; health surveillance; health promotion; disease and injury prevention; and health protection.

2. Develop a system wide view of public health that strikes a balance in the reinvestment of resources between infectious diseases and public health emergencies and other public health mandates that address determinants of health, health promotion, and disease and injury prevention.

3. All Public Health Units should have an appointed Chief Nursing Officer and the HPPA should legislate that all Public Health Units have an appointed Chief Nursing Officer.

4. Ensure Medical Officers of Health have the authority and resources in an emergency situation to protect the public without political or bureaucratic hindrances.

5. Acknowledge that the roles, functions, and skills of the MOH and CEO are distinctly different; do not mandate a local MOH to have CEO authority for local public health services.

6. Ensure adequate resources and stability through the transition period.

7. Revise Mandatory Health Programs based on five core public health functions.

8. Adequate and stable multi-year funding facilitates planning.

9. Establish and resource integrative mechanisms among ministries which carry out public health functions (Public Health Division of Ministry of Health and Long Term Care, Ministry of Health Promotion, Ministry of Children and Youth Services).

10. Introduce “Whistle-Blower Protection” legislation to protect workers who express concerns.

11. Institute equitable reimbursement for nurses across health units and equal to nurses working in the acute care sector.

12. Increase participation of nurses in meaningful decisions at local and provincial levels.

13. Significantly increase opportunities for professional development, including resourced structured mentoring opportunities.

14. Implement strategies to encourage experienced public health nurses to remain in workforce as then near retirement to capitalize on their extensive experience.

15. Promote discipline specific networks—nurses need peer support and professional nursing leadership.

16. PHRED programs be 100% provincially funded.

17. Public health nursing be resourced in order to provide link/collaboration/ Partnership/integration with primary care sites such as Family Health Teams and community health centres.

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association for registered nurses in Ontario. RNAO represents nurses who practice in all roles and sectors across the province, including public health nurses through the Community Health Nurses Initiatives Group (CHNIG). Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontario residents. We welcome this opportunity to respond to the Interim Report of the Capacity Review Committee titled **Revitalizing Ontario's Public Health Capacity: A Discussion of Issues and Options.**

In the wake of SARS and Walkerton and in anticipation of challenges that will be posed by a possible avian influenza pandemic, CHNIG and RNAO commend the commitment to revitalizing public health capacity in Ontario. A robust infrastructure to respond to infectious diseases and other public health emergencies is vital. At the same time, a dynamic public health system also needs to be attentive to population health, health promotion, and disease and injury prevention in order to protect individuals and improve the health of communities.[1] Mounting evidence demonstrates that the determinants of health include income inequality, employment and job security, early childhood development, social inclusion and exclusion, education, food security, and housing. As a result, health promotion in the broadest sense must include diminishing poverty, unemployment, and inadequate housing; promoting healthy growth and development; closing the gap between rich and poor; improving literacy and access to life long learning; creating supportive communities; clean, safe environments; and community control/self-determination for Aboriginal Peoples.[2] We support the strengthening of Ontario's public health system so that it can perform all five essential functions: population health assessment; health surveillance; health promotion; disease and injury prevention; and health protection.[3] All these functions are inextricably linked. The best control measures will accomplish little if Ontarians are left living in the conditions that made them ill in the first place. A system wide view of public health must strike a balance[4] in the reinvestment of public health resources between infectious diseases and public health emergencies and the up-stream, determinants of health approaches to health promotion and disease and injury prevention that address root causes of ill health.

Within this context of the need for a comprehensive vision for public health, we will respond to key themes of the report.

Public Health Governance and Structure

Earlier governance and structural changes to public health units arising from the introduction of the *Health Protection and Promotion Act* (HPPA), the establishment of Mandatory Health Programs and Services Guidelines (MHPSG), and the downloading of funding responsibility for public health to the municipalities had dramatic implications for public health nursing and community health. These changes included: loss of public health nurses[5] in the community and at senior leadership levels; decreased access to traditional public health services for individuals and families across the lifespan; and increased reliance on a biomedical and biobehavioural models of service delivery rather

than a social determinants approach.[6] Given the experience of governance and structure that have had a negative impact on public health service delivery and human resources, we welcome transformations that will revitalize Ontario's public health capacity. We support the identification of markers of good governance and support for Boards of Health as concrete ways of strengthening public health leadership. The following recommendations address factors to be considered when reconfiguring public health units so that capacity may be enhanced.

HPPA should legislate that all public health units have an appointed Chief Nursing Officer (CNO). Population-based public health interventions by public health nurses improve health outcomes at the individual/family, community, and systems levels.[7] The knowledge and skills of public health nurses as they bring their holistic bio-psycho-social expertise to the management of infectious diseases is essential during outbreaks just as every day community nursing is a cost-effective means of improving health.[8] The importance of professional nursing leadership to guide the development and practice of public health nursing in emergent and non-emergent situations will be discussed in more detail in the section on Public Health Human Resources.

Medical Officers of Health (MOHs) require the necessary authority and resources to carry out public health's mandate, including that of protecting the public in emergency situations, without bureaucratic or political hindrances. While the role of MOH in public health emergencies needs to be strengthened, we disagree with those who support the MOH maintaining the additional role of chief executive officer (CEO) of the board of health. The role, function, and core competencies of CEOs are distinct from those of MOHs. The CEO of a health unit must be a person with the knowledge, skills, and experience to run a multi-million dollar, non-profit corporation, and this person could emerge from any of the public health disciplines. While a specific MOH may have the skill set to be a CEO, there should not be a legislated mandate for the local MOH to have CEO authority for local public health services.

The model of governance or configuration of structure chosen must ensure adequate resources and stability throughout the transition period. A staged or phased-in implementation plan might be the best means to ensure continuity of public health services and accommodate different community needs and assets. The overarching criteria for evaluating reform is the extent to which the rebuilt governance and structure improves population health by integrating and implementing the core public health functions of population health assessment; health surveillance; health promotion; disease and injury prevention; and health protection.[9]

Public Health Funding

CHNIG/RNAO agrees with the guiding assumptions of a funding allocation model to improve the capacity of public health and provide equitable access to programs and services to decrease inequalities in health outcomes. When defining public health capacity, it is important that all five of the core public health functions be included and funded. We therefore support the funding of the development and implementation of revised Mandatory Health Program and Service Guidelines, that include standards,

across all five Ontario public health core functions, including population health. This would ensure a system-wide view of public health that strikes a balance in the re-investment of public health funding between infectious diseases and public health emergencies with the other core functions of population health assessment, health promotion, and disease and injury prevention.[10] Adequate and stable multi-year funding to all sectors would facilitate long-term planning and build capacity in order to improve delivery of quality health care services and foster healthy, safe workplaces.[11]

The importance of investing in public health interventions that are directed to determinants of health may be illustrated by early childhood development. The evidence is clear that a poor start in life can have immediate and long-term negative consequences such as restricted brain development; impaired language development; decreased capacity for communication and literacy; and poorer physical and mental health throughout life.[12] Early childhood development links with another health determinant in that, in general, as family income falls, the likelihood that children will experience problems increases.[13] In addition to adequate income, effective parenting and supportive community environments contribute to positive child outcomes. Improving child health requires addressing these key determinants of health such as poverty as well as investing in child and youth programs and services. Funding for interventions not only promotes health and well-being for individuals but the societal benefits generally outweigh the costs of programs. In one early childhood intervention program studied, for every $1 invested, there was roughly US$4 in benefits as participants had long-term benefits of improved general health, higher educational attainment, higher productivity, and higher income levels, which in turn reduced demand on income support and health programs.[14] Prenatal and early childhood home visitations by nurses to low-income mothers of children living in risky conditions were shown to reduce the number of subsequent pregnancies, child neglect and abuse, the use of welfare support, and criminal behaviour for up to 15 years after the birth of the first child.[15] Investing in early childhood development as a public health intervention will improve the well-being of individuals, families, and the larger community.

Public Health System Accountabilities

CHNIG/RNAO supports a process of establishing population health goals, requirements, and mandatory standards that bind all government funded agencies and government ministries that are congruent with national public health goals and the determinants of health. It is important that there be integrating mechanisms among ministries for collaborative and comprehensive planning, implementation, and evaluation of services such as child and youth health promotion that span the Ministry of Health and Long Term Care, Public Health Division, Ministry of Health Promotion, and the Ministry of Children and Youth Services.[16]

Accountability will be improved by a performance management system that ensures that Ontario's public health system is meeting legislated standards and expectations. Meeting performance standards will be facilitated by providing resources to support the process of continuous quality improvement as well as funding a strong, uniform,

consistently applied accountability structure such as accreditation or accreditation-style review.

Since March of 1998, RNAO has been requesting whistle-blower legislation to ensure that nurses and other health care workers can express their concerns without fear of reprisals from their employers. When other strategies fail, it is important that whistle-blowing to force accountability remains as an option; otherwise, an important safety valve is missing from the health care system.

Public Health Human Resources

A successful program of revitalizing public health capacity is contingent on recognition of the vital role of public health nurses.[17] Nurses make up an essential part of the public health system, both as a large percentage of the workforce and for the work that they do. As shown in Table 1 on page 31 of the Interim Report of the Capacity Review Committee, nurses in a variety of roles, from advanced practice to registered practical nursing, make up 47 percent of the direct program delivery staff in Ontario's public health units. The majority (41%) of these are public health nurses.

Public health nurses are an essential component of rebuilding Ontario's public health system. A public health nurse is a community health nurse who synthesizes knowledge from public health, primary health care (including the determinants of health), nursing science, and theory and knowledge of the social sciences to promote, protect, and preserve the health of populations.[18] Public health nurses embody a holistic perspective[19] as their practice of community health nursing is informed by values and beliefs of caring; principles of primary health care; multiple ways of knowing; individual/community partnership; and empowerment. Nursing research on the implementation of the Intervention Wheel population-based practice model, for example, demonstrates the importance of community health assessment[20] linked with 17 public health interventions that span individual/family, community, and systems level of practice. Each intervention at each practice level contributes to improving population health.[21] This population-based, practice-based, evidence-supported model may be viewed as Appendix 1. Specific examples of how public health nurses in Ontario have made a difference through their practice outcomes include reducing incidence of child abuse and neglect, delayed and decreased institutionalization of elders, fewer and less frequent hospitalizations for people with mental illness, and improved quality of life for individuals and families.[22]

The following section outlines multiple ways in which the quality of working life could be enhanced to improve recruitment and retention of public health nurses thereby strengthening public health capacity. The Interim Report noted that a large proportion of those who participated in the Capacity Review Committee survey reported feeling undervalued and unappreciated (p. 34). One manifestation of respect would be to have equitable remuneration, benefits, and working conditions so that there are not large discrepancies between health units and different health-care sectors. Compensation for years of clinical experience and salaries that are congruent with the acute care sector are both issues that require attention. "Better alignment of salaries across disciplines

and health units" (p. 34) should not be a downward harmonization or a loss of remuneration in the same way that "transition to a new funding model should not result in a budget cuts to health units that are adequately resourced now" (p. 24).

Non-monetary manifestations of respect could include increased staff participation in workplace decision-making which can increase job satisfaction as well as improve the quality and effectiveness of care.[23] Job stability arising from predictable funding would increase morale and decrease worker preoccupation about seeking on-going employment when project funding has terminated. Attentiveness to work/life balance so that public health professionals who seek part-time employment could be accommodated would assist with retention of experienced personnel.

Opportunities for professional development and life-long learning could be supported by a variety of strategies that would improve health services, strengthen health units, and improve work satisfaction. These include: formal partnerships with educational institutions with cross-appointments and clinical placements; funded or partially subsidized continuing education opportunities; and support for involvement with professional organizations on professional development, integration of community health nursing standards, and recruitment and retention issues. Structured mentoring initiatives with resources to implement best practices in mentoring[24] could include such practical steps as a) a funded position to coordinate student clinical placements; b) funding summer stipends across disciplines for clinical placements as is currently done with public health inspector "apprenticeship" placements; and c) financial and other types of recognition for preceptors and mentors. Supporting professional development for clinicians working in public health includes advocating for support for the roles of primary health care nurse practitioners and clinical nurse specialist or consultant positions in public health.

Due to impending losses as a result of predictable retirement of an aging workforce, there is a particularly urgent need for both a short-term and long-term action plan to prepare leaders and managers as well as clinicians in public health. Strategies to support experienced nurses who are at the pre-retirement stage of their career have been identified and could be implemented in the public health sector.[25] Financial subsidies and administrative support for educational leaves would help to overcome disincentives to continuing education and thereby build capacity. Alternative forms of delivering educational programs such as distance education and part-time programs would encourage nurses' participation. An educational initiative targeted to nurses working in the public health sector could be modeled after the government of Ontario's initiative to support nurse educators that was announced October 27, 2004.[26]

Discipline specific communities of practice at the local, regional, and provincial levels and more opportunities to network with peers to discuss profession-specific issues would strengthen the capabilities of all public health workers. Strengthening professionals in their disciplines makes them stronger partners when working within multidisciplinary teams. Public health nurses need discipline-specific peer support and discipline-specific nursing leadership.

Professional nursing leadership is essential to improving health outcomes and for the effective maximizing of nursing resources in a complex and fluid health care environment.[27] Public health nursing leadership eroded in Ontario as public health units moved to program based service delivery. In February 2000 the Chief Medical Officer of

Health and the Provincial Chief Nursing Officer called on Medical Officers of Health to support visible nursing leadership positions in their health unit organizations. An Association of Nursing Directors and Supervisors of Official Health Associations in Ontario survey conducted in the Spring of 2001 identified only 50% of provincial health units had a Chief Nursing Officer or equivalent position.[28] As little progress has been made since then, we recommend that HPPA be amended to require each health unit to appoint a Senior Nursing Officer in order to promote excellence in professional nursing practice and sustain a vibrant, healthy work environment.[29] These roles require sustainable funding, including access to clerical support, and the authority to carry out their responsibilities. In addition, public health nursing needs a strong voice at the broader public health and provincial nursing tables. This could be provided by appointing a CNO to the Public Health Branch of the Ministry of Health and Long Term Care with cross appointments to the Ministry of Health Promotion and Ministry of Children and Youth Services. There is clear evidence that there is a correlation between nurses reporting to nursing leaders, provision of quality care, team functioning, and morale that has implications for overall recruitment and retention.[30] Literature reviews by RNAO's Healthy Work Environment Best Practices Guidelines Project have found excellent leadership makes a difference in improving client care and organizational effectiveness. Transformational and relationship based leadership has been associated with positive outcomes for clients such as increased client satisfaction; improved quality of life for clients; and improved clinical outcomes. Transformational and relationship based leadership have been shown to lead to increased job satisfaction, quality of life, and empowerment for nurses; decreased absenteeism; increased perceived unit effectiveness; and increased retention of nurses.[31]

Research Knowledge and Transfer

The Public Health Research, Education and Development (PHRED) Program has been an excellent resource for research knowledge and transfer. We support 100% provincial funding of this program so that all health units, especially the smaller ones, might have access to PHRED. Creating outreach and collaborative research opportunities so that local health units could work closely with PHRED would build skills and capabilities for all participants. The public health practitioners would have increased incentive to integrate best practice evidence into their practice while researchers' work could be enriched by recognizing and valuing the realities of public health practice. PHREDs with a regional perspective, as well as central coordination and other supports from a new Ontario Public Health Agency, could help ensure that valuable lessons were being shared in order to avoid duplication of efforts.

We support the suggestions on page 38 of the Interim Report for strengthening research and knowledge transfer, including the use of eHealth resources. Disseminating and implementing the best evidence based practices in public health, while leaving room for innovation, could be assisted by the additional support of evaluation specialists or research analysts to work along side program delivery staff. Once again, strong leadership within health units to support evidence-based approaches as discussed on page 40 would be facilitated by having a Chief Nursing Officer and nursing practice leaders in each health unit. Strong nursing leadership would also support expansion of research in public health nursing in public health units. Given the rapid changes in the

health system, creating opportunities to share research and evaluation results related to public health with LHINs will also be important.

Primary Health Care and Public Health

In the context of health system restructuring in both the curative and preventative domains of practice, it would be helpful if the Capacity Review Commission would help decision-makers understand the difference between primary care[32] and primary health care.[33] The comprehensive vision of the primary health care movement has been foundational in inspiring health promotion, disease and injury prevention, and population health approaches to public health in order to keep people well while also being the first contact for people who are experiencing ill health or injury. The evidence-based, multi-disciplinary approach of primary health care is based on the principle that health is a basic human right. The implications of primary health care reform are significantly more transformational[34] than changes to methods of health service delivery often denoted by primary care reform. A primary health care approach is a pragmatic model of working on the Health Goals for Canada[35] and is congruent with international initiatives such as the World Health Organization's Commission on the Social Determinants of Health.[36]

Local Health Integration Networks and primary care reform initiatives such as Family Health Teams (FHTs) are two intriguing areas of possible collaboration with public health. In addition to collaboration between LHINs and public health with respect to population health assessment mandates (p. 5), other possible linkages include: research and knowledge transfer related to public health science; communicable disease prevention; infectious diseases control; environmental health; workplace health for health care institutions and programs such as hospitals, long term care facilities, and community care access centres. Family Health Networks and the Family Health Teams that are in the process of being implemented could be sites for new linkages. A public health nurse linked with each FHT, for example, could be a resource to facilitate access to Healthy Babies Healthy Children and Best Start for individual clients and their families. This same public health nurse could also be working on improving the aggregate health of the population served by the FHT by her community and systems level work on improving health through community mobilization and advocacy. In addition, she or he could facilitate access to other Health Unit resources, which would benefit families and professionals who are part of the FHT. Such partnerships move any setting that does primary care (solo medical practitioner, FHT, or community health centre) closer to a primary health care approach.

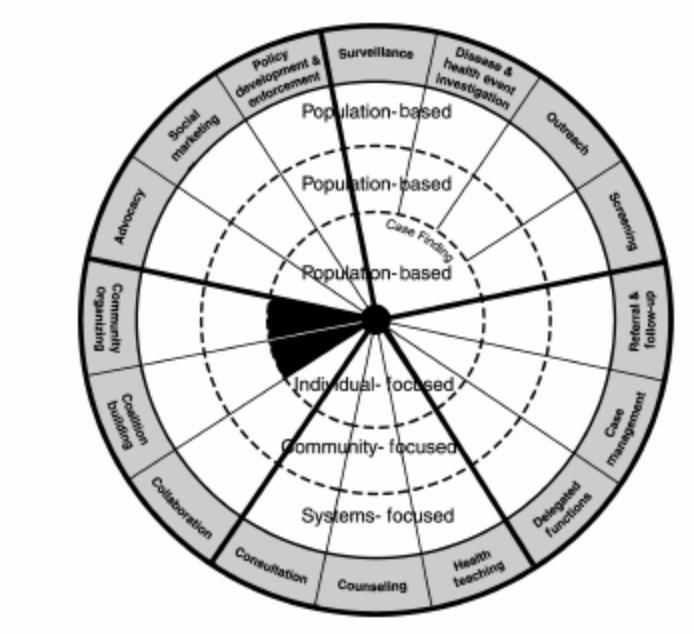
A cautionary note is that while strong collaborative relationships between public health and LHINs will be useful in advancing primary health care, integration of public health into the LHINs structure should not be considered.

Conclusion

Although Canada led the world in understanding health promotion and population health since the Lalonde Report in 1974, over the last decade Canada has fallen behind the United Kingdom, Sweden, and some jurisdictions in the United States in implementing evidence-based population health interventions.[37] Just as Ontario is now exploring how to best rebuild the capacity of the public health system to perform traditional public health tasks that are so essential, now is also the time to revisit and refashion a public health system that looks upstream to the social determinants of why people are unwell in the first place. CHNIG/RNAO's key messages/recommendations speak to selected issues from the Interim Report of the Capacity Review Committee within an overarching thirst for a comprehensive vision for public health.

Appendix 1

Intervention Wheel



Used with permission from Keller, L.O., Strohschein, S., Lia-Hoagber, B., & Schaffer, M. (2004). Population-Based Public Health Interventions: Practice-Based and Evidence-Supported. Part 1. **Public Health Nursing,** 21, 455.

Public health nurses generally implement these 17 public health interventions across three levels of practice (individual/family, community, and systems). The exceptions are case finding, which occurs only with individuals, and community organizing and coalition building, which occur only with communities and systems.[38]

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http://www.who.int/chronic_conditions/primary_health_care/en/almaata_declaration.pdf

[34] See, for example, RNAO's policy statement on Primary Health Care:
http://www.rnao.org/policy/primary_health_care.asp

[35] Health Goals for Canada 2005. http://www.healthycanadians.ca/home.html

[36] Two of the twenty Commissioners for the Commission on Social Determinants of Health are from Canada (Monique Begin and Stephen Lewis) and two of the Knowledge Networks (early childhood development and globalization) are situated in Canada.
http://www.who.int/social_determinants/en/

[37] Canadian Population Health Initiative. (2002). **Brief to the Commission on the Future of Health Care in Canada**. Ottawa: Canadian Institute for Health Information, p. 1.
http://secure.cihi.ca/cihiweb/en/downloads/cphi_policy_romanowbrief_e.pdf

[38] Keller, L.O., Strohschein, S., Lia-Hoagberg, B. & Schaffer, M. (2004). Population-Based Public Health Interventions: Practice-Based and Evidence Supported. Part 1. **Public Health Nursing**. 21, 458.