THE ROLE OF HEALTH PROMOTION WITHIN INTEGRATED HEALTH SYSTEMS

A POSITION PAPER BY
THE CENTRE FOR HEALTH PROMOTION

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WORKING GROUP ON INTEGRATED HEALTH SYSTEMS—MEMBERS

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EXECUTIVE SUMMARY

The purpose of this paper is to inform the members of the Ministry of Health's Health Strategies Group about the critical role of health promotion within IHS reform in Ontario. It addresses, in turn, questions concerning the meaning of health and health promotion, what it means for IHSs to be held accountable for promoting the health of their members, evidence regarding the effectiveness of key health promotion strategies and their inclusion as core IHS' services or areas of activity, and the practical implications of embedding the values of health promotion into the design and operations of IHSs.

Health promotion theory and practice is grounded on the belief that health is far more than the absence of disease. Rather, it is a positive concept that emphasizes one's mental, social and spiritual well-being, and one's personal and social resources, in addition to one's physical well-being. In order to effectively enhance the health of Ontarians, our health system needs to be reoriented from its primary focus on treatment, rehabilitation, and the prevention of physiological risk factors, to a more balanced and comprehensive approach to promoting health. It is our position that this outcome can be successfully realized by guiding IHS reform according to the philosophy and values of health promotion, and by incorporating key health promotion strategies into the mandate of IHSs.

In order to most effectively influence the health outcomes of their clients and communities, IHSs must balance their attention and resources amongst a medical, lifestyle/behavioural, and a socioenvironmental approach to promoting health. These three approaches each target a specific set of health determinants. Therefore, IHSs will need to incorporate a variety of complementary health promotion strategies into their core basket of services and activities.

As the different approaches to health promotion address different health determinants, IHSs should be evaluated against a comprehensive set of indicators that measure the effectiveness of each approach, and the impact that each approach has on the health outcomes of their clients and communities. Among other factors, evaluation indicators should measure reductions in morbidity and mortality rates, physiological health risks, and high risk behaviours, as well as increases in quality of life and social well-being. Recognizing that these latter measures are beyond the sole control of both our health system and individual IHSs, IHSs should be held accountable for working collaboratively with others to address the broader determinants of health.

Of these three approaches to promoting health, this paper focuses on a lifestyle/behavioural approach and a socioenvironmental approach. A lifestyle/ behavioural approach is concerned with the development of personal skills and public policies that support healthy choices and reduce individual risk factors. Strategies encompassed in this approach include health education, health

communication, brief interventions, self-help and mutual aid, self-care, and healthy public policy. Based on substantial evidence supporting the appropriateness and effectiveness of adopting each strategy to address all major risk factors across all levels of care, it is recommended that these strategies become core IHS services. Strategies should be supported by multidisciplinary teams of IHS' staff across all health delivery domains, particularly in the area of primary health. The feasibility of incorporating these health promotion strategies into the core business of IHSs is demonstrated through examples of possible IHS implementation within the community, diverse health settings, clients' homes, and other sites such as schools and workplaces. More comprehensive, multicomponent efforts are also recommended, and suggestions are made for potential collaboration between IHSs and a variety of community partners.

A socioenvironmental approach to health promotion addresses the health impacts of broader, socioenvironmental issues such as income, housing, social support etc.. Key strategies encompassed in this approach include community development, community economic development, healthy public policy, and creating environments that are supportive of health. Based on evidence regarding the contribution that each strategy can play in addressing the health impacts of these broader issues, it is recommended that they be incorporated as core areas of IHS activity. A portion of IHS' staff and other resources should be therefore be dedicated to this purpose. Examples are provided to illustrate how IHSs could foster and support collaborative initiatives with external health-related agencies and sectors at both the provincial and local levels. Of all potential partners, IHSs will need to work most closely with their communities, supporting members in identifying their own priority issues, and in working to positively influence those factors which affect their health and well-being.

In addition to incorporating key health promotion strategies into the mandate of IHSs, it is our position that the core values of health promotion are embedded in the design and operation of IHSs. Standards and guidelines that support the values of empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration are provided. Recommendations address:
- the empowerment of IHS' rostered communities, clients, agencies, organizations and employees;

- meaningful, representative public participation on IHS' governance bodies and committee structures, as well as in regard to specific programs and projects, including community health assessments;

- IHSs allocation of adequate resources to support efforts and collaborative partnerships that recognize and act upon the broader determinants of health;

- the reduction of social inequities and injustice through risk-adjusted funding formulas and special funding for programs that meet the needs of marginalized or high risk populations, and setting clear standards for IHS outreach efforts, committee structures, and efforts to remove systemic barriers to the determinants of health; and,

- collaboration amongst the component parts of the IHS (e.g. acute-, long-term-, and primary-care, health promotion, health-related social services), the adoption of a cooperative or corporate model of governance that represents the community served rather than the component provider parts of the system, core services and activities that IHSs should be accountable for providing, and issues related to intersectoral collaboration between IHSs and other agencies and sectors that have an impact on the broader determinants of health.

This paper suggests that, through its philosophy, strategies, and core values, the field of health promotion can and should play a critical role in IHS reform in Ontario. It is our hope that the Health Strategies Group at the Ministry of Health will understand and support our position, and will work in partnership with those who are and will be involved in IHS reform, to ensure that our health system is reoriented to promote and enhance the health of Ontarians. For our part, we are willing and eager to be involved in all IHS initiatives that are founded on the philosophy and values of health promotion, and that incorporate health promotion strategies into the core business of IHSs.

BACKGROUND STATEMENT

One of five key health promotion action areas identified in the Ottawa Charter is the reorientation of health services (WHO, 1986). A reoriented health care system has health, and not merely the absence of disease, as its primary outcome. To support prevention and promotion initiatives, increased attention and resources must be redirected from treatment and rehabilitation. Second, a reoriented health system emphasizes services located in communities, and relevant to their particular needs. This demands a shift from an "institutional" model of service delivery to strengthened "community-based" health services. It also demands a commitment to foster active public participation in the planning, development, operation and evaluation of health services. Lastly, the Charter describes a reoriented health system as operating according to a "health promotion" rather than a "service delivery" philosophy, such that the system's primary outcome is the enhancement of health at the individual and population levels.

Health reform presents a valuable opportunity to reorient Ontario's health care delivery sector according to the goals, objectives and values described in the Ottawa Charter. The field of health promotion supports the Ministry of Health's commitment to improve the health system's responsiveness, effectiveness, efficiency and accountability. We also support the Health Strategies Office in their efforts to develop a policy framework for Integrated Health Systems (IHSs). A draft of the framework describes an IHS as a non-profit organization with a single point of accountability. The IHS is responsible for meeting a broad range of health needs for a defined group of Ontario residents (its roster) through the provision or purchase of a coordinated continuum of horizontally and vertically integrated services. Primary care is identified as the essential foundation of the system, which has an increased focus on health promotion and disease prevention. Needs-based capitated funding is reallocated by the IHS governance board in a way that best meets the needs of its members. Integrated information systems facilitate needs-based planning, evaluation, and coordination within each system and between IHSs and the Ministry of Health. The IHS operates under broad rules and standards set by the Ministry of Health in areas such as scope of and access to services, use of funds, and expectations for health outcomes/accountabilities (Health Strategies Group, 1997). Upon reviewing these key elements, the field of health promotion believes that Integrated Health Systems can be aligned with the goals, values, and practice of health promotion.

However, simply restructuring our traditional health care delivery organizations into an integrated system will not effectively the promote the health of Ontarians. In 1974, the Lalonde Report, entitled *A New Perspective on the Health of Canadians*, broke new ground by drawing attention to the fact that, on their own, traditional health care organizations are insufficient to achieve better health for Canadians (Lalonde, 1974). Up until this time, health status was largely considered to be the result of biology and, more importantly, access to a quality tertiary health care system (Hyndman, 1997). In addition to genetics and a formal health care system, the report identified lifestyles and environments as significant determinants of health (Lalonde, 1974). Despite these findings, the vast majority of health resources continue to be allocated to health care

organizations and providers with a medical focus on cure and treatment of disease. In Canada, approximately half of all health care expenditures are spent on institutional care (39% hospitals, 10% homes for special care), about one quarter on professional services (23%, of which physicians receive the bulk), and about 14% on drugs and appliances (Shah, 1994). The remaining 13% of our health budget covers the costs of research, health insurance administration, and public and voluntary health agencies, with less than 3.5% of all health care dollars spent on activities related to disease prevention and health promotion (Shah, 1994).

While restructuring may be an effective and efficient way to maintain the quality and reduce the overall costs of health care delivery, these efforts will not significantly improve our system's ability to enhance health outcomes. For this vision to be reached, Integrated Health Systems must be reoriented toward the promotion of health.

INTRODUCTION

Believing that IHSs have the potential to promote the health of Ontarians, the field of health promotion is prepared to support and contribute to their development. This position paper is intended to support IHS reform in two ways. First, it outlines our position on the direction of IHS reform and the role of health promotion within it. Secondly, it provides the Ministry of Health with our best thinking to date on practical ways in which to ensure that health promotion values and strategies are embedded in the planning, development and operations of IHSs.

Section I identifies the promotion of health as the primary goal or purpose of an IHS. It clarifies what is meant by *health*, defines the process of health promotion, and describes the core values and principles of health promotion, which we believe should guide IHS reform. Three distinct approaches to enhancing health are outlined: the medical approach to illness prevention; the individual/lifestyle approach to illness prevention and health promotion; and the socioenvironmental approach to health promotion. The integration of these three approaches within IHSs is identified as necessary to significantly improving the health outcomes of the populations served. Accountability for promotion of health is discussed, along with different types of indicators required to evaluate the effectiveness of IHSs in improving health outcomes. A list of suggested indicators can be found in Appendix A.

Section II identifies and describes the effectiveness of key health promotion strategies that address individual/lifestyle risk factors. The goal of these strategies is to assist individuals in making healthier choices through changing health related knowledge and attitudes, developing personal skills, and supporting healthy lifestyles through public policy. Inclusion of these strategies as core IHS services is supported through examples of how these strategies can be integrated throughout the IHS.

Section III describes and identifies the effectiveness of key health promotion strategies to address the impact of the socioenvironmental determinants of health. The goals of these strategies are to create environments that are supportive of health, to strengthen community action, and to develop healthy public policy that addresses the risk conditions in which people live and work. The inclusion of these strategies as core IHS services is supported with examples of how IHSs can work collaboratively with others to achieve these goals.

Section IV reviews the core values and principles that should guide IHS reform, and outlines how they should be reflected in the planning, development and operation of IHSs. Their incorporation into Ministry of Health standards and guidelines, is addressed, as are implications for recommended IHS strategies, structures, culture, and services.

The paper concludes with a summary of our position on the critical role that health promotion strategies and values can and should play within IHS reform.

I: THE PRIMARY GOAL OF IHSs: THE PROMOTION OF HEALTH

THE MEANING OF HEALTH

It is our position that the primary objective and outcome of Ontario's integrated health systems should be the promotion of health. This requires a common understanding of what is meant by health. At the root of health promotion theory and practice is the belief that health is "a positive concept emphasizing social and personal resources, as well as physical capacities" (WHO, 1986).   Far more than the absence of disease or illness, health is the maximal attainment of physical, mental, social and spiritual well-being. This broad, holistic understanding of what it means to be healthy radically challenges our health sector's dominant, narrow definition of health. A health promotion perspective demands that we surface and test our assumptions of what it means to be healthy, how health is measured or assessed, the factors that determine health, and, most importantly, how we can most effectively employ our personal and public resources to enhance health at the individual, community and population level.

It is our position that these are the fundamental questions that need to be addressed in order to develop an effective policy framework for the development of IHSs that will in fact enhance health. This means that in addition to providing and co-ordinating health care services, integrated health systems must be concerned with, and actively promote, all aspects of health.

WHAT IS HEALTH PROMOTION?

Health promotion is "the process of enabling people to increase control over, and to improve, their health" and the issues that are identified as important health determinants (WHO, 1986). The overarching goal of health promotion is to achieve health for all, and to enhance individual and societal well-being. To move us toward this outcome, the field has developed an ethical and theoretical body of knowledge regarding the holism of health and its determinants (Rootman and Goodstadt, 1996). At a more practical level, this philosophical approach is supported by a wide variety of tools and techniques that may be categorized according to the five action areas identified in the Ottawa Charter: developing of personal skill; strengthening community action; creating and supporting healthy environments; building healthy public policy; and reorienting health services. Health promotion strategies are complementary and effective at the individual, organizational and community levels.

It is our position that founding IHS reform on the philosophy of health promotion, and incorporating health promotion strategies into the core business of IHSs, we will succeed in reorienting our health system and enhancing the health of Ontarians.

CORE VALUES

The process of health promotion is characterized by a set of core values or principles that guide all efforts to enhance health and support individual and societal well-being. Underlying all health promotion initiatives is the concept of *empowerment.* Empowerment refers to the capacity of individuals and communities to improve their health by increasing their control over the determinants that are important to their health.

Secondly, health promotion emphasizes active *public participation* in processes that encourage and enable individuals and communities to define, analyze and act upon events affecting their lives and living conditions (Labonte, 1993, 5).

Recognizing that health is influenced by more than genetics, individual lifestyles, and the provision of a health care delivery system, the field is committed to *addressing the impact of broader determinants of health*. This requires that health promotion interventions recognize and act upon the socioenvironmental conditions that shape the world in which we live.

Fourth, health promotion is committed to *reducing social inequities and injustice*, such that every individual, family and community may benefit from living, learning and working in a health-supporting environment.

Finally, health promotion seeks to *facilitate intersectoral collaboration* and initiate coordinated efforts to promote individual and community health.

It is our position that these same core values should guide the planning, development and operation of IHSs. This assertion is further developed in Section IV of this paper.

PROMOTING HEALTH: THREE COMPLEMENTARY APPROACHES

Our definition of health shapes our assumptions about its determinants, and the approaches we adopt in an effort to promote health. It also determines the indicators we use to measure how effective our efforts have been. Outlined below are three distinct approaches to enhance or promote health: medical; lifestyle or behavioural; and socio-environmental (Labonte, 1992). Each approach targets a specific set of health determinants through a variety of strategies or interventions. As each approach is distinct, its effectiveness must be evaluated against a unique set of health indicators. In isolation, each approach is insufficient to significantly impact the health of Ontarians. When integrated, however, they provide a comprehensive approach to promoting health. IHSs must balance their attention and resources between our current focus on treatment, rehabilitation, and the prevention of physiological risk factors, with strategies targeting individual risk factors, and socioenvironmental risk conditions.

THE MEDICAL APPROACH

THE MEDICAL APPROACH TO PROMOTING HEALTH: AN OVERVIEW

Traditionally, our health services system has understood health to be the absence of disease or illness. Therefore, the primary focus has been on curing, treating, and, more recently, preventing disease and illness. Targeted risk factors tend to be medically or physiologically defined. Preventive medical efforts are directed toward individuals whose genetic, behavioural, personal or family history places them at greater risk of developing a serious disease or disability (Labonte, 1997). While the medical approach improves or promotes health through the prevention of disease, it is not a "health promotion" approach in that it is directed toward specific diseases rather than a positive concept of health. This distinction holds true for treatment and rehabilitation efforts which are directed toward the care of specific diseases and injuries. Distinguishing a medical approach from a health promotion approach should not be taken as a criticism of preventive medicine. The field of health promotion recognizes the need for, and fully supports the incorporation and enhancement of preventive efforts as core IHS services that are integrated throughout the system at all levels of care and across all delivery settings.

Health and Welfare Canada's *Strategy for Enhancing Preventive Practice of Health Professionals* (1990, 1990a, 1991), defines three levels of preventive medicine. "Primary prevention reduces the likelihood of a disease or disorder developing in a person" (Health & Welfare Canada, 1990). Specific examples include periodic health examinations, prenatal care and immunizations. "Secondary prevention interrupts, prevents or minimizes progression of a disease, or irreversible damage from a disease, at an early stage; it comprises the early detection and treatment of disease before irreversible damage has occurred" (Health & Welfare Canada, 1990). Breast and testes self-examinations, early cancer detection, and screening for high blood pressure and cholesterol are examples of secondary prevention. "Tertiary prevention focuses on the progression or damage in a disease where such damage has already occurred irreversibly; the emphasis is on measures to alleviate disability and to slow progression of established diseases or disorders" (Health and Welfare Canada, 1990). Examples of tertiary prevention include monitoring of diabetes, and nutritional and physical activity regimens for those with heart disease. Best practice guidelines for preventive medicine have been developed by The Canadian Task Force on the Periodic Health Examination (1994).

As quality recommendations on incorporating the role of preventive medicine within our health system are readily available from numerous sources, this approach is not developed further in this paper. Instead, we have concentrated on areas where we can make a more significant contribution to the success of IHS reform.

It is our position, however, that preventive medical interventions (like all health services), should be guided by the core values of health promotion. Interactions with clients should foster a sense of empowerment and increase client control over their health, thereby reducing anxiety and dependency. Health education and personal skill development strategies should be employed to enable clients to manage their health to the greatest extent possible. Self-help and mutual support strategies

should also be used where appropriate. Furthermore, practitioners must consider the impact of the social context in which a client lives so as to better meet their health needs.

THE LIFESTYLE/BEHAVIOURAL APPROACH

THE LIFESTYLE/BEHAVIOURAL APPROACH TO PROMOTING HEALTH: AN OVERVIEW

Beginning in the 1950s, epidemiological data revealed the link between multiple causative factors related to lifestyle (e.g. tobacco use, excess alcohol consumption, high-fat diets, lack of physical activity) and the incidence of major non-infectious diseases (Hyndman, 1997). These health risk factors were considered a matter of personal choice, and under the control of individuals. Emphasis was placed on health promotion activities directed towards promoting healthy individual lifestyles and reducing health risks (Tones, 1986; Raeburn and Rootman, 1989). This approach gained support in the 1970s, as a result of growing concern regarding the rising costs of health care. Chronic degenerative diseases had become recognized as a leading cause of morbidity and mortality in the Canadian population, with the bulk of rapidly escalating health expenditures going to expensive medical technologies and facilities directed at treating these conditions (Hyndman, 1997). In an attempt to reduce the incidence of these conditions and contain health care costs, the federal and provincial governments looked to individual/lifestyle health promotion strategies (Labonte, 1993).

The Lalonde report of 1974 (*A New Perspective on the Health of Canadians)* demonstrated the federal government's official recognition and support of disease prevention and health promotion strategies that addressed lifestyle/behavioural and socioenvironmental risk factors. In particular, the contribution of individual lifestyle risk factors to one's health was emphasized, overshadowing the effects of one's environment. Focusing on personal responsibility for one's health status, the report stated that "individual blame must be accepted by many for the deleterious effect on health of their effective lifestyles" (Lalonde, 1974, 26). This assumption led to the development of multiple health promotion strategies aimed at developing individuals' knowledge, attitudes and behaviours to promote healthy lifestyles and prevent disease.

Strategies included in this approach are largely concerned with individuals or groups whose behavioural or social situation place them at greater risk for developing unhealthy lifestyles. These efforts are supported by a "population approach" used by public health authorities to lower the distribution of a given factor within a larger aggregate, thereby reducing population rates of certain diseases (Labonte, 1997). Targeted behavioural risk factors include: nutrition (diet and weight), physical activity, sexual practices (STDs and unwanted pregnancies), the use of tobacco, alcohol and drugs (prescription and illicit), sun exposure, and injury prevention.

Strategies associated with an individual/lifestyle approach to health promotion include health education, social marketing, brief primary care interventions, self-help and mutual aid, self-care, and public policies aimed at supporting healthy lifestyles.

It is our position that each of these strategies be included as an integral component of IHSs. This position is developed in more detail in Section II.

THE SOCIOENVIRONMENTAL APPROACH TO PROMOTING HEALTH: AN OVERVIEW

While acknowledging the value of interventions that support healthy lifestyles, and advocating for their inclusion within IHSs, we recognize the limitations of a behavioural/lifestyle approach to promote health. By the early 1980s, it was recognized that emphasizing one's personal responsibility for health while neglecting the social and environmental conditions which inhibit the adoption of healthy lifestyles tended to "blame the victim" and ignored issues of social responsibility (Crawford, 1977; Labonte and Penfold, 1981; Buck 1984; Freudenberg, 1985). Furthermore, the approach was proving most effective with the better educated, more privileged members of society. The health status of high risk populations was not being significantly affected, and inequities in health were not being reduced (Labonte, 1993).

Upon critical re-examination, the field of health promotion became more fully aware of the impact that psychosocial and socioenvironmental factors have on one's health. Not only do these factors influence an individual's physiological and behavioural health risks, these conditions are, themselves, independent health risks (Labonte, 1993). This awareness led to the development of a socioenvironmental approach to health promotion.

A socioenvironmental approach to health promotion is founded on the evidence that health is affected by many factors outside the sphere of traditional health care. In this approach, concern is redirected from behavioural risk factors to socioenvironmental risk conditions. Risk conditions refer to socioenvironmental factors that deny individuals or groups of people access to the prerequisites for health. As defined by the World Health Organization, these prerequisites include "peace, shelter, education, food, income, a stable ecosystem, social justice and equity" (1986).

THE SOCIOENVIRONMENTAL APPROACH

THE SOCIOENVIRONMENTAL APPROACH TO PROMOTING HEALTH: AN OVERVIEW CONT.

By the early 1980s, research from multiple fields was beginning to suggest that risk conditions and psychosocial risk factors may be more significant determinants of health than physiological or behavioural risk factors, a claim that appears to be supported by current population health research (Evans et al., 1994). Within the field of social psychology multiple studies demonstrated the importance of social networks and social support on health status (Berkman and Syme, 1979; Israel, 1985; Gottlieb, 1987). Meanwhile, repeated social epidemiological surveys documented the significant correlation between socioeconomic status and inequities in health (Black et al., 1982, 1988). These findings reveal that people living in high risk conditions independently have more disease and premature death and less well-being than average (Labonte, 1997). Over the past decade, population health research has reaffirmed these findings, reporting that psychosocial risk factors and risk conditions are probabilistically associated with individual morbidity and mortality, and population health status (Evans et al., 1994).

Individuals and groups living in high risk conditions often internalize the unfairness of their social circumstances, and blame themselves for their situation. These reactions are reinforced by our culture's emphasis on individual freedom and responsibility. What remains hidden is the degree to which our society's economic and political practices and our dominant ideologies structure our living and working conditions (Labonte, 1997). As a result, self-blame increases feelings of powerlessness and other psychosocial risk factors which are associated with poorer health outcomes. Further research reveals that often people living in high risk conditions adopt unhealthy lifestyles as a way to cope with or bring pleasure to their undesirable situation (Labonte, 1997). For many, the adoption of a healthier lifestyle is of lower priority than the need to address the basics of housing, transportation, food security, etc. (Labonte, 1997). All of these factors serve to increase the prevalence of health threatening physiological risk factors of people living in high risk conditions.

Strategies falling under a socioenvironmental approach to health promotion are directed at reducing and preventing risk conditions, unlike the other two approaches that target high risk individuals or groups. Examples of socioenvironmental determinants of health targeted by this approach include: income, food security, pollution, shelter, employment and working conditions, education, social support, violence, and legal issues.

Strategies associated with a socioenvironmental approach to health promotion are strengthening community development and community economic development, creating environments supportive of health, and advocating for and developing healthy public policy.

It is our position that these strategies be included as integral components of IHSs. Furthermore, to effectively influence the impact of these broader determinants of health, part of the IHS mandate should be to work collaboratively with the communities they serve, other IHSs, the Ministry of Health, and other sectors. This position is developed in more detail in Section III.

IHS ACCOUNTABILITY

The Ministry of Health has stated its commitment to improve the responsiveness, effectiveness, efficiency and accountability of the health system, intending that IHSs be outcomes oriented and evidence based. In order for the Ministry to appropriately set standards against which IHSs will be evaluated, a comprehensive set of indicators must be identified and used to measure health outcomes. These indicators need to reflect the position that health is more than the absence of disease; that it is a positive concept that includes physical, mental, social and spiritual dimensions. Holding IHSs accountable to a comprehensive set of health status evaluation indicators is the strongest, most effective way for the Ministry of Health to ensure that our health system promotes health in addition to treating sickness.

Clearly, neither the health system nor individual IHSs can be held solely accountable for the health status of the population served, or for the risk conditions and psychosocial risk factors that affect the health of Ontarians. Due to the broader determinants of health, this needs to be a collective responsibility that is shared by all sectors, public and private, and all government Ministries. The importance of socioenvironmental determinants of health needs to be better understood and supported by deliberate, collaborative actions and policies. Despite this acknowledgment, it must be recognized that the fundamental purpose of the health system is to promote the health of Ontarians. Therefore, IHSs should be held accountable for incorporating the three approaches to promoting health into their core business. IHSs and the Ministry of Health should also be held accountable for working collaboratively with other agencies and sectors on initiatives that effectively target the broader determinants of health. The outcomes of these efforts should be evaluated by the Ministry of Health.

Within the Ministry of Health's IHS evaluation framework, morbidity and mortality rates are appropriate indicators of the effectiveness of a medical approach to promote health status. Particular attention should be given to measurements related to illness, disability and premature death from specific and/or prevalent diseases, such as heart disease, stroke, cancer, mental illness and AIDS/HIV infection. Other examples of appropriate health status evaluation indicators include: the adoption of best practices regarding screening and immunization coverage; reduced perinatal and infant mortality and long-term morbidity of perinatal origin, reduced disability among physically and mentally impaired citizens, and reductions in cholesterol levels/high blood pressure.

The Ministry of Health should also incorporate evaluation indicators that reflect the effectiveness of individual/lifestyle health promotion strategies and their impact on the health of the populations served. Examples of appropriate indicators include: reductions in consumption of dietary fat; decreased prevalence of overweight; increased rates of physical activity; reductions in the use of tobacco and illicit drugs; reductions in the hazardous use of alcohol and prescription drugs; and reductions in the incidence of STDs, unwanted pregnancies, and injuries related to personal behaviours. A more detailed list of suggested evaluation indicators related to a lifestyle/individual approach to health promotion can be found in Appendix A.

Supporting the position that health is a positive resource for everyday life, indicators that are based on assets, or positive attributes at an individual and/or community level need to be included in the Ministry's evaluation framework (Jackson, 1995; Rajkumar, 1997). Furthermore, social indicators appropriate for a socioenvironmental approach to health promotion must incorporate subjective notions of "wellness" and "quality of life," as well as subjective and objective measures of "social justice" and "social well-being" (see Appendix A for suggested quality of life and social well-being indicators). In order to measure subjective concepts such as what we mean by a "well" society, evaluations should include the perspectives of clients or populations served. This approach requires meaningful public debate in the setting of goals, purposes, guiding principles and evaluation indicators for IHSs at both a provincial and local level, and is consonant with health promotion's emphasis on public participation (Eyles, 1994). It also demands that evaluations of IHSs impact on health include qualitative and quantitative measures. Not all areas of concern regarding the promotion of health can be quantifiably measured (e.g. wellness), and for these concepts rigorous qualitative evaluation methods are appropriate, valid and useful (Eyles, 1994).

Finally, evaluation indicators need to reflect health status outcomes at both a population and a local community level. Population level indicators (e.g. epidemiological data, prevalence of risk factors across the province according to sociodemographic characteristics) can provide a profile of population or community health, against which the entire IHS system and individual IHSs can be evaluated. Population-based indicators of health are unlikely to be sensitive enough to reflect the degree to which IHSs effect the health and well-being of the most marginalized or at risk populations (e.g. the homeless, people living with AIDS, refugees, people with mental illness). Therefore, social indicators are needed to evaluate the extent to which an IHS has addressed social inequities and discrimination by narrowing the gap in health status between those most at risk and the general population. By adopting these types of indicators, the Ministry of Health would hold IHSs accountable for meeting the special needs of marginalized groups on their roster, as well as those who may be unenrollable (e.g. homeless, refugees). Local community level indicators should be developed by each IHS according to provincial guidelines, in partnership with the community served. This will enhance the ability of individual IHS to properly assess the unique health needs of their communities, and the effectiveness of their efforts in meeting those needs.

II: AN LIFESTYLE/BEHAVIOURAL APPROACH TO HEALTH PROMOTION: KEY IHS STRATEGIES

A lifestyle/behavioural approach to health promotion is concerned with the development of personal skills and public policies that support healthy choices and reduce individual risk factors. Key strategies encompassed in this approach include health education, health communication, brief interventions, self-help and mutual aid, self-care, and health promoting policies.

The effectiveness of each of these strategies is described, and examples are provided as to how the strategy could be integrated as a core IHS service. Each strategy is appropriate across all levels of care, with certain strategies (e.g. health education, brief interventions) appropriate or use at all health delivery sites. Within all health delivery domains, and particularly for primary health care, these strategies should be supported by multidisciplinary teams of health practitioners. The cost-effectiveness, quality and value of a collaborative, multidisciplinary approach to primary health care is supported by the WHO (1978) and the Advisory Subcommittee on Primary Care of the Joint Provincial Nursing Committee (1997). To reflect the broader concept of health that IHSs would be working to promote, a primary health team might include a physician, RN, RPN, NP or PHN, nutritionist, social worker, occupational therapist, chiropractor and/or a health promoter.

Each strategy is appropriate and effective across all major risk factors, although effectiveness may be increased by using strategies in coordination with each other. Multi-component strategies may be used to target a specific risk factor or multiple risk factors, and may be directed toward a specific population group, or the community at large. Broad, multi-component community-based strategies, such as the Heart Health Initiatives and Focus Communities in Ontario, may achieve the added benefits of strengthening community action and creating health-supportive environments while promoting healthy lifestyles and reducing individual health risks.

To enhance the effectiveness of such strategies, IHSs would often be required to collaborate with the Ministry of Health, other IHSs, and external organizations or sectors which have an impact on the health of the population. For example, a team of individuals from IHSs across the province could work together to achieve consistent, comprehensive health education, health communication or healthy public policy strategies for the province of Ontario. In other cases, local collaborative efforts involving partners outside an IHS should be supported through IHS' staff and other resources, as part of the system's mandate to foster local intersectoral health promotion efforts.

Again, each of the strategies described through out this section must be guided by the core values of health promotion, outlined in Section IV.

HEALTH EDUCATION

Health education can be defined as "any combination of learning experiences designed to facilitate voluntary adoption of behaviours conducive to health"(Green et al, 1980, 7). This is done through increasing people's knowledge about and awareness of the health benefits and risks associated with certain behaviours. Health education also involves the development of understanding and skill so that individuals are able to adopt positive lifestyles, and resist or change behaviours that pose a risk to their health.

A strong body of evaluation evidence has shown that health education strategies can produce statistically significant changes in health related knowledge, attitudes and behaviours across risk factors, population groups, and delivery sites. Studies have further demonstrated that a multi-faceted approach to support health education strategies can contribute to the achievement of positive health outcomes (see Table I).

Table I: Evidence for the Effectiveness of Health Education Strategies

Health Education Outcome Evaluations:	References:
Statistically significant changes in health related knowledge, attitudes and behaviours achieved across risk factors, population groups, and delivery sites.	Kok et al., 1997; Glanz et al., 1990
A multi-faceted approach to support health education strategies can contribute to the achievement of positive health outcomes.	Glanz et al., 1990; Bracht, 1990
Statistically significant changes in knowledge, attitudes and behaviours have been demonstrated by: • school-based tobacco, alcohol and drug prevention programs • alcohol-server intervention programs • smoking cessation programs based in primary health care settings • nutritional health education initiatives targeting individuals of all ages and socioeconomic groups, in schools, worksites, points of purchase, community-based health settings, and hospitals • interventions in the community, worksite, school, home and health care setting to increase physical activity • school- and community-based programs to reduce sexual risk behaviours and prevent STDs/HIV • Best Start programs to promote breast feeding • community-based health education strategies to reduce or prevent injuries	• Sheehan et al., 1996; Tobler, 1994; Botvin & Tortu, 1988; Rundall & Bruvold, 1988 • Shah, 1994 • Strecher et al., 1994 • Contento et al., 1995 • Dishman & Buckworth, 1996; Schooler 1995 • Kirby et al., 1994; Kim et al., 1997; Holtgrave et al., 1995 • Hartley & O'Connor, 1996 • Ontario Injury Prevention Resource Centre, 1996; Smith Ulione, 1997
Can be effectively delivered by various program leaders.	Tobler, 1994; Botvin & Tortu, 1988; Contento et al., 1995

Too often, however, health education strategies have focused on changing knowledge and attitudes while neglecting to incorporate skill development and a socio-cultural perspective into their efforts.   As changes in knowledge and attitudes do not necessarily

result in changed behaviour, evaluation results for this strategy have been mixed. In order to enhance the effectiveness of health education interventions, comparative evaluation studies have been used to identify best practices and critical success factors for achieving desired behaviour change (see Table II). It is our position that all IHS' health education efforts be developed according to these guidelines to optimize positive health outcomes.

Table II: Best Practices for Health Education Strategies

Best Practices for Increasing the Effectiveness of Health Education Strategies:	References:
Personal skill development components significantly increase programs' effectiveness.	Sheehan et al., 1996; Tobler, 1994; Botvin & Tortu, 1988; Rundall & Bruvold, 1988; Contento et al., 1995; Dishman & Buckworth, 1996; Oldenberg et al., 1995; Main et al, 1994; Kim et al., 1997; Kelly & St. Lawrence, 1990; Holtgrave et al., 1995; Eldridge et al., 1997
Understanding lifestyles and behavioural choices from a socio-cultural perspective, and designing health education strategies accordingly.	Viswesvaran & Schmidt, 1992; Sheehan et al; 1996; Tobler, 1994; Botvin & Tortu, 1988; Rundall & Bruvold, 1988; Contento et al., 1995; Schooler, 1995; Bryan et al., 1996
Planned and systematic application of behavioural and social science theory.	Botvin & Tortu, 1988; Rundall & Bruvold, 1988; Contento et al., 1995; Schooler, 1995; Schaalma et al., 1996; Holtgrave et al., 1995; Hartley & O'Connor, 1996
Appropriate use of rewards, financial incentives, feedback, and reminders.	Rundall & Bruvold, 1988; Contento et al., 1995; Schooler, 1995
Collaborative development of health education interventions with representatives of the target and user groups, interventions targeted to specific audiences, and interventions that are participatory in nature.	Kok et al., 1997; Strecher et al., 1994; Tobler, 1994; Botvin & Tortu, 1988; Contento et al., 1995; Schooler, 1995; Schaalma et al., 1996
Initiatives producing desired behaviour changes reinforced with a combination of health promotion interventions intended to change social norms (e.g. advocacy, social marketing) and support healthy environments (e.g. healthy public policy, community-based programming).	Contento et al., 1995; Osganian et al., 1996; Llytle et al., 1996; Jeffery et al., 1995; Wilson 1991; Schooler, 1995; Ontario Injury Prevention Resource Centre, 1996

HEALTH EDUCATION: A VISION FOR IHS IMPLEMENTATION

As with all health promotion strategies, health education is most effective when used in conjunction with other health promotion strategies. Multiple human services are therefore often involved in integrated intervention efforts. For example, an IHS might initiate a comprehensive health education strategy in order to reduce the hazardous consumption of alcohol and the incidence of alcohol related motor vehicle accidents within their rostered community.

IHS' staff might work with the education sector to provide a progressive health education curriculum along with general life skills and refusal behaviours in the schools. Some of the system's efforts might go toward developing linkages with the private sector to implement education and training programs for people who sell or serve alcohol. Other staff might work with media and voluntary agencies to develop community educational and social marketing activities such as Drug Awareness Week and campaigns by Mothers Against Drunk Driving. Other educational material, such as posters, pamphlets and self-help resources could be made available in different languages across IHS' delivery sites. The IHS might help to facilitate police involvement in enforcement activities under the Ontario Liquor Licence Act including RIDE (Reduce Impaired Driving Everywhere) and Sober Driver programs. Meeting rooms, support staff and some materials could be provided to assist with the mobilization of the IHS' community in encouraging municipal governments to establish alcohol control policies (Ontario Ministry of Health, 1994). These supports might also be directed towards mutual support groups like AA. Staff may develop programs like Ontario's Focus Communities, which combine adult education, community mobilization to improve high risk conditions, and build social support networks at the same time as they change awareness, knowledge and problem behaviours associated with alcohol and drug use. Primary health teams could use risk factor questionnaires with their rostered members at periodic health examinations to assess for (potentially) problem drinking behaviours, and use brief interventions to change or prevent these behaviours. Furthermore, specific health education initiatives could be developed to integrate with health and health-related social services within the IHS which are directed towards target populations such as children and youth, pregnant women, people who have experienced abuse, and/or the homeless.

A further example of how IHSs could develop comprehensive community initiatives that integrate health education strategies with other complementary health promotion and preventive medicine strategies is provided in the following discussion of Health Communication.

Based on the evaluation evidence presented for the effectiveness of health education strategies to positively impact behaviour change across different health risk factors, target groups, and delivery settings, and the feasibility of integrating health education within IHSs, it is our position that health education strategies should be incorporated as a core IHS service.

HEALTH COMMUNICATION

Health communication incorporates a broad range of health promotion interventions including media advocacy, risk communication, social marketing and other activities focused on individual and environmental determinants of health (Rootman & Hershfield, 1994; Maibach & Holtgrave, 1995). It is a comprehensive approach to health communication involving activities that communicate to, educate, and persuade audiences

so as to promote health. Communications are not limited to lifestyle behaviours, but address any issue which supports individual health and social well-being, such as public participation in civil society (Hershfield, 1997).

Traditionally, social marketing has been the most frequently used approach to health communication. Social marketing can be defined as "the design, implementation and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s)" (Kotler, 1982). Social marketing campaigns involve "the deliberate and intentional use of marketing tools and techniques to plan, implement and evaluate efforts designed to increase support for a wide range of ideas and practices that change the world (at the individual, organizational, and collective levels), for the better (acting in alignment with commonly held health promotion values)" (Hershfield, 1997). Typically, social marketing strategies have attempted to increase audiences' knowledge and awareness of the benefits and risks of lifestyle choices, to promote healthy social attitudes, and to encourage the adoption of health-promoting skills and practices through an organized set of communication activities (e.g. TV/radio public service announcements, posters, booklets, brochures) (Ling et al, 1992; Maibach & Holtgrave, 1995; Freimuth & Taylor, 1995).

Social marketing strategies are distinguished from other health communications strategies by their grounding in corporate advertising and consumer psychology theory. These strategies focus on the beliefs, preferences, needs and characteristics of target audiences, and the "saleable" qualities of the desired outcome or product (Kotler & Zaltman, 1975). Key social marketing concepts include processes of audience analysis and segmentation to better define the group of intended recipients, and the integration of basic marketing elements (price, product, place, promotion and, more recently, participation) to enhance campaign success (Lefebvre and Flora, 1988; Mintz, 1989).

A variety of health communication strategies have been implemented by a wide range of health organizations, including government agencies, local health agencies, and non-profit groups (Ling et al., 1992; Maibach & Holtgrave, 1995). The potential effectiveness of these strategies has been demonstrated in numerous evaluation studies and meta-analyses, for a diverse range of risk factors (see Table 3).

Interventions using media alone are generally most effective in changing awareness, knowledge and stimulating information seeking. These outcomes begin to shift individuals and communities closer to a stage of readiness for actual behaviour change, and contribute to the framing the public agenda around key health issues. In some cases, highly targeted, audience-centred social marketing or health communication campaigns have used a carefully focused message to achieve changes in actual behaviour (Contento et al., 1995). The Stanford Five community-based cardiovascular disease prevention program is a classic example of the potential effectiveness of intensive mass media campaigns to achieve significant changes in health behaviours (Shea & Basch, 1990). The study was based on a community trial in which a control city showed increased prevalence of CVD risk factors during the two year study period, while the experimental community, exposed

to intensive mass media campaigns, witnessed a reduction in risk behaviours (Shea & Basch, 1990). In most cases, however, social marketing and health communications strategies are used in conjunction with other health promotion strategies, in order to achieve significant changes in health-related attitudes and behaviours (see Table 3).

TABLE 3: EVIDENCE FOR THE EFFECTIVENESS OF SOCIAL MARKETING/ HEALTH COMMUNICATION STRATEGIES

Outcome Evaluation:	References:
Significant change in knowledge, attitudes and/or behaviour demonstrated for strategies targeting: • multiple risk factors related to cardio-vascular disease • nutrition • physical activity • HIV/AIDS prevention	 • Shea & Basch, 1990; Noack & McQueen, 1988 • Contento et al., 1995 • Schooler, 1995 • Wagman, 1993
Significant changes in attitudes, contemplation of and readiness for behaviour change, and framing the public agenda around key health issues	Shaw, 1994
Results from a meta-analysis of the empirical evidence on effectiveness of mass mediated health campaigns in the United States since 1980: • 100% of evaluations found effects on awareness and knowledge, and stimulated information seeking (effects particularly strong when exposure guaranteed; campaigns that saturated a targeted community without guaranteed exposure approximately 25% effective). • 85% + evaluations found significant improvements in attitude (guaranteed exposure resulted in considerable changes; general results were more modest). • 3 out of 7 studies evaluating behavioral intentions found change rates from 18-73%. • 20 out of 29 studies evaluating behaviour change found change rates from 4-74% (median of 29%)	Freimuth & Taylor, 1995
When combined with other health promotion strategies, (e.g. health education, healthy public policy or community organization), has led to significant changes in health-related attitudes and behaviours.	Farquhar et al, 1977; Flay and Burton, 1990; Redman, Spencer and Sanson-Fisher, 1990; Ling et al, 1992

Ontario's Heart Health Action Program (HHAP) provides an excellent example of how IHSs could use social marketing and health communications as an important component of comprehensive, community-based programs that are developed to enhance the health outcomes of an entire rostered community. Building on similar European and American community initiatives (see Table 4), five Heart Health demonstration sites were developed to learn about effective multiple risk factor community-based programs. Their goal was to reduce risk factors associated with high morbidity and mortality from CVD, and to promote heart health (RBJ Health Management Associates, 1995). Rather than focusing

on high-risk individuals, the HHAP sites targeted various groups throughout their communities (e.g. youth, employees, community leaders and health providers), using a mix of health promotion strategies (e.g. social marketing and health communications, health education, healthy policy, community organizing). Multiple risk behaviours were addressed (physical activity, nutrition, tobacco use), and many sectors were involved in an attempt to build community commitment to the project's overarching goal.

TABLE 4: COMPREHENSIVE, COMMUNITY-BASED BEHAVIOURAL/LIFESTYLE HEALTH PROMOTION INITIATIVES

Previous Community-based Initiatives to Reduce CVD Risk Factors:	References for Program Overviews:
- Stanford Three-Community and Five-City Projects - Minnesota Heart Health Program - Pawtucket Heart Health Program - Pennsylvania County Health Improvement Project - Heart Beat Wales - North Karelia Project	Elder et al., 1993; Jacobs et al., 1986; Mittlemark et al., 1993; Shah, 1994; Shea & Basch, 1990

HEALTH COMMUNICATION: A VISION FOR IHS IMPLEMENTATION

Similar comprehensive, community-based health promotion initiatives are feasible, and make sense for IHSs. As most people have some level of risk related to preventable behaviour/lifestyle factors, IHSs would be in an excellent position to develop initiatives intended to reduce risk and improve health outcomes across their entire rostered community. IHSs would also be able to ensure that complementary messages are delivered through multiple channels (e.g. school programs, worksite/adult education programs, mass media campaigns, health provider interventions), by facilitating and integrating the active participation of multiple sectors stakeholders within the community.

Clearly, such efforts would reflect a long-term process of change. During the early stages of change, awareness raising strategies are particularly effective at building a profile for the initiative as an important community issue (RBJ Health Management Associates, 1995). The Heart Health sites used specific social marketing/health communication interventions such as a television series on heart health topics, transit ads, regular newspaper columns and ads, and illuminated signs in local public arenas throughout their programs, but particularly during the early stages. IHSs could use similar health communication activities early on in their broad-based community initiatives to increase awareness around specific health-related behaviours and to increase individuals' readiness to make changes in their lifestyle.

IHSs could also use health communication strategies to support and reinforce other health promoting activities. For example, routine personal health risk assessments could be conducted within IHS' primary health delivery sites. Based on the assessments, members

of the health team could provide health education and brief interventions as needed to promote healthy eating and physical exercise amongst clients, and to encourage smoking cessation. The opportunity for similar interventions might also arise with clients admitted to secondary care institutions who are found to have an elevated risk in at least one of these areas. IHS' staff could develop heart health promotion projects for workplaces, schools, and summer camps, and provide training for local personnel and teachers so that they are able to sustain the programs themselves. Supermarket tours, dining guides, and classes teaching low-cost, nutritional cooking skills could be developed by IHS' staff. Educational and self-help resources could be made available, emphasizing a holistic approach to individual and family health, and providing practical tips for action and contacts for support. The IHS could assist local community groups in the development of health-promoting community events, and ensure lots of opportunity for community involvement in related activities and projects. IHS' staff could also assist the community in developing and advocating for healthy public policies such as smoking bylaws, bike lanes, and cafeteria policies.

Given the evidence that social marketing and health communication techniques effectively increase individuals' awareness about the health consequences of their behaviours, and that they have a positive "complementary" effect on other health promotion interventions intended to produce health-related behaviour change, it is our position that these strategies be included as a core IHS service.

BRIEF INTERVENTIONS

Brief interventions optimize the role of health professionals in motivating clients to alter their health risk behaviours (Skinner & Bercovitz, 1996). Clinical encounters between health providers and clients provide an excellent opportunity for brief health promotion and disease prevention interventions. For example, studies show that approximately 10-15% of clients in family practice settings are problem drinkers, and that problem drinkers consult their physicians twice as often as non-problem drinkers (Shah, 1994). Health providers are therefore in a good position to identify clients who are/are at risk of becoming problem drinkers, and offer early brief interventions to reduce the risk of related medical and psychosocial consequences.

Table 5: Evidence for the Effectiveness of Brief Intervention Strategies

Brief Intervention Outcome Evaluations:	References:
Smoking Cessation: • cessation rates increased by physicians providing advice during a single routine consultation, or brief smoking cessation messages reinforced on multiple occasions	• Skinner & Bercovitz, 1996; Kottke et al. 1988; Wilson et al., 1988

• tremendous cost effectiveness of cumulative impact of even modest cessation rates (5.8% - 10%)	• Skinner & Bercovitz, 1996; Ockene, 1987
• success rates increasingly effective when interventions target special risk groups (e.g. pregnant women, those with ischemic heart disease)	• Dolan-Mullen et al. 1994
• extreme cost effectiveness of brief counseling during routine office visits combined with nicotine replacement therapies (e.g. nicotine transdermal patches) to increase cessation rates	• Wasley et al., 1997; Fiore et al., 1994; Silagey et al., 1994
• increased effectiveness of advice when used in combination with low to high intensity counseling, more frequent contacts, self-help booklets, and/or the use of nicotine replacement therapies	• Ockene, 1987
Problem Drinking:	
• effectively reduced/changed alcohol consumption behaviour and achieved treatment referral	• Bien et al., 1993; Shah, 1994; Wilk et al., 1997
• single sessions of sympathetic, constructive advice concerning behavioural self-control strategies, substitutes for drinking behaviour, and brief monitoring consistently found to be more effective than no interventions, and often just as effective as more extensive treatments, in moderating consumption	• Bien et al., 1993; Wilk et al., 1997
Physical Activity: Increased levels of physical activity in high to low risk individuals through:	
• use of counseling	• Lewis et al., 1991; Schooler, 1995;
• video tapes prior to/after health visits	• Nader et al., 1989
• distributing materials promoting physical activity during routine health visits	• Campbell et al., 1994
• evaluating clients' activity levels using Physician-Based Assessment and Counseling for Exercise model (PACE)	• Calfas et al., 1996
Injury Prevention: 90% of brief childhood injury prevention counseling initiatives in primary care settings reviewed achieved positive outcome effects (e.g. increased knowledge, improved behaviour, decreased injury occurrence)	Bass et al., 1993

Recognizing the potential effectiveness of these opportunities, comprehensive guidelines for preventive counseling services have been developed (Skinner & Bercovitz, 1996). Areas of focus include: diet/weight; physical activity; sexual practices/prevention of unwanted pregnancies; tobacco, alcohol and drug use; injury prevention; and more preventive medical focuses (e.g. breast and testes self-exam). Evidence supporting the effectiveness of brief interventions in achieving desired behaviour change is summarized in Table 5.

These findings and others form an impressive body of research supporting the effectiveness of brief interventions across a variety of risk factors. In particular, autonomy supportive approaches that empower clients, that increase their feelings of self-efficacy around healthy behaviour change, and that motivate them to change unhealthy behaviours have been found to increase the effectiveness of brief interventions across health risk factors (Williams et al., 1996; Botelho & Skinner, 1995). Yet, despite the evidence, and the fact that a majority of adults visit health practitioners annually, expecting that their

practitioner will ask about and provide assistance for health behaviour concerns, practitioners are not routinely raising health risk behaviours with clients (Skinner, 1993; Skinner & Bercovitz, 1996; Wallace & Haines, 1984). Opportunities to maximize brief interventions are avoided due to practitioners' general pessimism regarding their ability to intervene effectively (Skinner & Bercovitz, 1996).

BRIEF INTERVENTIONS: A VISION FOR IHS IMPLEMENTATION

To remove this barrier, IHSs should take advantage of the numerous strategies developed to increase practitioners self-efficacy and increase the likelihood and effectiveness of brief interventions. Educational programs and materials for practitioners that demonstrate the success of skills and approaches to facilitate health-promoting client behaviours have been successful in increasing practitioners use of this strategy (Ockene, 1987). For example, The College of Family Physicians of Canada has developed an Alcohol Risk Assessment and Intervention (ARAI) Resource Manual for Family Physicians (1994) to help educate practitioners regarding this type of brief intervention.

IHSs should also support the use of teamwork, flexible routines and joint problem solving amongst physicians, staff and clients, factors which have been found to enhance and facilitate the use of preventive care interventions in clinical settings (Dietrich et al., 1994; Jaen et al., 1994; Ockene, 1987). IHSs could incorporate the use of a general lifestyle or health-risk assessment survey (self-administered or directed by a member of the primary health team) into routine primary care visits. It should be noted that the use of brief interventions by health practitioners is not limited to physicians but is intended for use by a variety of health practitioners (Botelho & Skinner, 1995). Therefore, based on survey findings, the most appropriate member of the primary health team (e.g. nurse practitioner, nurse, allied health professional, nutritionist, or other lay health worker) could address areas of concern with the client to help them change their behaviour.

Brief interventions are most effectively employed in the primary care setting, as this is usually the first, and therefore most upstream contact that clients have with the health system. However, they are also an appropriate and effective strategy in all IHS' delivery settings. For example, hospital staff could easily incorporate brief smoking cessation interventions into their pre and/or post-operative consultation with clients. The initial intervention could be noted on the client's integrated health file, making it easier for a member of their primary health team to follow up and/or monitor the intended change in behaviour. Staff in long-term care facilities see their clients on a daily basis, and therefore have the ongoing opportunity to identify high risk behaviours and intervene before problems develop. Home care health providers could use brief interventions as needed, for example in the area of injury prevention or smoking cessation during post-natal home visits, or to promote proper nutrition and appropriate levels of physical activity amongst the elderly living at home. By training staff across delivery sites in the appropriate, opportunistic use of brief interventions, IHSs could maximize their opportunity to positively effect health-related behaviours, and enhance the health status of their clients.

Based on the evidence of outcome effectiveness, it is our position that the use of brief interventions be expanded and included as a core service through out IHSs.

SELF-HELP AND MUTUAL AID

Self-help or mutual aid have been described as "a process wherein people who share common experiences, situations or problems can offer each other a unique perspective that is not available for those who have not shared these experiences" (Self-help Resource Centre of Greater Toronto, 1996). Self-help and mutual aid groups are run by and for their members. Any involvement by professionals is limited to a consultative or ancillary role, and is at the request of the members (Kurtz, 1990). Groups are open to all members of the general public, offering free and voluntary help (Kurtz, 1990).

The primary objectives or beneficial outcomes of a self-help or mutual-aid strategy include the exchange of emotional support, self-disclosure, problem clarification, information sharing, friendship, identity formation, personal growth and transformation, advocacy, and collective empowerment (Kurtz, 1990). A review of research literature reveals that self-help initiatives enable people to cope with range of health-related problems (e.g. addictions, bereavement, abuse, cancer, disabilities and mental health issues) (Rogers, 1989; Kurtz, 1990; Medvene, 1990; Powell, 1994; Hyndman, 1996). They also have been found to encourage the adoption of preventive practices amongst members, such as decreasing high-risk injection practices and promoting HIV prevention measures amongst intravenous drug users (Sibthorpe et al., 1994).

Few formal outcome or impact evaluations of self-help and mutual aid groups have been conducted, for a number of reasons. Some barriers to formal outcome evaluations include concerns regarding anonymity and privacy, altering the natural helping process through intrusive evaluation methods, a lack of interest on the part of members to measure impacts and keep files or records, variable group participation, self-selected heterogeneous populations, and the lack of proven causal relationships between positive benefits of self-help or mutual aid groups and changes in standardized, clinical health status outcomes (Kurtz, 1990a; Hyndman, 1996; Romeder et al., 1990; McCrady & Miller, 1993). As a result, qualitative studies that capture the "lived," personal and subjective experiences of group members and the underlying socio-cultural context are a valid and appropriate alternative method for evaluation. Qualitative studies can be used to gather evidence as to the nature and extent of the strategy's impact on members, and explain why or how that impact occurred (Hyndman, 1996).

Despite the challenges to conducting impact evaluations on self-help/mutual aid groups, research has shown this strategy to be effective at promoting the health and well-being of group members. For instance, changes in US cirrhosis mortality rates have been positively associated with changes in per capita consumption and negatively associated with membership to Alcoholics Anonymous (Mann et al., 1991). While a causal interpretation is not possible, the hypothesis of its existence (i.e. lowered levels of per

capita consumption and increased AA membership reduce the drinking levels of individuals who might otherwise die from liver cirrhosis) is supported by Swedish and Canadian data (Mann et al., 1991). Furthermore, members of GROW, a twelve step self-help group designed to help members suffering from a history of psychiatric problems in preventing or recovering from mental illness, were found to have fewer hospitalized days over a thirty-two month period than did a comparable group of non-members (groups were matched on twelve variables including history of hospitalization) (Kennedy, 1989).

Self-help and mutual aid groups are increasingly seen as effective strategies used to support caregivers (Toseland et al., 1990; Toseland et al., 1989) and, more commonly, individuals with disease-related health concerns (Trojan, 1989). A review of the benefits of these strategies as reported by members from 65 disease-related groups found that for the vast majority, participation positively impacted disease-related stress, relationships with family and friends, and patient behaviour and professional services (Trojan, 1989). These findings are supported by an evaluation of Edmonton's Cross Cancer Institute (CCI). The majority of women who attended CCI self-help group sessions for four months described the strategy as a good way to find effective coping skills to get them through the cancer treatment, and felt that the sessions increased their self-esteem (Look Good, Feel Better, 1997). Supportive data have also led the Canadian Cancer Society to develop a Reach to Recovery program in which volunteers who have had breast cancer visit one-to-one with women newly diagnosed with the condition (an impact evaluation is currently underway).

Studies have found that self-help and mutual aid strategies are more likely to achieve positive outcomes if they increase members' degree of participation in the group. Increased participation has been linked to increased satisfaction and self-esteem, reduced treatment utilization, greater coping skills, and more positive attitudes towards health-related problems (Kurtz, 1990; Reissman & Carroll, 1995).

SELF-HELP/MUTUAL AID: A VISION FOR IHS IMPLEMENTATION

IHSs would be in an excellent position to support interested members of their rostered community in developing self-help/mutual aid groups. IHS' staff could provide professional assistance (when requested), meeting space, and other appropriate resources to support these groups. This form of IHS' support should be made known to clients through publicized posters, pamphlets and other modes of communication. IHSs could be particularly helpful in assisting established self-help/mutual aid groups overcome barriers to regular attendance and participation by interested members of the rostered community. IHSs could help to market the groups, their meeting places, and their meeting schedules. They could also provide self-help groups with information, contact numbers, supportive research, and practical tips on the particular issue of interest, increasing participation within groups, ensuring accessibility, and other related matters.

Therefore, it is our position that, as a mandatory core service, IHSs should support the creation and existence of self-help and mutual aid groups by interested members of their rostered community.

SELF-CARE (SELF-GUIDED HEALTH EDUCATION)

Self-care has been described as a set of unorganized health activities and health-related decision making by lay people to promote healthy personal skills and behaviours on their own or their families behalf (Hatch & Kickbusch, 1983). Self-care actions may concern medical problems (e.g. prevent disease, evaluate symptoms, restore health), or they may be aimed at maintaining and improving health (Health Canada, 1997). They have been characterized by several health care disciplines as: "being situation and culture specific; involving the capacity to act and make choices; being influenced by knowledge, skills, values, motivation, locus of control and efficacy; and focused on aspects of health care under individual control (as opposed to social policy or legislation)" (Health Canada, 1997).

Increasing evidence indicates that a substantial percentage of individuals who resolve their health risk behaviours do so without relying on formal or professional help (Sobell et al., 1993; Cunningham et al, 1992; Stall and Beirnacki, 1986). Approximately 80-90% of cigarette smokers quit (Fiore et al,, 1990; Orleans et al , 1991), 60-75% of problem drinkers abstain or achieve moderation (Cunningham et al, 1992), and 60% of overweight individuals lose weight (Schachter, 1982) on their own. These rates suggest the need for greater support of self-care or self-guided strategies.

While conclusive evidence on the health impacts of self-care is lacking, a review of the effectiveness of self-care interventions reveals that (1) self-care is widely practiced, (2) self-care actions are often beneficial and seldom harmful, and (3) self-care appears to be a universal behaviour (Health Canada, 1997). Self-care strategies may include planned self-care education programs, booklets, manuals, video cassettes and other tools that are directed to individuals who want to guide themselves to healthy lifestyles or behaviours. Self-care materials most often provide health education related to smoking cessation, moderating alcohol consumption, dietary compliance, physical activity, self-medication, self-treatment, and social support activities that take place within context of people's normal, everyday lives (Hyndman, 1996; Hatch & Kickbusch, 1983).

For example, self-care manuals used in minimal contact smoking cessation programs have been found to be useful in enhancing self-efficacy and self-management skills, key success factors required for permanent smoking cessation (Pederson et al., 1981; Utz et al., 1994). Initial assessments of self-care books offered to persons wanting to quit or cut down on their alcohol use have also been shown to achieve significant short-term effects in moderating drinking behaviours (Sanchez-Craig et al., 1996). Dietary self-care materials promoting healthy eating patterns in the general population suggest the potential for modest positive changes in behaviour, particularly in the preparation of food for families

(Beresford et al., 1992). Similarly, a review of physical activity interventions suggests that providing individuals with information promoting non-structured physical activities that can be done at home at the individual's convenience may be an effective strategy, especially if used in combination with programs delivered in multiple settings (King et al., 1991).

There is also evidence to indicate that use of self-care resources is a cost-effective strategy for encouraging health promoting practices (Hyndman, 1997). Although not all outcome evaluations have found self-care interventions to achieve the sustainability or high rates of behaviour change as more intensive programs, self-care strategies are generally more portable, and therefore have widespread potential for dissemination and broad-based impact on population health (Hyndman, 1997).

SELF-CARE: A VISION FOR IHS IMPLEMENTATION

While the limits to self-care must be acknowledged, this strategy can add significantly to a person's competence and skills (Health Canada, 1997). The aim of self-care should be "to develop a more efficient health care system, one based on fuller exploitation of every component and every competence, and on the dynamic and integral involvement of people" (Perreault & Malo, 1989). IHSs could support self-care strategies in a number of ways.

A precondition for the development of self-care by individuals has been found to be the presence of receptive providers (Barofsky, 1978). Therefore, primary health teams within IHSs need to develop open, autonomy-supportive, collaborative partnerships with their clients. IHSs need to ensure providers have time for consultation and the appropriate transfer of some aspects of care (e.g. assessment, monitoring and treatment) to their clients during client visits. Building clients' self-efficacy (the belief that one is capable of dealing with a specific problem) and self-concept have been reported to play a potentially greater role in self-care than having information or skills (Health Canada, 1997). Therefore, health providers could support clients through counseling that addresses these factors, and client motivation.

Education and intervention strategies could be developed to increase clients' knowledge and skills, enabling them to more actively participate in creating their own health. Providers could discuss with clients the activities they envision themselves engaging in to promote their own health. Reinforcing positive health behaviours with feedback and follow-up, assisting clients to develop short- and medium-term goals for behaviour change, and helping clients build support from family, social networks and their community are all ways IHS staff could support self-care. Workshops that focus on self-care could be organized for clients in various settings, and user-friendly self-help materials related to a range of lifestyle issues could be developed to address the health and language needs of different client groups. These tools could be placed in all IHS' primary health delivery sites near to the comprehensive lifestyle or risk-assessment survey previously mentioned. Clients would therefore be able to select material related to areas of personal concern.

IHSs could make self-care materials available at community health delivery sites, long-term care facilities, pharmacies, community health resource centres, worksites, and schools. IHSs could integrate this strategy into their primary health practice with a well-developed assessment of clients' self-care behaviours (a framework to support this approach has been developed by Health Canada), and by recommending self-care tools, materials and programs to clients (Health Canada, 1997). Finally, self-care strategies could become an integral part of other IHS' health education and brief intervention activities.

Based on initial evaluation data it is our position that, as a core service, IHSs provide support materials to assist clients attempting to promote their own health through self-care strategies.

HEALTHY PUBLIC POLICY

The Ottawa Charter for Health Promotion defines the building of health promoting public policy as a combination of "diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change" (WHO, 1986). This strategy demands coordinated action and shared responsibility amongst policy makers in all sectors and at all levels, requiring that they "be aware of the health consequences of their decisions and to accept their responsibilities for health" (WHO, 1986). The aim of healthy public policy in relation to an individual or lifestyle approach to health promotion is to prevent unhealthy public risks and to facilitate and support the adoption of healthy choices.

Policy measures to control tobacco generally have widespread support within the health system, and their effectiveness is backed up by strong scientific evidence. Policies on pricing have been shown to have a strong impact on consumption of tobacco products. With every 10% price increase, studies from Canada, Europe, the United States and New Zealand have found a corresponding drop in consumption of 3-6% (Godfey & Maynard, 1988; Townsend, 1988; Pekurinen, 1991; Sweanor, 1991, 1992; Andrews & Franke, 1991; European Union/HEA, 1995).   Tobacco taxation policies have the greatest impact on adolescents and low-income groups, whose consumption patterns are more price-sensitive (Sweanor, 1991; Townsend et al., 1994). While effective, pricing policy strategies are most difficult for low-income smokers, whose disposable income may be significantly reduced as a result (Marsh & McKay, 1994). Therefore, pricing policies should be used in combination with policies targeting availability, distribution and promotion, and with interventions that assist these populations in smoking cessation and in enhancing their living conditions.

Pricing policies are also one of the most effective policy strategies for reducing the consumption of alcohol, and for reducing the harmful social consequences of dangerous alcohol consumption, such as motor vehicle accidents and deaths (Moskowitz, 1989; Edwards et al., 1994). Although to a lesser extent than with tobacco, taxation rates for

alcohol effect the consumption patterns and the disposable incomes of low-income individuals the hardest. To be most effective, pricing policies should be used in combination with other policies around the system of alcohol distribution, minimum drinking age laws, restrictions on advertising, municipal alcohol legislation, and legislation requiring liquor licence holders to provide their staff with server training interventions, and with other health promotion strategies (Ontario Task Force on the Primary Prevention of Cancer, 1995).

Nutrition policies are internationally recognized as an appropriate strategy for the promotion of healthy eating and the reduction of diet-related chronic diseases (Edwards, 1996). Dietary policies include the development and promotion of dietary guidelines such as those found in the Canada Food Guide, and economic strategies to ensure access to a high-quality, affordable supply of nutritious food (e.g. reducing the price of whole wheat flour, lowering the duty on imported fruits) (Posner et al., 1994). Other examples of suggested policy strategies include an intersectoral approach between government, the agri-food industry, food retailers and food services to ensure the comprehensive implementation, monitoring and evaluation of policies to promote healthy eating habits in stores, restaurants, and school/worksite/health organization cafeterias, and the development of an adequate food labeling system to assist consumers in making informed nutritious food choices (Ontario Task Force on the Primary Prevention of Cancer, 1995).

In regards to physical activity, this type of "passive" intervention strategy is often found to be more successful at achieving population wide changes than those requiring active decision making by individuals (King, 1995). From posting point-of-choice messages next to stairwell entries, elevators and escalators in public buildings, which significantly increase stair use by both obese and fit people, to multi-policy community-based strategies, physical activity can be positively effected (Brownell et al., 1980). For example, a community-based intervention combined legislation with other health strategies to significantly increase their community's fitness levels, including levels among persons with substandard fitness levels at baseline (Linenger et al., 1991). The intervention included increasing access to recreational facilities and extended their hours, building bicycle paths, installing new exercise equipment in gyms, scheduling community-wide athletic events, opening women's fitness centres, marking running courses throughout the community, organizing running and cycling clubs, encouraging employees to provide release time for physical activity, and initiating rewards for improved physical performance. In another low-income community physical activity levels were moderately increased through policies that upgraded community recreation facilities and enhanced general safety precautions (i.e. the presence of police during outdoor exercise session), thereby making activity more convenient and safe (Lasco et al., 1989).

Various health bodies have recommended the development and implementation of appropriate policies targeting other diverse unhealthy public risk factors, including sun exposure (e.g. mandatory available shaded areas at all school yards, beaches, playgrounds and other outdoor public and work places where feasible, and a labeling system to identify the degree of UV protection for all articles of recreational clothing) (Ontario Task Force

on the Primary Prevention of Cancer, 1995), healthy sexual practices (e.g. availability of condom machines in school and public restrooms, subsidized pricing for contraceptives), and injury prevention (e.g. road safety standards, speed limits, the creation of bicycle lanes, mandatory bicycle helmets).

HEALTHY PUBLIC POLICY: A VISION FOR IHS IMPLEMENTATION

IHSs could allocate a proportion of financial resources and staff time to develop, research and advocate for the implementation of healthy public policies that promote and support healthy lifestyle choices. Healthy public policy efforts can be directed towards multiple levels of government, in multiple sectors. In order to improve the outcome effectiveness of this strategy, IHSs could work with other IHSs, as well as initiate intersectoral collaborative efforts towards a common cause. IHSs could also support the mobilization of members of their rostered communities to advocate for healthy public policy around issues that most concern them. IHS' support could include the provision of meeting rooms, research support, administrative support in drafting reports or position papers, and staff support in organizing and outreach efforts.

It is our position that a core IHS service should involve development, research and advocacy efforts to promote the implementation of healthy public policies. As part of this core strategy, IHSs should be required to demonstrate their involvement in a certain amount of intersectoral collaborative efforts, and their support for community mobilization and advocacy around healthy public policy issues.

III: A SOCIOENVIRONMENTAL APPROACH TO HEALTH PROMOTION: KEY IHS STRATEGIES

A socioenvironmental approach to health promotion is concerned with strengthening community action, building healthy public policy and promoting environments that are supportive of health. Key strategies encompassed in this approach are described below. They include community development and community economic development programs, healthy public policy and health advocacy, and developing comprehensive health promotion initiatives for schools, workplaces and communities.

The contribution each of these strategies can play in addressing the health impacts of broader socioenvironmental issues is described, and examples are provided as to how the strategy could be integrated within an IHS. It is our position that each of these strategies be incorporated as a core IHS activity area. This does not mean that these strategies should be the sole responsibility of IHSs. Clearly, they will require a collaborative effort with partners outside the IHS. However, IHSs should be held accountable for incorporating these health promotion strategies into their core business. IHSs and the Ministry of Health should also be held accountable for working collaboratively with external health-related agencies and sectors on provincial and local level initiatives that effectively target the broader determinants of health. Collaborative initiatives of this nature should be supported through IHS' staff and other resources as part of the system's mandate to address the impact of the broader determinants of health, and to foster local intersectoral health promotion efforts. Anticipated partners will include grassroots community groups, local schools and/or school boards, municipalities, religious organizations, businesses, social service and related health organizations that may be external to the IHS, other IHSs throughout the province, and various provincial Ministries.

Again, each of the strategies described through out this section must be guided by the core values of health promotion, outlined in Section IV.

COMMUNITY DEVELOPMENT

Community development (CD) has been defined as "the process of supporting community groups in identifying their health issues, planning and acting upon their strategies for social action or social change, and gaining increased self-reliance and decision-making power as a result of their activities" (City of Toronto, 1993). The fundamental purpose of a CD strategy is to improve people's immediate psychosocial health and to strengthen community action, or the collective ability to influence those living and working conditions that effect health. This outcome requires changes in the thinking of community members, and their willingness to participate in planning and implementing actions so as to achieve better health.

A CD strategy first requires clarity about the community to be developed. For IHSs, all rostered members may be considered a community. Yet within that rostered community, there are other groups of people who share a collective identity, and a sense of collective purpose. These groups, or communities, may or may not live in the same local neighbourhood. They may be a community based on a shared belief system, common interests, or some other defining characteristic. Therefore, IHSs, like most neighbourhoods and towns, will have multiple communities within them. A CD strategy may be used to support any type of community group in identifying and acting to resolve the concerns and issues that are important to them (Labonte, 1993). These efforts may be most leveraged, however, when they are used to build community capacity within groups living in high risk conditions, so that they are better able to address the root causes of health and social inequities.

The major underpinning of CD is the notion of empowerment (Wallerstein, 1993; Eisen, 1994; Raeburn, 1996, WHO, 1986). Empowerment has been defined as the capacity for choice. It includes "the ability to define, analyze and act upon problems one experiences in relation to others, and in one's social and environmental living conditions. Empowerment as a process describes the means through which internal feelings of powerlessness...are transformed, and group actions initiated to change the physical and social living conditions that create or reinforce inequalities in power" (Labonte, 1993). Empowerment is what distinguishes CD from many other broad, community-based health promotion strategies, like the heart health initiatives described in Section II.

In community-based health promotion strategies, health professionals and/or health agencies defines a health problem to be addressed (that is usually related to the prevention or reduction of a health risk factor), rather than the community residents. In community-based strategies, health agencies develop specific strategies or interventions to resolve the problem (e.g. health education, brief interventions, healthy public policy), that are implemented according to defined timelines (Hyndman, 1997). While local community members and groups are encouraged to actively participate in community-based health promotion efforts, and, ideally develop the capabilities to take ownership and responsibility for maintaining these efforts, community based strategies are not underpinned by the principle of empowerment (Labonte, 1993; Boutilier, 1996).

In contrast, community development begins with the community defining the issue or problem to be addressed (usually a socioenvironmental factor). Continual negotiation between a community worker, community organizations and community groups enable community participants to critically analyze their broader living conditions, and work together to improve them. The community, not the health authority, is the primary decision-maker with regard to the planning and implementation of health promoting strategies (e.g. mobilization, social action). Furthermore, the outcome focus of CD is enhanced community capacities and improved living conditions, rather than measurable changes in specific health risk factors (Hyndman, 1997).

These distinctions are not a criticism of broad, community-based health promotion strategies. As has been shown in Section II, they are an effective means of reducing health risk behaviors and promoting healthy behaviours within a community, and should therefore become core components of IHSs. The intent of this review is to achieve a common understanding of the process, purpose and value of community development, so that it too can be incorporated as a core IHS area of activity.

Although CD strategies require a long-term impact evaluation, evidence supporting the effectiveness of this approach can be found from a variety of sources. Perhaps one of the most well known projects is the Tenderloin Senior Organizing Project (TSOP), of San Francisco (Minkler & Cox, 1980; Minkler, 1985, 1990, 1992). The project has helped low income seniors meet their health needs for over two decades. Established in the mid 1970s, TSOP responded to the needs of elderly residents of local hotels and rooming houses. Residents were living in extremely high risk conditions, including poverty and social isolation. They had internalized strong feelings of powerlessness, and were plagued by health problems including alcoholism, hypertension, and malnutrition. By slowly gaining the trust of residents, community development workers organized residents to discuss and share their concerns. Gradually, hotel-based coalitions were formed. One of the first issues participants wanted to address was the problem of malnutrition, which was partly the result of a lack of access to fresh fruits and vegetables. Two action plans were developed and implemented. A collective of residents from three hotels arranged contracts with a local food service and established their own hotel-based mini-markets one morning per week. A group of residents in another hotel established a cooperative breakfast program, which qualified their residents for participation in a local food bank. Other initiatives have focused on concerns around crime and violence. They include recruiting local businesses and agencies to serve as "safehouses" where seniors can go in times of emergency. A participant advocacy effort was successful in increasing the number of patrol officers in the neighbourhood, which, along with other measures, brought about an 18% reduction in crime during the year following the project's beginnings (Minkler, 1992). Physical and mental health indicators have improved as the result of stronger social networks, relevant health education, and increased access to the determinants of health (Minkler, 1992). Through continued support for lobbing and advocacy skill development, and leadership and communications training, TSOP has sustained community involvement and strengthened community capacity to successfully promote the health of its members (Minkler, 1992).

Evidence also comes from two winning entrants of the Caring Communities Award sponsored by the Trillium Foundation (Trillium Foundation, 1997). Both communities were recognized for their outstanding leadership in community development initiatives that addressed some of the most pressing issues that are being faced by Ontario communities. In Cornwall, for example, a diverse range of community stakeholders, from residents, local industry, Boy Scouts, and the Kiwanis and Rotary Clubs, worked together on a number of initiatives to protect and enhance their local environment. Their efforts were sparked from community concern about how local economic dependence on textile and paper industries was negatively impact the health of the natural environment, and the community.

Collaborative efforts included the development of an Ecology Park and Community Garden on 4.5 acres of St. Lawrence River Shoreline. The site includes a Community Garden for seniors and low-income residents, a demonstration of how Domtar industrial waste can be used as a fertilizer, a central pond, and a Pavilion.

Successful community-wide development initiatives also enhanced the health of the West Bay First Nation community on Manitoulin Island (Trillium Foundation, 1997). Over the last 15 years, West Bay residents have come together to revive the Native culture that had traditionally bound their community together. Their efforts revitalized a sense of pride and self-identity amongst residents, and generated further energy for community development projects. Community recreation facilities have been built, and the youth of West Bay have become involved in a range of sporting activities. Local jobs and economic growth have been created as a result of a new found entrepreneurial spirit. As the community grows stronger and more vibrant, residents are celebrating the return of educated young people who are now moving back into the community, and there is a growing sense of optimism about the community's capacity to care for the economic and social well-being of its people.

COMMUNITY DEVELOPMENT: A VISION FOR IHS IMPLEMENTATION

Adopting asset based planning like that used by the York Region District Health Council, and by providing resources, training, facilitation and other sources of support to interested community groups, IHSs can enhance the health-promoting capacity of its rostered community. When communities are empowered in this way, they can truly work in partnership with the formal health system towards the shared goal of improved, and equitable health and social well-being.

Based on the value and feasibility of incorporating community development into the ongoing work of an IHS, it is our position that this strategy should also become a core IHS area of activity. A CD strategy will enable IHSs and the communities they serve to really focus upstream, working to address the most fundamental determinants of health and of health and social inequities. By strengthening community capacity, and empowering communities to have greater control over the factors that determine their health, CD has the potential to help IHSs achieve the most sustainable positive impacts on health and social well-being for the people of this province.

COMMUNITY ECONOMIC DEVELOPMENT

Community economic development (CED) is a health promotion strategy that builds on community development. The distinguishing characteristic between the two strategies is CED's focus on addressing the impact of economic factors on communities. Strong evidence points to the importance of adequate income, meaningful employment opportunities, and healthy work environments as fundamental determinants of health

(Wilkinson, 1986; Mustard & Frank, 1991; Evans et al., 1994). Macro-level trends and policies (e.g. long-term unemployment, fiscal restraint policies) can impair equitable access to these determinants, thereby negatively effecting the health of individuals and communities (Hyndman, 1997). Community economic development is a strategy for strengthening communities' economic capacity and self-sufficiency, so that they are less vulnerable to the negative impact of macro-economic trends. The strategy has been defined as "a process by which communities initiate and generate their own solutions to shared economic priorities to enhance their economic and social well-being" (Ross & Ushser, 1986).

An example of a successful CED strategy is the story of Bethel New Life, a community development corporation. New Bethel Life was initiated by two church-based volunteers living in a Chicago neighbourhood. When the local hospital announced plans to close, Bethel New Life mobilized their community and raised the funds needed to buy the hospital's campus. Starting with a budget of $9,600, the community group now has a $6.5 million dollar budget. Working with local businesses, community leaders, citizens, government and other sectors, the group developed a day care centre, drug store, bank, and training institute for office workers and certified nursing assistants in the old hospital buildings. It now has plans for converting the main building into housing units for elderly and adult day care, and in the future opening a primary health care centre on the grounds. The community economic development strategy was founded on the principles of empowerment and self-sufficiency. Building on community assets and resources, the group identified that many people in their community had the skill base to become caregivers, yet they lacked the required formal certification. In response, they developed a local training institute for certified nursing assistants housed in a local building site (the old hospital). The collaborative effort was organized to address issues that the community itself identified as a priority, such as the need for services for the elderly, and job training for people in community. Broad-based communication, public involvement, and partnerships were continued throughout the process, with community leaders guiding the strategy and decision-making around the action plan, and health practitioners serving to facilitate and support the process. Not only was the strategy a major economic and employment success, New Bethel Life developed the community's capacity to exert greater control over the factors that effected its health and well-being (Zablocki, 1996).

Local CED strategies can be found in a number of Ontario communities. For example, the Milverton-Mornington Revitalization process was developed by residents of Milverton to address the closure of the Deilcraft furniture factory. The factory was the largest employer in the community, and its closure left many people unemployed. To improve their economic and living conditions, a community group formed with purpose of revitalizing economic opportunities in the community using, as much as possible, the skills of the unemployed workers. Some success was achieved in buffering the effects of the factory closure, and fostering economic self-sufficiency in the community (Bennet, 1992).

Residents in Ear Falls, a finalist for the Trillium Foundation's Caring Communities Award, joined together in response to the devastating economic effects from the mid-1980's

closure of the town's main employer (Trillium Foundation, 1997). Based on an enduring commitment to build a supportive and open community, local efforts have won new investment and jobs. A proactive community spirit and a strong relationship with local First Nations communities were two of the critical factors that convinced Avenor Inc. to invest $60 million in a new sawmill in Ear Falls.

In Collingwood, another Caring Communities Award finalist, the Healthy Community Council mobilized different stakeholders in the community to rebuild the region's economic base (Trillium Foundation, 1997). Since 1986, Ontario's leading shipyard had entered a period of uncertainty and business decline. Focusing new efforts on tourism, the community has worked together to restore the town's harbour, and transform itself from a once designated "Area of Concern" to the only North American site to be given a clean bill of health by the International Joint Commission. Impressive growth in tourism has been balanced with a sensitivity to local residents, some of who were dislocated. Conscious, innovative efforts have been made to retrain the area's workforce and draw upon community resources in order to meet the demands of the region's new area of economic development.

Different health agencies and providers also support CED strategies on a smaller scale. For instance, the Black Creek Focus Community, a community coalition that takes a CD approach to addressing alcohol and drug related health risks, supported community members in setting up a local bakery. The project was not only intended to generate income, but to develop community members' skills in negotiating and setting up a business, to build on members' existing skill sets (baking, handling money), and to develop a sense of self-efficacy and pride in what community members could collectively accomplish.

COMMUNITY ECONOMIC DEVELOPMENT: A VISION FOR IHS IMPLEMENTATION

IHSs could help members of their rostered community organize and mobilize to address their concerns. Resources such as staff time, planning and administrative skills, and expertise in writing grants and facilitating intersectoral collaboration are all practical ways IHSs could support local efforts. IHSs could also develop CED strategies as ways to assist persons with mental and physical disabilities, and other groups experiencing high risk conditions that negatively impact their access to the basic necessities for health. The Mad Market, a non-profit, used goods store was developed in 1980. Staffed and controlled by mental health consumers, the store provided members of that community with valuable job training, skill development, self-esteem and paid employment (Weitz, 1988). Community groups could explore and develop many more options with the support of IHSs.

Based on the reality that individual and community health is primarily determined by social and economic issues, it is our position that community economic development should become a core IHS area of activity. Enabling IHSs and the

communities they serve to really focus upstream and address the most fundamental determinants of health, CED is a key strategy to promote health and to redress health and social inequities. Furthermore, by strengthening community economic capacity and self-sufficiency, CED, like CD, offers the potential for achieving the most sustainable positive changes in health and social well-being.

HEALTHY PUBLIC POLICY and HEALTH ADVOCACY

In Section II, the strategy of healthy public policy was defined as it relates to an individual/lifestyle approach to health promotion. In that context, healthy public policy refers to policies from any sector that are intended to reduce risk behaviours or promote health behaviours.

In relation to a socioenvironmental approach to health promotion, the strategy takes on a different dimension. "There are many policies that have a direct bearing on the extent of inequality in our society, and thus on the extend to which people from different social circumstances have access to health related resources" (Link & Phelan, 1995). Such policies are often considered to lie beyond the realm of responsibility of the health system. Yet, if root causes of health are these broader living and working conditions, then the potential impact of these broad policies needs to be thoroughly understood and addressed by the health system. As a strategy addressing the broader determinants of health, healthy public policy "is characterized by an explicit concern for health and equity in all areas of policy and by an accountability [in each of those areas] for health impact" (The Adelaide Recommendations, 1988). Healthy public policies can be developed to address the multiple risk conditions and prerequisites to health described in Section I. Whichever risk condition they target, however, they are united by a common goal of redressing structures of social inequities, which have been identified as the root causes of health inequities (Edwards, 1996; Evans et al., 1994; WHO, 1992).

The key factors that determine whether a public policy is "healthy" is that it has a positive impact on health (as it is broadly defined), that it is directed towards achieving social equity and justice, and that intersectoral collaboration and public participation were involved in the development and implementation of the policy (Draper, 1988; Edwards, 1996).

Clearly, the best way to enhance community health and well-being is to create healthy communities. Healthy public policies can serve as an effective framework for helping us shift in this direction. Often, however, the general public equates "healthy policies" with "health policies" related to the organization, funding and delivery of health care (OPHA, 1993). Therefore, IHSs and our health system should develop awareness and education campaigns that help communities understand the impact that their living and working conditions have on health. Once people understand the concepts of and evidence relating to the socioenvironmental determinants of health, they will be better able to make informed decisions and advocate for the public policies they desire to support health and

social well-being. In addition to awareness and education efforts, IHSs should allocate a proportion of financial resources and staff time to research and develop healthy public policies that promote and support healthy environments.

France provides an excellent demonstration of the potential effectiveness of a public policy strategy to promote health. In the early 1980s, the French government passed a number of social and economic policies directly aimed at reducing the risk of premature birth (Kushner & Rachlis, 1994). For example, the government paid women to attend prenatal sessions, and provided them with food supplements during pregnancy. These policies helped to redress income inequities, and ensure that all women had equal access to prenatal education, support, and adequate nutrition, factors that are critical to both the health of the baby and mother (Walker, 1991). Maternity leave before delivery was extended to nine weeks, and pregnant women in Paris were given 30 minutes off at the start and end of every working day to help them avoid the most hectic part of rush hour. Through the collaboration and commitment of national and municipal governments, health authorities, labour unions, and private and public worksites who supported this legislation, the rates of prematurity dropped by 30%, with a 50% decrease in the rates of the lowest birthweight babies (Rachlis & Kushner, 1994). France now has one of the lowest infant mortality rates in world, an outcome achieved primarily through healthy public policy. Not only was policy development a cost effective strategy for avoiding ongoing and costly medical interventions, it also prevented a lifetime of disability and health problems often associated with Low BirthWeight babies (Rachlis & Kushner, 1994).

HEALTHY PUBLIC POLICY: A VISION FOR IHS IMPLEMENTATION

Here in Ontario, IHSs could initiate and support the development of similar healthy public policies that meet the needs of women before, during and after pregnancy, as well as addressing the health of children and families. For example, IHSs could work with community projects like "Healthy Beginnings" and "Best Start" to develop policies for providing food supplementation to pregnant women, infants and children. They could collaborate with low-income housing projects, and local high schools to reach as many "high risk" pregnant women as possible, providing free, accessible prenatal sessions, social support networks, and post-natal home visiting programs. In partnership with the education system and other social service agencies, IHSs could work to implement policies providing parenting courses at little or not cost to families. Parenting courses have been found to have a positive effect on parents' attitudes, knowledge and behaviour, as well as on child behaviour (Gottlieb et al., 1995). These positive outcomes are consistent for programs directed toward all parents interested in acquiring better parenting skills, as well as high-risk parents, suggesting that policies should include all families throughout the rostered community (Gottlieb et al., 1995). Staff could help rostered community members advocate for adequate and effective childhood programs. These could include preschool and Head Start programs, that bring groups of 3-5 year olds together in centres of school settings to offer educational programs to improve children's readiness to succeed in school, as well as health and developmental screenings, parental

involvement, and social service assistance (Gomby et al., 1995). IHSs could also be instrumental in developing policies to provide affordable, accessible child care, including prenatal support and involvement, to all families on a continuing and respite basis (Pransky, 1991; Steinhauer, 1996). Child care programs can promote child development, and free parents from their child care responsibilities so that they can work. Short- and long-term outcome studies on high-quality early childhood programs found positive effects on children's cognitive and social development, and physical health, as well as positive effects on the life outcomes of mothers (Gomby et al., 1995). It therefore makes sense for IHSs to actively support the development of such policies in an effort to promote the health of the women, children and families in their community. Local worksites might also be a potential partner for IHSs to work collaboratively with in trying to develop family-friendly work policies that provide extended parenting leave, flexible hours for pregnant women and sole support parents, and provide child-minding facilities on the premises. IHSs could also join coalitions working for changes to legislation that affect children and families - social services, health care, and financial support for low-income families.

Given the evidence for the effectiveness of policies promoting women, children and families health, and the long-term health and social costs associated with current high risk conditions affecting children and families, it makes absolute sense for IHSs to actively work to develop and support healthy public policies (CICH, 1994; CPHA, 1997; Steinhauer, 1996). A policy strategy is a highly leveraged strategy for IHSs to focus upstream, to promote the health of its members, and to achieve greater health and social equity.

As another example, IHSs could assist in the development and implementation of policies that ensure a supply of affordable and accessible housing for its rostered members. For example, IHSs could work with municipal governments, social housing authorities, and citizens to develop innovative alternatives for public building policies. Working with financial institutions and government departments, IHSs could investigate increasing the availability of financing to make it easier for people to buy or repair houses, or set up co-operative housing structures. Community policies could be developed in collaboration with local businesses, the education system, and the stakeholders identified above to train communities in planning, building and renovating their own houses with the use of appropriate technology (Haglund et al., 1996). Reducing isolation and ensuring the inclusion of the elderly and people with physical and mental disabilities within our communities is critical to promoting the health of these groups, as well as the health of our communities (The Roeher Institute, 1994; Haldemann & Wister, 1994). In addition to strengthening community capacity to include everyone, IHSs could investigate policy options for creating local, supportive low-cost housing that permits social contact between the young, elderly, and people with disabilities. Community facilities could be built into the plans, so that the entire community benefits from, and takes part in maintaining such centres. These types of policy options have contributed to more supportive social environments, and reduced problems from lack of appropriate housing and support

services in Scandinavian and American municipalities (Haglund et al., 1996; Houben & van der Voordt, 1993; Vestbro, 1993; Silver, 1991)..

These examples are intended to demonstrate that IHSs could, and, we believe, should be concerned with public policy that addresses risk condition(s) that members of their rostered community have identified as a priority issue. It should be recognized, however, that of all risk conditions, relative income inequality has been identified as a primary determinant of health inequities (Wilkinson, 1992; Wilkinson, 1986). Relative income inequality means that after a country has achieved a certain level of Gross National Product (GNP) per capita annual income (approximately $5,000, 1990 values), then overall health status depends more on the internal distribution of wealth than increases in income (Wilkinson, 1986). The health impacts of poverty and inequitable income distribution have been well documented (see the Canadian Public Health Association's *Discussion Paper on the Health Impacts of Social and Economic Conditions*, 1997 for a review of Canadian data). In Ontario, women, children and youth, seniors, people with disabilities, and aboriginal peoples are particularly vulnerable to associated health inequities (CPHA, 1997). Therefore, it is of particular importance that IHSs play a role in healthy public policy development and advocacy addressing the impact of poverty and inequitable income distribution.

Health advocacy is closely related to the strategy of healthy public policy. It is a strategy or process by which participants attempt to influence the policy decisions of governments or other authorities that exert control over the factors influencing health (Hyndman, 1997). For health promoters and health care professionals working within an IHS, particularly in the area of primary health and health-related social services, advocating for the health of one's clients and rostered community is a legitimate and valuable role. Advocacy efforts have been a critical factor in bringing about the adoption of various health promoting policies including the implementation of our National AIDS strategy, and the prior banning of print advertising of tobacco products (Kinsman, 1992; Ferrence & D'Souza, 1993).

HEALTH ADVOCACY: A VISION FOR IHS IMPLEMENTATION

IHSs could become advocates for the health of their community and for the people of Ontario in a number of ways. They could support efforts of members of their rostered community, who want to participate in the development of healthy public policy around issues that most concern them. Support could include the provision of meeting rooms, research support, administrative support in drafting reports or position papers, and staff support in mobilization, organization and outreach efforts. Furthermore, IHSs could develop stronger, united advocacy efforts through intersectoral collaboration towards a common cause. By placing health outcomes on the agenda of multiple levels of government and multiple organizations, health will no longer be thought of as the sole responsibility of the health system, but as a collective and social responsibility.

It is our position that a core IHS service should involve development, research and advocacy efforts to promote the implementation of healthy public policies. As part of this core strategy, IHSs should be required to demonstrate their involvement in a certain degree of intersectoral collaborative efforts, and their support for community mobilization and advocacy around healthy public policy issues.

CREATE SUPPORTIVE ENVIRONMENTS

Of the five health promotion action areas identified in the Ottawa Charter, the creation of supportive environments is the broadest. While the creation of supportive environments can be considered a goal or outcome of the other health promotion strategies discussed in this section, it is also a strategy that encompasses a distinct range of approaches to the promotion of individual and community health (Hyndman, 1997). The foundation of this action area is the knowledge that people's health and their relationships with their environments are inextricably linked. As a result, health cannot be separated from other goals in society (WHO, 1986). To be healthy, individuals need to live in social environments (families, communities) that are "healthy," and communities need to exist in physical environments that are "healthy." The overall guiding principle for all levels of human society (national, regional, local) should therefore be that of reciprocal maintenance -- taking care of each other, our communities and our natural environment (WHO, 1986). This principle of reciprocal maintenance extends into all human activity and organization - our work, schools, families, and communities. The strategy of creating supportive environments focuses on the settings where relationships between people and their environments occur. By seeking new, holistic ways to organize or balance these relationships, this strategy guides us towards creating social and physical environments (both natural and human-built), that are supportive of health. More specifically, it guides efforts to create environments that are safe, stimulating, satisfying, enjoyable, and sustainable, the most basic conditions required for optimal levels of health (Ottawa Charter; 1986).

The Healthy Communities movement provides an excellent example of how this strategy has been used around the world to create urban environments or communities that are supportive of health. In Ontario, the Healthy Communities Coalition is a grass roots community movement that links and facilitates partnerships among non-profit groups, neighbourhood and provincial associations to develop a broad, multi-sectoral approach to community planning (City of Toronto Healthy City Office, 1995). The 300 involved communities across the province share a strategy of creating supportive environments in order to address a diverse range of local issues. The strategy usually begins with the establishment of an intersectoral committee within the community, which includes strong representation by community residents. The committee identifies local conditions affecting the health of neighbourhoods, and "realistic" or feasible projects that will address those priority issues (Wharf-Higgins, 1992; Poland, 1996). Some of the many projects supported by communities across Ontario include self-help for homeless people, plans for sustainable development and recycling, changes to official municipal plans, improving air,

soil and water quality, and creating a community safety strategy (City of Toronto Healthy City Office, 1995). Often these projects are delegated to subcommittees, who assume responsibility for actively involving community residents and multiple sectors, and for generating funds (Hyndman, 1997). Most healthy community initiatives involve some degree of representation and support from municipal bodies, encouraging the development of innovative responses to health-related issues by local governments (Hyndman, 1997). To date, local level evaluations suggest that the strategy to create community environments that are supportive to health have achieved a number of positive environmental changes (Hyndman, 1997).

Other examples of Ontario communities that have rallied together to create environments that are supportive of health include many of the finalists for the Trillium Foundation's Caring Communities Award (Trillium Foundation, 1997). For example, in the region of Waterloo, there is a strong tradition of community building. Local businesses, police, social agencies, municipal government, and many residents from the communities of Kitchener, Cambridge and Waterloo have pulled together and found local solutions to overcome major challenges such as natural disasters, pollution crises which threatened their water supply, and economic recessions. Community resources, energy and action have resulted in among the lowest employment (7.5%) and poverty (12%) rates in the country, a 27% decrease in the rate of violent crime since 1990, and one of the lowest school drop-out rates in Ontario.

The Coalition of Community Health and Support Services in Hamilton-Wentworth provides another example of a successful strategy to create a community environment that supports health (Trillium Foundation, 1997). Today the Coalition brings together 35 non-profit or public service agencies, and a range of ethnic communities, all working toward the primary health and well-being of the region's communities and their residents. A flexible inter-service model of Team Practice, and effective use of volunteers, including volunteer training in their own neighbourhoods optimizes people's use of energy and skills. Understanding the importance of supporting family caregivers, the Coalition has consistently worked to enhance the quality of life for seniors and individuals with disabilities. This has included coordination of transportation providers and specialty services, and the establishment of an Elder Abuse Task Force. All efforts have emphasized community involvement and interservice delivery.

CREATE SUPPORTIVE ENVIRONMENTS: A VISION FOR IHS IMPLEMENTATION

IHSs could become an active participant in their area's Healthy Community initiative, or efforts similar to those in the Caring Communities described. In communities without an organized strategy in place, IHSs could initiate the establishment of an intersectoral committee, and recruit interested rostered members to get involved. IHSs could help facilitate a broad, participatory process for the community to develop a collective vision about what kind of community they want in order to optimize health and social justice.

This vision could then lead to the development of a strategic plan for the creation of those environmental conditions. IHSs could assist this process by providing statistics and user-friendly information on the health of the community, and areas of health inequity. Through sharing knowledge about the health status and needs of their entire rostered community, IHSs can help keep initiatives focused on the community as a whole. These efforts will contribute to community empowerment, enabling communities to shape public agendas and the distribution of resources, thereby achieving greater health equity and social justice (Flynn et al., 1994). IHSs could also promote their members health and well-being by dedicating staff time and resources to specific projects that address the broader determinants of health at a local level.

Another example of possible IHS involvement could be to create supportive environments that protect women from violence. Again, an intersectoral approach would be most effective in dealing with this issue, so IHSs could initiate or facilitate the development of a multi-sectoral committee with broad based community representation. IHSs could work collaboratively with women's groups, religious organizations, schools, media, and social services agencies to develop awareness and education campaigns aimed at shifting social constructions of gender and raising the issue as a community priority. IHS' staff could work in partnership to provide school programs that teach youth healthy ways to think about their sexuality and their bodies, that increase self-esteem and life skills, and that analyze issues of power imbalances in society, and in personal and work relationships. Staff could develop partnerships with local businesses and organizations to address the issue of sexual harassment. Recommended actions include the creation of empowering organizational climates based on caring and responsibility, that support diversity, and that reduce divisions based on gender (Bond, 1995). Developing crisis shelters and support networks for women within the community could be another project for IHSs to support through staff time, money, and or resources such as building space. More upstream efforts could include working to enhance women's self-sufficiency and financial security through advocating for improved child-support and employment equity policies. These outcomes could also be achieved through skill development and employment efforts.

Whatever the issues identified, a multi-dimensional, participatory strategy to create health-supporting environments is an effective way for IHSs to promote the health of their clients and rostered community. Therefore, it is our position that involvement in intersectoral, participatory, collaborative efforts to create supportive environments within their communities should be considered a core IHS area of activity, requiring dedicated financial and other resources.

SECTION IV

CORE VALUES AND THEIR IMPLICATION FOR IHSs:

As identified in Section One, the core values that characterize the field of health promotion are empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration. These same values can and should be applied to the planning, development and operation of IHSs. They will not only enrich the ethical base and understanding of health practices, they will increase the effectiveness of those who are actively working to contribute to the health and well-being of individuals and our society.

Experts in systems integration agree that the foundation for any system is not a question of structure or the function of governance, but the mission and culture of that system (Orlikoff, 1995; Ball, 1995). Therefore, the core values of empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration should be legislated as part of the IHS mandate. Each IHS should incorporate these core values into their mission and/or vision statements, which should be visibly displayed in all IHS' delivery sites.   These values should guide all IHS' operations, including the design of appropriate management, funding, and accountability structures. The Canadian Hospital Association, the Ontario Nurses' Association, and experts in health system integration recognize that this position requires a paradigm shift for organizations currently operating in a medical model (Fyke, 1989; ONA, 1996; Shortell et al., 1993; Orlikoff, 1995). We join these groups in their support for a shared visioning and strategy process that would realign the culture, structure and skills of IHSs around a health promotion approach.

Many of the recommendations below support multiple values. For example, recommendations for empowering IHS' communities and clients often involve increasing public participation, while reducing social inequities often requires facilitating an intersectoral approach to address the impact of the broader determinants of health. For the sake of clarity, the following recommendation have been grouped according to the value that they primarily support. Each grouping is not intended to stand independent of the other recommendations, however. It is as an integrated framework that these recommendations will most effectively strengthen the health promoting mandate of IHSs.

EMPOWERMENT

Empowerment refers to the capacity of individuals and communities to exercise the power they require to improve their health through increasing their control over the determinants that are important to their health. IHSs should make every effort to increase the degree of control that the rostered community and the individual clients have over the determinants that effect their health.

Ensuring that rostered communities are involved in a meaningful way in the design and operations of IHSs is fundamental in this regard. Flexibility in the Ministry's legislative framework is also necessary to allow for local-level decision-making around the design and operation of each IHS. By devolving certain responsibilities for resource allocation, strategic planning, and structure to IHSs while establishing and enforcing critical provincial wide standards, the Ministry of Health can create the opportunity for community empowerment, and free IHSs to best meet their rostered community's needs.

To ensure an empowering approach to IHS design and operations, we recommend the following.

I.   Two-way communication opportunities such as community forums, Town Halls, and information resources should be sponsored by the Ministry of Health, giving citizens throughout Ontario the opportunity to learn about IHSs, and enabling grassroots involvement in process of health reform.

II. IHSs should be required to develop accessible two-way information loops with their rostered members.

Information related to opportunities for involvement on IHS' decision-making bodies, committees, or projects should be provided to rostered members on a regular basis, as should information regarding IHS' priorities, strategies, structure, resource allocation, and services. Modes of communication may included Town Halls, 1-800-information phone lines, mail-outs, posters and pamphlets, and community newspapers.

Formal, accessible processes should be put in place to ensure community involvement in determining how the IHSs will address the above areas. Suggested channels of communication include sample surveys, focus groups, community consultations, and robust committee structures with high membership involvement. Whatever communication system adopted, IHSs should be accountable for ensuring their accessibility to rostered members by actively addressing systemic barriers to information such as language, literacy, physical disabilities, transportation to public events, alternative times for public events, etc..

III. The planning, development and operations process of IHSs must be open to rostered members.

This includes open Board and Annual meetings, and publicly accessible records of these meetings' minutes and resolutions. It also demands that the process and criteria used to determine membership on Governance Board and various IHS' Committees, and decisions regarding positions filled on IHS' decision-making bodies be open to public scrutiny.

IV. We recommend the development of an IHS Report Card that will include both process indicators (e.g. IHS' operations and strategic decisions; public participation and representation; distribution and types of services and service providers) and outcome indicators (e.g. medical, lifestyle/behavioural, and socio-environmental indicators of community health status; efforts to address inequities and injustice within the rostered community).

Consistent with the principle of empowering communities through access to information, the IHS Report Card must be made available to all rostered members as well as the general public, thereby enabling the public to make more informed choices about the IHS they wish to belong to. The IHS Report Card is one means of holding IHSs accountable to their members for its operations, costs and outcomes. It is also a tool to assist IHSs in identifying areas of strength and areas for improvement, in setting priorities and planning, and in supporting the identification of best practices and benchmarking throughout the province. To this end, the data collected and measured must be reliable, relevant, predictive, clearly operationally defined, and useful in helping IHSs continuously improve (Nelson et al., 1995).

In an effort to ensure that individual clients rostered to IHSs have as much control as possible over the determinants that effect their health, we recommend the following:

V. The core values of empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration should be incorporated into all contracts between IHSs and their rostered clients.

VI. A province-wide Comprehensive Client Bill of Rights for all rostered IHS' members should be developed.

Similar in principle to Netherlands' Act on the Medical Contract, which clarifies the principal rights of patients (WHO, 1996), the Bill would enshrine clients' right to roster with an IHS that meets provincial standards of operations, core services, accessibility and quality, that upholds the core values identified above, and that protects the rights guaranteed in the Canada Health Act and the Charter of Human Rights and Freedoms.

VII. IHSs should be held accountable for ensuring that all practitioner/client interactions are based on an autonomy-supporting partnership, consistent with the principle of empowerment.

This requires that all service providers, enrollment processes, and services offered are sensitive to and respectful of different cultures, religions, language groups, and persons with disabilities. In support of this position, the onus should be on IHSs to provide, where appropriate, interpreters, and information materials in multiple languages (e.g. health education information, enrollment contracts).

VIII. To increase clients' control over the factors and conditions that affect their health, the health promotion strategies outlined in Sections II and III of this paper should be incorporated within the Ministry of Health's legislative framework as core IHS services or areas of activity. All of this strategies must be developed based on the principle of empowerment, in partnership with the clients served.

IX. Consistent with the principles of client empowerment, integration and collaboration, we support the development of an Integrated Health File for each rostered IHS' client.

Client accessibility to their personal file must be ensured (which includes addressing potential barriers related to language, literacy, and/or physical disability), while clients' rights to privacy and confidentiality must be protected.

X. The principle of client empowerment should be supported by ensuring that citizens are free to contract or roster with the IHS of their choice, and that the allocation of capitated funding follows the client to whichever system they choose to roster with.

However, we recognize the limited effectiveness of this strategy for individuals, who, due to disabilities, poor health status, age, geographic location, or other disadvantages, may be prevented from choosing to roster with an alternate IHS. Therefore,

IHSs should be held accountable for ensuring that formal structures and processes are in place to ensure client choice in service and care provider, and a "client-focus" for all services and operations.

This latter goal could be achieved through: adopting quality enhancement programs within each IHS; establishing a client advocate body within each IHS that deals with client satisfaction and client complaints; establishing an independent, ombudsman-like office for the province where all citizens can feel completely safe to complain about violations of their rights, neglect, abuse and inadequate services, and can bring unresolved complaints that have been brought to their IHS' client advocate body. Similar suggestions are supported by consumers groups and professional health care associations (ONA, 1996; MCCLTC, 1997).

XI. IHSs must ensure clients have equitable access to service and to involvement on decision-making bodies and committees.

IHSs should be held accountable for demonstrating how they are actively addressing systemic barriers to accessibility related to: race, sex, age, culture, religion, language, physical or mental disability, socio-economic status, transportation, hours of operation etc..

While IHSs must first and foremost be concerned with meeting the health needs of their clients and community, effort should also be directed towards empowering the agencies, organizations and employees that work within the IHS. In this regard, we have the following recommendations.

XII. IHSs should be committed to creating work environments that are supportive of employees' physical, mental, and social health, as laid out in Health Canada's Corporate Health Model (Health Canada, 1991).

XIII. IHS' structures should reduce power and income hierarchies, and health providers' dependence on physicians by moving to collaborative, multidisciplinary work teams and empowering accountability structures.

This position is consistent with reform recommendations made by health promoters (Labonte, 1997), health systems integration experts (Gauthier, 1995; Sigmund, 1995), the Canadian Hospital Association (Fyke, 1989), the Ontario Nurses' Association (ONA, 1996), other health reform advisory bodies (WHO, 1996; Roeher Institute, 1994; Subcommittee on Primary Health Care, 1996).

XIV. IHSs should be held accountable for actively working to achieve parity between the salaries or financial compensation of IHS' employees working in institutional and community settings, and within health or health-related social services (Labonte, 1997).

XV. IHSs should be held accountable for demonstrating, to the greatest extent possible, the sustainable use of sustainable environmental resources (Labonte, 1997).

PUBLIC PARTICIPATION:

All health promotion efforts emphasize active ***public participation***. The field is committed to a process that encourages and enables individuals and communities to define, analyze and act upon problems in their lives and living conditions (Labonte, 1993). It is our position that the Ministry of Health require that significant levels of public participation be incorporated into the design and ongoing operations of IHSs. This position demands that citizens have equal access to opportunities for active involvement, and that their efforts are supported with the tools, skills and resources required for meaningful participation. To support our position, we make the following recommendations.

I. IHSs should be held accountable for ensuring the meaningful participation of their rostered members in the design and planning of IHSs.

Based on Arnstein's Ladder of Citizen Participation (Arnstein, 1969), meaningful participation must go beyond consultation, where citizens have advisory or informative roles. At a minimum, we support a partnership model of participation, similar to the Finish health system in which citizens have formal influence on the health care authority through seats on a municipal health board (WHO, 1996).

This requires rostered members to hold 40% of all seats on IHS' governance boards.

Processes to protect real negotiation between citizens and other committee members must be established, and once the committee ground rules are set they should be protected from unilateral change. Making citizen representatives answerable to a clear, external constituency of the rostered population would also help to strengthen their role in decision-making (Arnstein, 1969).

As IHSs evolve, we support the move to a model of delegated power where rostered members occupy the majority of seats on the governance body.

Our vision for true community empowerment is that IHSs become not only community-based, but community owned, a position supported by experts in health systems integration and by professional health provider associations (Griffith, 1996; Warden, 1996; ONA, 1996).

II. In addition to public participation on governance structure, it is our position that IHSs should immediately begin delegating responsibility for certain projects or areas of activity to a robust committee structure, in which a majority of seats are held by rostered members.

Such committees should be contracted to undertake particular parts of IHS' projects, which might include community health assessment processes, community health advocacy functions, evaluation processes, and the selection of evaluation indicators to assess the enhancement of social health or well-being. Alongside two-way

communication systems formal community consultation processes and advisory boards, a robust committee structure will ensure public participation in multiple key areas of IHS' operations.

III. IHSs should provide opportunities for the meaningful participation of clients in development, management and day-to-day operations of services directed towards their specific needs.

For example, senior citizens should have the opportunity to participate in management and program planning activities of long-term care facilities and home care services, and multicultural services should developed in partnership with representatives from those communities.

IV. IHSs should be held accountable for establishing a process which ensures that their governance board and other key decision-making bodies are representative of the characteristics of the rostered community served.

The onus should be on IHSs to demonstrate efforts taken to remove systemic barriers to participation of disadvantaged groups, thereby facilitating the involvement of those groups not generally represented on decision-making bodies (i.e. discrimination based on ethno-cultural background, language, socio-economic status, age, sex, physical or mental disability etc.).

V. IHSs should be accountable to develop a formal process which would provide members elected or selected to sit on governance board with the tools, skills and resources necessary to for meaningful participation.

Prior skills or experience on governance bodies should not be a barrier to public participation in decision-making. Orientation training, capacity-building, and upgrading processes for Board members should address generic governance skills (e.g. resource allocation and budgeting, decision-making, group process), a broad understanding of the health system, an orientation to health promotion (e.g. the determinants of health, health promotion strategies), and an understanding of the broad-based and specific health needs of the rostered community. The United Way and the Social Planning Council provide two models for this type of comprehensive governance training process.

ADDRESSING THE IMPACT OF BROADER DETERMINANTS OF HEALTH:

Recognizing that the factors that most effect health extend beyond genetics, individual lifestyles, and the provision of a health care, part of the mandate of IHSs must be to *address the impact of broader determinants of health*. This requires IHSs to allocate money, staff and other resources to support interventions and collaborative partnerships which recognize and act upon the socio-environmental conditions that shape the world in which we live. To support this position, we recommend the following.

I. To ensure that resources are reallocated upstream and include health promoting activities that address the impact of the broader determinants of health, we support a provincial standard on the minimum budgetary proportion that IHSs must allocate to health promotion.

While further investigation is required to determine the optimal proportion of health dollars to be dedicated to health promotion, we recommend an initial minimum standard of 2-3% of the total IHS' budget be allocated specifically for Lifestyle or Behavioural approaches to health promotion (see Section II), and an additional 2-3% of the total IHS' budget dedicated to socio-environmental approaches to health promotion (see Section III).

The minimal proportion of each IHS' budget allocated towards health promotion would therefore be between 4-6%. As IHSs evolve, we recommend increasing this amount to 10% of the total budget.

These figures are distinct from, and in addition to, the money that IHSs allocate for preventive medicine, which should also be increased from current levels. These initial base amounts are consistent with the range supported by public health and health promotion research (Labonte, 1997).

II. The Ministry of Health and IHSs should work with communities in a broad-based, participatory process to identify and develop assessment indicators which reflect a broad definition of health.

Indicators should be qualitative and quantitative, and include assessments of Quality of Life and social well-being. The Ministry of Health should incorporate the responsibility of actively working to enhance these measures of health into the mandate of IHSs, and hold them accountable for the effectiveness and extent of their efforts.

III. The Ministry of Health should set aside a pocket of special funding for efforts directed towards addressing geographic issues related to the impacts of the broader determinants of health (e.g. environmental or food production issues that extend beyond the rostered community of any particular IHS).

Funding applications should be granted on a competitive basis, with applicants including, but not limited to, IHSs. Successful applicants should be those organizations or coalitions which are best able to demonstrate effectiveness, efficiency, and alignment with the core values of health promotion (empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration). Special funding is not intended to be continuous source of funding to IHSs. Pilot projects that demonstrate successful outcomes would become part of the best practices used within IHSs across the province.

REDUCING SOCIAL INEQUITIES AND INJUSTICE:

It is our firm position that IHSs be committed and accountable for working to *reduce social inequities and injustice*, such that every individual, family and community may benefit from living, learning and working in a health-supporting environment. This requires IHSs to ensure that the needs of all members of their rostered community are addressed fairly. It also demands IHSs focus special attention to the needs of those individuals who are most at risk for poor health as a result of systemic discrimination and inequity. IHSs must formally assess the impact that they are having on the health of the most marginalized members of their community. In support of this position, we make the following recommendations.

I. **We support further research into the development of a risk-adjusted capitated funding formula which would serve as an effective, equitable and responsive funding mechanism for IHSs.**

We believe that a risk-adjusted capitated funding system has the potential to redress current funding inequities in our system that result from historic utilization rates, and volume-driven mechanisms like fee for service.

In order to ensure that risk-adjusted capitated funding does reduce, rather than contribute to, inequities or injustices in our health system, adjustment factors must include age, sex, health status and socio-economic status.
Evidence clearly shows that an individual's socio-economic status is one of, if not the, greatest determinant of health. Without an adjustment for SES, we would create an incentive for IHSs to cream skim and/or under serve those most in need. Legislation preventing IHSs from "dumping" clients from their rosters would be inadequate protection, as IHSs could still fail to address the needs of low-income members through discriminatory practices that would be difficult for the Ministry of Health to detect or prevent.

II. We oppose the use of personal financial incentives or bonuses to IHS' providers based on savings achieved through increased efficiencies or effectiveness.

Our concern is that such a method would open the door to a profit-motive or personal gain mentality, which is contrary to the value of reducing social inequities and injustice, and of serving the clients' best-interests. We are satisfied that needs-based capitated funding, and making IHSs accountable for resource allocation decisions (within broad provincial standards for health promotion funding) provides adequate financial incentives for IHSs to adopt progressive strategies which will promote the health of their rostered communities.

We recommend that savings achieved by IHS reform be reinvested into the individual systems, so as to provide new or improved services to their rostered community.

This model of system versus personal financial incentives is similar to that used by New Zealand's independent practice associations, and has been found to be effective and well received by both clients and health providers (Malcolm, 1997).

III. To ensure that the health needs of all Ontario residents are addressed, we recommend that the Ministry of Health set clear standards against which they will hold IHSs accountable, and that the Ministry of Health become responsible for tightly monitoring and evaluating the operational and health outcomes of IHSs.

The monitoring and evaluation role of the Ministry of Health will be particularly crucial if a strategy of limited competition amongst IHSs is pursued. While limited competition may be an effective strategy to improve responsiveness to the needs of the general population served, market share provides a disincentive for IHSs to meet needs of small, high risk groups.

IV. To support the principles of reducing social inequities and injustice, we recommend that the Ministry of Health reserve special funding for programs that meet the needs of marginalized or high risk populations.
Funding applications should be granted on a competitive basis, with competition including, but not limited to, IHSs. Successful applicants should be those organizations which are best able to demonstrate effectiveness, efficiency, and alignment with the core values of health promotion (empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration). Funding should be directed towards programs that address the needs of populations who may not roster with IHSs (e.g. homeless, refugees), as well as to support the development if innovative new approaches to meeting the needs of marginalized or high risk populations within IHSs (e.g. those with mental illness, people living with AIDS, low-income single parent families).

Special funding is not intended to be continuous source of funding to IHSs. Pilot projects that demonstrate successful outcomes would become part of the best practices used within IHSs across the province.

V. IHSs should be required to develop a formal body whose purpose would be to monitor and protect the needs of marginalized or at-risk groups within the rostered community (e.g. the Community Health Advocacy Committees used by British Columbia's regional health authorities). A majority of seats on these bodies should be held by rostered members representing the population groups in question.

VI. The Ministry of Health should hold IHSs accountable for improvements in health status of the rostered population as a whole, as well as for actively working to narrow the gap between the health status of the general rostered community served and the health status of the most marginalized groups within that rostered community.

This requires the use of population-based health indicators, community-based health indicators, and social indicators which reflect the extent to which IHSs have reduced social inequities and injustice by addressing the special needs of high-risk populations within their rostered community.

VII. The Ministry of Health should set provincial standards for IHS' outreach efforts to encourage marginalized and at-risk populations to roster and utilize IHS' services.

The onus should be on IHSs to demonstrate the effectiveness of their efforts to overcome systemic barriers which often prevent those who are most in need from accessing health and health-related social services, and expressing their needs.

VIII. IHSs should be required to provide care for individuals requiring immediate assistance regardless of whether or not they have an Ontario Health Card or are a rostered member of that IHS.

IX. IHS reform should not be evaluated solely on its success in containing costs, but on wider range of societal objectives, such as enhancing the health of population (with health broadly defined), reducing health inequities and injustice, increasing efficiency, etc..

Similar objectives have been used by the World Health Organization in their evaluation of European health reform (WHO, 1996). This sort of evaluation requires that the

Ministry of Health use different accountability systems and indicators for the different approaches to promoting health outlined in section 1. Furthermore, as the different approaches to health promotion outlined in Section One are intended to achieve different outcomes, economic comparisons across health promotion approaches would be inappropriate (i.e. socioenvironmental approaches to health promotion should not be evaluated against preventive medicine or lifestyle approach to health promotion, but should be assessed according to their effectiveness at enhancing social health and well-being). Therefore, the Ministry of Health should develop and adopt distinct accountability systems and indicators for the different approaches to promoting health (see Section One and Appendix A for a more detailed discussion).

FACILITATE INTERSECTORAL COLLABORATION

Recognizing that the promotion of individual and community health requires an integrated effort from all sectors of our society, IHSs should be committed to *facilitating intersectoral partnerships and collaborative efforts*. Collaboration must be supported amongst the component parts of the IHS (e.g. acute care, long-term care, primary care, health promotion) in order for the IHS to effectively function as a single system. Collaboration must also be supported amongst IHSs and external organizations that have an impact on health and its determinants.

In accordance with the value of facilitating collaboration within IHSs, we have the following recommendations.

I. **While the structural design of IHSs should be determined according to the unique characteristics and needs of each community, the Ministry of Health should require IHSs to adopt what has been described as a cooperative or corporate model of governance that does not represent the component (provider) parts of the system.**

This model would recognize the IHS as a single not-for-profit corporation that provides and/or purchases services to a rostered community. The IHS governance board would be accountable for making decisions that are in the best interest of the population served. At the most fundamental level, "the role of governance in [IHSs] is to change organizational focus - from the parochial control of institutional assets to the stewardship of community resources coordinated and brought to bear on both the underlying and obvious community health problems" (Lerner et al., 1995). Therefore, board composition should be representative of the rostered community served. It should not, however, be representative of the components (or different provider groups) within the system. In other words, Board members would be elected or selected to solely represent the system as a whole, working in service of the rostered community. It is our position that this type of corporate or cooperative governance structure is more consistent with the goals of system integration and collaboration than

what has been described as a federated, representative, or constituency assembly model of governance.

Federated governance models, based on strategic alliances amongst several independent partners, builds fragmentation and competition into IHSs. Federated models. like representative corporate models of governance, divide the loyalty and accountability of board members between the IHS' rostered community and the health organization or system component which they represent (Pointer et al, 1995). Such a structure makes full collaboration within IHSs difficult, if not impossible, as each IHS "partner" works to protect and/or advance the interests of their component part (Pointer et al, 1995). Not only would a federated model work against integration, it also presents the risk of maintaining our current health system's power imbalances, thereby preventing the reorientation of IHSs from focusing downstream on cure and treatment to more upstream health promoting strategies.

II. To ensure a fully integrated continuum of health services, IHSs should be held accountable for providing their rostered members with the following core services: primary care, secondary care, long-term care, mental health services, and health-related social services. Preventive medicine, lifestyle/behavioural-, and socio-environmental health promotion strategies should also be considered core IHS services that are provided at all levels of care.

These services should be provided to members in their homes, in the community, and in institutional settings as required, with an emphasis on providing home and community care wherever appropriate. Core services should be funded entirely through the risk-adjusted capitated funding envelope provided to each IHS based on their rostered membership (Shortell et al., 1993; Pointer et al., 1995).

III. IHSs and the Ministry of Health should be held jointly accountable for providing the citizens of Ontario with tertiary/quaternary health care.

We oppose the full integration of these services within IHSs due to their high associated costs. Instead, we support the Ontario Nurses' Association's recommendation that tertiary/quaternary care services be funded in part by IHSs which require services for their rostered members, and in part directly by the Ministry of Health (ONA, 1996).

IV. Recognizing that health and social well-being are significantly determined by broader socio-environmental factors, we join other health providers and health consultants in recommend the integration of certain health-related social services within the basket of core IHS services. In particular, we consider those social services concerned with psychosocial risk factors to be a natural and essential fit

within IHSs (e.g. children's services such as children's mental health and children's aid, and family support services).

In much of the literature on health system integration, the scope of collaboration is limited to traditional health sector services (Marriott & Mable, 1996; Leatt et al, 1995) Shortell et al, 1994). Yet without this broader, intersectoral integration, we and other health providers and health consultants believe that IHSs will be limited in their ability to enhance the health status of their rostered communities (ONA, 1996; Verlaan-Cole, 1996; Ball, 1995; Conrad & Shortell, 1996; Labonte, 1997). For health and health-related social services to effectively operate within a single system, some degree of integration between the Ministries of Health and Community and Social Services must be achieved in terms of budgets (i.e. parts of the Community and Social Services budget must be incorporated into IHS' funding envelopes), policy, macro-level systems' management, standard-setting and monitoring.

V. We recommend that the mandate or mission of the provincial health system and IHSs should include the creation of deliberate and strategic partnerships with community and social services, and other public and private sectors that provide services, organize actions, and enact policies that have an impact on the broader determinants of health (e.g. municipalities, supportive housing, community and religious groups, education, environmental protection agencies, etc.).

In order for Ontario's health system to effectively address the impact of the broader determinants of health, intersectoral collaboration beyond the scope of IHSs is needed (Verlaan-Cole, 1996; Ball, 1995; Conrad & Shortell, 1996; Lerner et al, 1995; Labonte, 1997). These efforts will require the provincial health system and IHSs to dedicate a proportion of their budgets, staff, time, and other resources to the development and support of these partnerships. To ensure their effectiveness in this area, IHSs should honour the best practices and lessons learned for building strategic, collaborative partnerships. Critical success factors can be found in health promotion literature, and from demonstration projects such as Ontario's Heart Health Action Program that depended on intersectoral collaboration (Labonte, 1997; Purdon, 1997; RBJ Health Management Associates, 1995; Zuckerman & Kaluzny, 1991).

VI. We recommend the inclusion of enhanced health and social well-being outcomes on the policy agendas of all government ministries (particularly those responsible for community and social services, education, housing, the environment, and economics). To provide steering and direction for this collaborative effort, we recommend the establishment of an interministerial committee.

This would encourage Ministries to work collaboratively towards, and to some extent be held accountable for, the improvement of health and social well-being. Representation from large affiliated agencies (e.g. Worker's Compensation Board, The United Way), might also be considered as a means of developing strategic partnerships and linkages

necessary for collaborative efforts to enhance the health and well-being of the people of Ontario.

VII. We recommend that the bulk of primary health and health promotion services be provided directly by IHSs, as these services should make up the central business of the system.

Purchasing contracts arranged with other IHSs and/or external providers must reflect the core values of the IHS, must ensure the conditions of the Comprehensive Client Bill of Rights are upheld, and must incorporate core health promotion strategies into its mode of service delivery. Whether through direct provision or purchase of core services, IHSs should be held accountable for meeting the health needs of their rostered community.

VIII. If IHS' purchasing contracts are open to competition by private, for-profit providers, we recommend that the Ministry of Health and IHSs tightly monitor and hold providers accountable to provincial and IHS standards and guidelines (e.g. issues of service accessibility, quality, and availability, alignment with the core IHS values, ensuring the conditions outlined in the Comprehensive Client Bill of Rights, etc.).

A review of European and New Zealand health care reforms found that market-oriented systems which allowed private, for-profit competition required an equal or greater amount of government activity as public, not-for-profit systems (WHO, 1996; Ham, 1997; Hornblow, 1997; Malcolm, 1997). Activity simply changed, taking on the responsibility for tight monitoring and evaluation in order to ensure that market participants are meeting the government's health care standards (WHO, 1996). Findings also revealed that anticipated cost efficiencies, improved effectiveness and decreases in waiting times for prioritized services were often unrealized (WHO,1996; Ham, 1997; Hornblow, 1997; Malcolm, 1997).

IX. IHSs should adopt remuneration methods which are consistent with the Canada Health Act, which support and promote core IHS values (i.e. empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration), and which provide an incentive for practitioners to integrate health promotion into their daily work.

CONCLUSION:

This paper has presented the case for the critical role of health promotion in IHS reform. It has clarified the holistic concept of health, and the meaning of health promotion. Three complementary approaches to promoting health were summarized, along with the need for IHSs to incorporate all three into a comprehensive approach to enhancing client and community health. The issue of IHS' accountability for promoting the health of their rostered community was discussed. A list of suggested evaluation indicators has been provided for monitoring the effectiveness and of individual/behavioural, and socio-environmental health promotion strategies, and their impact on client and community health and social well-being.

Key health promotion strategies falling within an individual/behavioural and socio-environmental approach to health promotion were identified, and evidence concerning their effectiveness was summarized. Visions for the integration and implementation of each strategy as a core IHS service or area of activity was described, illustrating the natural fit between IHSs and health promotion.

Most importantly, perhaps, this paper has indicated how health promotion values and principles can guide IHS reform. Practical standards and guidelines have been recommended to ensure that the values of empowerment, public participation, addressing the impact of the broader determinants of health, reducing social inequities and injustice, and facilitating intersectoral collaboration are applied to the planning, development, and operation of IHSs.

It is our position that an effective policy framework is required to ensure the development of IHSs that will promote health. It is our hope that the Ministry of Health will support this position, and will work in partnership with those who are and will be involved in IHS reform, to reorient our health system to one that promotes and enhances the health of Ontarians. For our part, we are willing and eager to be involved in all IHS initiatives that are founded on the philosophy and values of health promotion, and that incorporate health promotion strategies into the core business of IHSs.

APPENDIX A:

SUGGESTED EVALUATION INDICATORS RELATED TO AN INDIVIDUAL/ LIFESTYLE APPROACH TO HEALTH PROMOTION

Increase the Proportion of the Population Practicing Healthy Eating and Physical Activity Habits
- Consumption of dietary fat as a percentage of total calories (fat as a percentage of energy)
- Percentage of people aged 18 and older who participate in physical activity equivalent to daily brisk walking for at least 60 minutes (Population distribution of physical activity)
- Percentage of children in Grades K to OAC who participate in daily physical activity within the school program
- Percentage of individuals who have a body weight-for-height that puts them at increased risk to health (BMI/Body Mass Index is a measure of weight-for-height and is the weight in kilograms divided by the square of height in meters)

Reductions in Hazardous Use of Alcohol
- Average annual adult consumption of alcohol per year
- Proportion of population consuming 15 or more alcoholic drinks per week
- Population distribution of binge drinking
- Percentage of alcohol-involved motor vehicle accidents as total of all motor vehicle accidents
- Use of alcohol among young people aged 12-18
- Incidence of fetal alcohol syndrome
- Incidence of long-term health problems associated with alcohol abuse
- Incidence of harmful behaviour induced by alcohol (violence and public disorder, family violence, failure to fulfill family, work and other social roles)

Reductions in Tobacco Use and Exposure to Second Hand Smoke
- Total tobacco sales
- Proportion of current cigarette smokers
- Quitting rates of smokers
- Percentage of: men; women; young people (aged 12-19) who smoke
- Percentage of schools, workplaces and public places that are smoke-free
- Improvements in air quality
- Eliminate sales of tobacco products to minors
- Eliminate the use of tobacco products by pregnant women

Reduce Injury and Death Arising From Motor Vehicle Traffic Accidents
- Number of MVTA per 100 million kilometers traveled or per 10, 000 vehicles registered

- Death rate due to MVTA in the: 0-14; 15-24; 25-34 age groups per 100, 000
- Measurements monitoring illness and disability resulting from MVTA
- Compliance rate regarding adult restraint use (proportion of population wearing seat belts)
- Compliance rate regarding infant and child carrier use in cars

Reduce Incidence of STDs:
- Use of condoms as protection of STDs

Note: The above indicators are based on work presented in Ontario Ministry of Health, Community Health Framework Project, 1995; and Premier's Council on Health Strategy, Health Goals Committee, 1991.

SUGGESTED EVALUATION INDICATORS RELATED TO A SOCIOENVIRONMENTAL APPROACH TO HEALTH PROMOTION:

Income:
- Proportion of population living below the low income cut-off point
- Proportion of social assistance recipients
- Average employment income
- Income distribution within a population

Education:
- Population aged 15 and over with less than 9 years of education
- Adult literacy rate
- Male to female ratio of population with various educational levels
- Number of people in training programs

Work:
- Unemployment rate
- Number of lay-offs
- Proportion of population with employment benefits
- Male to female ratio of population with employment benefits
- Occupational status integration index
- Proportion of population with part-time work
- Male to female ratio of population with part-time work
- Number of reported industrial accidents

Shelter:
- Number of homeless people
- Dwellings in need of major repair
- Percentage of owner occupied dwellings

- Proportion with subsidized rent
- Average number of persons per room
- Proportion spending 30%+ on housing

Food:
- Number of people receiving food through a food bank
- Cost of a nutritious food basket

Physical Environment:
- Number of hours of moderate/poor air quality
- Frequency of poor water quality
- Public green space
- Seasonal closing of beaches
- Ultra-violet (UV) index

Health-Related Social Services:
- Number of people receiving government assistance
- Community service adequacy indicators

Violence:
- Violent crime rate
- Sexual assault rate
- Incidence of spousal/partner abuse (emotional, physical, sexual)
- Incidence of child abuse (emotional, physical, sexual)
- Incidence of adolescent abuse (emotional, physical, sexual)
- Incidence of elder abuse (emotional, physical, sexual)

Social Support:
- Proportion of single parent families
- Proportion of dysfunctional families
- Proportion of population dissatisfied with their social life
- Number of social support networks and groups within a community

Assets/Positive Attributes at an Individual and Community Level:
- Extent of public participation in IHS planning, activities and evaluation initiatives
- Volunteer participation rates
- Voter participation rates
- Community Capacity Index (Rajkumar, 1997; Jackson, 1995)
- Social Well-Being/QOL Index (Eyles, 1994)
- Mental Health Index

Note: The above indicators are based on work presented in: Ontario Ministry of Health, Community Health Framework Project, 1995; and Premier's Council on Health Strategy, Health Goals Committee.

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