CONFERENCE PROCEEDINGS

The Role of Health Promotion Within a Reformed Health System

A conference for health service decision-makers, health administrators health planners and health promotion practitioners/researchers

Toronto
Friday, February 19, 1999
George Ignatieff Theatre, University of Toronto

Sponsored By
The Centre for Health Promotion
University of Toronto

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Conference Proceedings Prepared by:
Elise Davis (Editor) & Susan Gemmell

Table of Contents

Agenda for the Day ii
About our Speakers and Presenters iv
Planning Committee Members viii
Supporting Organisations viii
Financial Support viii
Conference Overview 1
Opening Remarks 2
Keynote Address 3
Panel Response to Keynote 7
Panel Response II 12
Response from David Korn 12
Concurrent Sessions 13
- *Long Term Care*, Camille Orridge 13
- *Policy*, David Butler-Jones 16
- *Primary Care*, Carol Kushner 18
- *Hospital Sector*, Hy Elisaoph 21

Luncheon Keynote Address, The Hon. Elizabeth Witmer 23
Concurrent Sessions 27
- *Integrated Health Systems*, Birse, Graham & Weary 27
- *Healthy Communities*, Finney, Perkins & Rhor 31
- *Mental Health*, Pape & Thompson 34
- *Brokering Relationships*, Simpson 36

Panel Discussion – Where do we go from here? 39
- Murray MackKenzie 39
- Lorne Zon 40
- Peter Cole 44
- Pegeen Walsh 45

Closing Remarks, Irv Rootman & Lori Wilson 46
List of Participants 47

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Agenda

Time	Agenda Item
8:30 am	**Registration:** Main Entrance, George Ignatieff Theatre, Trinity College
9:00 am	**Opening Remarks: (Conference Co-Chairs)** Irv Rootman, Director, Centre for Health Promotion Ted Mavor, Grand River Hospital
9:10 am	**Keynote Address:** **"The Role of Health Promotion within a Reformed Health System"** David Korn, Visiting Assistant Professor, Harvard Medical School
9:30 am	**Panel Response:** • David Butler-Jones, Saskatchewan Health • Hy Eliasoph, Ontario Hospital Association • Carole Kushner, Health Care Consultant • Camille Orridge, Toronto Community Care Access Centre
11:00 am	**Refreshment Break:** The Buttery
11:15 am	**Concurrent Sessions:** **Long Term Care** • Camille Orridge **Policy** • David Butler-Jones **Primary Care** • Carole Kushner **The Hospital Sector** • Hy Eliasoph

12:00 am **<u>Lunch:</u>**
The Buttery, Trinity College
<u>Luncheon Keynote Speaker</u>:
The Hon. Elizabeth Witmer, Minister of Health for the Province of Ontario

1:15 pm **<u>Concurrent Sessions</u>:**
Integrated Health Systems

- Elizabeth Birse, Quantum Solutions
-

About Our Speakers & Presenters…

Elizabeth Birse

Elizabeth Birse is a knowledge facilitator/consultant at Quantum Solutions. Her work at Quantum focuses on developing capacity for continuous, applied learning at the individual, team and organisational level; she helps clients develop their capacity for effective action within a rapidly changing environment. Before coming to Quantum Solutions, Ms Birse completed her Master's degree in Health Promotion from the University of Toronto. Her previous work experience in community and institutional health settings has provided Elizabeth Birse with an in-depth understanding of the key issues facing our health system.

David Butler-Jones

Dr. David Butler-Jones is the Chief Medical Health Officer for the Province of Saskatchewan. He is also an Assistant Clinical Professor in the Faculty of Medicine, University of Saskatchewan. Dr. Butler-Jones has worked in many parts of Canada and has experience with consultations and work exchanges in places as diverse as Turkey, the Dominican Republic and Scotland. He is President of the Canadian Public Health Association, Vice President of the American Public Health Association and International Regent for the American College of Preventative Medicine.

Peter Cole

Dr. Peter Cole has a Masters in Health Sciences and Certification in Community Medicine. His professional experience includes family practice medicine (1970-76), Director of Family Planning Services for the City of Toronto (1976-81), and Medical Officer of Health for Halton Region (1981-84). Dr. Cole has been the Commissioner and Medical Officer of Health for Peel Region since 1984. He has also been a lecturer at U of T since 1979. In 1986, he was President of the Ontario Public Health Association and a member of the Panel on Health Goals for Ontario. In 1997, Dr. Cole received a lifetime achievement award from OPHA for his work in public health.

Hy Eliasoph

Hy Eliasoph is the Director of Hospital Relations and Health Policy at the Ontario Hospital Association (OHA). Prior to joining the OHA, Mr. Eliasoph was the Executive Director of the Ontario Joint Policy and Planning Committee. He has over fifteen years of progressive professional experience consulting to and working with several Ministries of Health, as a senior private sector consultant and in several diverse portfolios at the Foothills Medical Centre. Mr. Eliasoph holds a Masters Degree in Planning from the University of Alberta and is a certified and active member of the Canadian College of Health Service Executives.

Heather Graham
Heather Graham is the Program Manager, Community Health & Education at the Toronto Hospital-Western Division. In this role, she manages the following Community Programs: Diabetes Education Centre, Seniors Wellness Clinic, and the Health Resource & Wellness Centre. In Ms Graham's previous position as Co-ordinator, Community Health Initiatives at The Doctor's Hospital, she began her involvement with the Community Health Network of West Toronto. During 1998 Ms Graham worked with the Mayor's Homelessness Action Task Force as a staff advisor for Health and Mental Health. Her volunteer contributions (past and present) include: Board member, South Riverdale Community Health Centre, and Concerned Friends of Ontario Citizens in Care Facilities.

David Korn
Dr. David Korn was the former Medical Officer of Health for Ontario and CEO of The Donwood Institute. He is currently a Visiting Professor at Harvard University Medical School, conducting research on gambling and public policy with the Gambling and Health Project. Dr. Korn's prior experience has included: Chair of the Health Promotion Committee of Health Net North; member of the panel which produced Health Goals for Ontario (Spasoff Report); international work as a clinical physician at St. Francis Hospital in rural Zambia; and epidemiologist with the Global Smallpox Eradication Program in Ethiopia.

Carole Kushner
Carole Kushner is probably best know for having co-authored (with Dr. Michael Rachlis) two best-selling books on health policy: *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It* (1989) and *Strong Medicine: How to save Canada's health care system* (1994). Ms Kushner's most recent work as a health policy consultant, writer, and researcher includes reports on primary care, home-care, and health care for homeless people, pharmaceutical policy, consumer health and approaches to integrating care. Carol Kushner is also a popular conference presenter and frequent health commentator in the media.

Murray MacKenzie
Murray MacKenzie holds a Masters in Health Administration from the University of Toronto and has been the President and CEO of North York General Hospital since 1989. He worked in senior management with Mount Sinai Hospital from 1974-89 and was the editor and researcher of "A History of Canadian Hospitals" from 1971-72. Mr. MacKenzie has held numerous positions on boards of organisations, including the Ontario Hospital Association, Cancer Care Ontario, the Ontario Cancer Institute/Princess Margaret Hospital, and the Regional Geriatric Program of Metro Toronto. He also served as a member of the Mayor's Advisory Committee on Race, Ethnic & Community Relations for the City of North York, and various District Health Councils.

Camille Orridge
Camille Orridge is Executive Director of the Toronto Community Care Access Centre. Prior to her current position, Ms Orridge was Senior Vice President at the Home Care Program for Metropolitan Toronto. She is the Past Chair of the Regent Park Health Centre, a Member of the Emergency Services Task Forces Advisory Committee and the Primary Ambulatory Community Advisory Committee. Ms Orridge is also a Board Member of HealthLink.

Bonnie Pape
Bonnie Pape is Director of Programs and Research at the National Office of the Canadian Mental Health Association where she provides leadership for the program and research priorities of the Association. Since 1986, Ms. Pape has been instrumental in the development and implementation of CMHA's policy model, "A Framework for Support". In recent years she has overseen the development of concepts and resource materials related to mental health promotion.

Clint Rohr
Clint Rohr is Executive Director of the Woolwich Community Health Centre. He holds a Bachelor's Degree from Wilfred Laurier University and a Master of Divinity from Waterloo Lutheran Seminar. His vocation led him to become involved in many community, parish ministry, and chaplaincy projects. These include development of community-based group homes, co-operative seniors' residence, and, since its inception in 1991, Woolwich Community Health Centre.

Rob Simpson
Rob Simpson is currently the Director of Homewood Behaviour Health Corporation (HBHC). Under his leadership, HBHC undertakings have included the development of a program for problem drinkers, a smoking cessation program, and the provision of Employee Assistance Programs (EAPs). Previous appointments include Executive Director of the Wellington Dufferin District Health Council, Provincial Health Promotion Consultant at the Centre for Addiction & Mental Health (formerly ARF), and various positions with Health and Welfare Canada. He has also served as an Assistant Clinical Professor with the Faculty of Health Sciences at McMaster University.

Walter Weary
Walter Weary is the Executive Director of Central Toronto Community Health Centres in downtown Toronto. Central Toronto has two sites, the Queen West Centre and the South Clinic. He is also Chair of the Community Health Network of West Toronto – a coalition of 18 community agencies and health centres. Mr. Weary is a member of the Toronto Hospital Primary and Community Care Sub-committee and the Toronto Urban Health Alliance. He is also a member of the Association of Ontario Health Centres Board of Directors.

Elizabeth Witmer
The Hon. Elizabeth Witmer, is the Minister of Health for Ontario and the MPP for Waterloo North. She was first elected to the Ontario Legislature in 1990. In June of 1995 Mrs. Witmer was sworn in as Ontario's Minister of Labour. She became the Minister of Health in October 1997. As Minister of Health, Mrs. Witmer is responsible for the most significant restructuring of provincial health services in Ontario's history. A former teacher, Mrs. Witmer served as trustee for the Waterloo Board of Education from 1980 to 1990, including five years as chairperson.

Lorne Zon
Lorne Zon is Executive Director of the Toronto District Health Council (TDHC), and is also an Assistant Professor in the Department of Health Administration at the University of Toronto. While at TDHC, Mr. Zon led the development of Metro's first strategic plan for its health system, and the first health system report card. Prior to joining the TDHC, Lorne held positions with the Premier's Council on Health Strategy, and the Ontario Ministry of Health. Lorne Zon holds a Masters in Environmental Studies from York University.

The Role of Health Promotion Within a Reformed Health System

Conference Planning Committee Members

Irving Rootman, Centre for Health Promotion, University of Toronto (Committee Chair)
Joanne Taylor Lacey, Centre for Health Promotion, University of Toronto
Rishia Burke, Association of Ontario Health Centres
Jennifer Craven, Department of Public Health Sciences, University of Toronto
Randi Fine, The Self-Help Resource Centre of Greater Toronto
Ted Mavor, Grand River Hospital, Kitchener
Linda Kremer, Hospital Health Promotion Network
Jan Silverman, Sunnybrook-Women's College Health Science Centre
Lori Wilson, Toronto District Health Council
Colin Young/Sandy MacLean, Canadian Mental Health Association

Supporting Organisations

Hospital Network in Support of Community Action
The Hospital for Sick Children
Ontario Public Health Association
Ontario Hospital Association
Organisations, Partners, Communities (OPC)
The Toronto Hospital

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Health Canada

Ontario Ministry of Health

CONFERENCE OVERVIEW

This one-day conference on "Health Promotion within a Reformed Health System" was well received and well attended by participants from a range of sectors within health care. It provided a good opportunity for networking between those who work in the various sectors of the health system. The conference also provided a good starting point for those who work within the various sectors to look strategically at the role and opportunities for health promotion within our health system.

The conference program included sessions on long term care, policy, primary care, the hospital sector, integrated health systems, healthy communities, mental health and brokering relationships. The conference ended with a panel discussion on "Where do we go from here?" Some of the key themes that emerged from the conference were:

- A regional health system can better facilitate the integration of health promotion, as it allows for greater citizen involvement, planning and accountability. However, even though Ontario is the only province that does not have a devolved regional system for health care delivery and planning, integrated health systems are not on the agenda in Ontario for now.

- Politicians and governments respond to the demands of its citizens. At this point in time, citizens are demanding hospital beds and health care services. Awareness of the links between determinants and people's health need to be better communicated to the public.

- Language is a barrier to greater support and action on health promotion. The language of health promotion needs clarity and consistency. The same terms can mean different things (e.g. health promotion can be a program or a principle, for instance). Also, the terms we use are not well understood by the public, and many of the stakeholders in the health care community.

- There are different perspectives on the most appropriate way to foster health promotion. Do we need a greater presence in health care circles, or amongst other sectors? Do we work on addressing the determinants of health, or support people in being as healthy as they can be given certain social and economic realities?

- We need to regroup as a field, and become more strategic to ensure that health promotion is planned for and implemented in a reformed health system.

- More opportunities for dialogue and networking between sectors of the health system are needed. Many are interested in the values and goals of health promotion, but we need to become strategic and form alliances to make it happen.

OPENING REMARKS – TED MAVOR

How did the planning for this day begin?

Mr. Mavor related that in 1995 the members of the Hospital Health Promotion group got together. The group consisted of 17 hospital health promotion practitioners from South Central Ontario. They met in Milton at the Golden Griddle to discuss and draft a vision for this conference, built around the idea of finding a way to make Hospital Health Promotion into a built-in rather than an add-on component of the health care system. From that, through collaboration with the University of Toronto Centre for Health Promotion and other collaborators, this conference came into being in its present form.

When the planning committee first discussed what this day would look like, it was felt that the key would be to choose a credible, tone setting keynote speaker. The speaker should be knowledgeable and sincere, elegant, eloquent and an excellent communicator. Dr. David Korn certainly answers these requirements.

David Korn is currently a visiting professor at Harvard University Medical School, conducting research on gambling and public policy. His past experience includes working as an epidemiologist with the World Health Organisation's Global Smallpox Eradication Program where he was responsible for the eradication of smallpox in Shoa province, Ethiopia. He has been the Medical Officer of health for Simcoe County and was the first Chief Medical Officer of Health for Ontario under the newly proclaimed Health Promotion and Protection Act. He has also been the CEO of the Donwood Institute, which incorporated health promotion principles and practices into its corporate policies and practices as well as clinical programs.

KEYNOTE ADDRESS: DR. DAVID KORN

HEALTH PROMOTION IN A REFORMED HEALTH CARE SYSTEM: A PERSONAL PERSPECTIVE

Dr. Korn began by thanking the organisers of this day. He also thanked all those people who faxed and sent him great amounts of material at short notice. He related that at the last minute he had scrapped his original plans for the talk and decided to speak from his own personal experience. Lessons he's learned from his experience in public health and health promotion.

First, Dr. Korn told a story about an experience that occurred in this reformed health care system. He declined to name the hospital where this event occurred, or the person to whom it occurred, but said that it had happened to a "friend". Now this friend cut himself in his kitchen. After applying some first aid, he called his wife who drove him to the local hospital and dropped him off at the door that said "Emergency". When he went through this first door he found himself in a small, empty room which contained two more doors, one of which had a sign which read "Clinics" and the other "Urgent". Since he felt that his cut was urgent, he walked through that door. On walking through that door he found himself once again in a small, empty room with two doors facing him. These doors read "Medical" and "Surgical" respectively. He looked at his cut finger and decided that he might need stitches, so that made him a "Surgical" case. After walking through that door, he found himself facing two more doors, these marked "Head" and "Body". Well he knew he had hurt his finger, which was part of his body, so he walked through the door marked "Body". At this point he came to two doors marked "Pain" and "Laceration". He clearly had a laceration, so he walked through that door. Upon his arrival, he came to two more doors, these marked "Bleeding" and "Not Bleeding". By this point his cut was not bleeding any more and so he walked through the "Not Bleeding" door... and found himself back outside! [Dr. Korn then conceded that this story was fictitious.]

Dr. Korn suggested that this story is a good reminder of the 30% of people who go to the emergency room, who don't need to be there. And, that much can be prevented too.

Dr. Korn noted the unusual timing of this conference, which fell in a very busy week for health care. He pointed out that the Minister of Health for Ontario would be speaking at the conference and that Federal Health Minister, Alan Rock, had been in Toronto earlier in the week. He remarked that a lot of money was currently directed toward health care. Dr. Korn suggested that the conference could be renamed "Sick Care in Crisis: Is there room for health promotion?"

[Dr. Korn next showed a cartoon marked: Illness Care in Crisis: Is there a role for Health Promotion? The caption on the cartoon read: "You're not ill yet Mr. Blendell, but you've got potential".]

Dr. Korn presented the audience with a quote from Hypocrites: "Health is the greatest of human blessings". He remarked that our society's general concern with health is in no way surprising, because it has to do with pain and suffering.

The notion of health has become highly complex and multidimensional. But on a personal level, we can ask ourselves "are we healthy"? Is the person beside me healthy? Is this a healthy community?

Health Promotion is one strategy that can be used to maintain, enhance or recover health. The World Health Organisation defines health promotion as "the process of enabling people to increase control over, and to improve their health". It speaks to empowerment, community development, etc. This is the framework he works from.

Dr. Korn next presented three points that were his reflections on the roots of health promotion:

1. Dr. Korn noted that everyone in the audience was probably familiar with the Lalonde Report, released 25 years ago (in 1974) entitled, "A New Perspective on the Health of Canadians". He related that the Lalonde Report divided health into four broad elements: Biology, Lifestyle, Environment and Health Care and that it rated these in terms of the percentage role each played in determining health. These came out to say that Biology was responsible for a 10% contribution to health, Lifestyle and Environment were responsible for 40% each contribution to health, and Health Care contributed only 10% to health. This challenged the fundamental precept of a hospital and doctor-based health care system – that better medical care necessarily leads to better health. It basically challenged the *Canada Health Act* and Medicare, etc, which effectively were funding only a 10% portion of the areas that effectively contribute to health. As Dr. Korn pointed out, the Lalonde Report noted that health care does not equal health. He went on to note that the Lalonde Report was particularly popular in the United States and internationally with the World Health Organisation, but that it took longer to catch on here in Canada.

2. At about the same time as the Lalonde Report came out (1974) ParticipAction was founded. Dr. Korn outlined how in the 1970s a 70-year-old Swede was fitter than the average middle-aged Canadian male, and that this embarrassing fact propelled the notion of the need for a Canadian fitness promotion project. ParticipAction was so successful that at one time it was the second most recognised Canadian 'symbol' after Pierre Elliot Trudeau. It was a brilliant example (and essentially invented the concept) of social marketing, which took the principles of product marketing and applied them to human behaviour and the promotion of a healthy lifestyle.

3. Finally, Dr. Korn discussed WHO's smallpox eradication program, which he was a part of, and which he felt was an exceptional example of planning, vision and goal-setting in a health project. In 1967 there were 15 million cases of smallpox worldwide. By 1977 there were no cases of smallpox in the world. This program succeeded by using a number of very important strategies, perhaps the most important

being an extreme clarity of vision. The goal of the program was to eliminate every human case of smallpox in 10 years, a huge but extremely focused task. The program also had sophisticated management strategies – a decentralised process with talented project managers in the field. Political strategies were also germane to the project's success. Dr. Korn related that many of the people who were involved in the smallpox eradication program have gone on to play leadership roles in other health care settings, including the Centre for Disease Control in the US. Donald Henderson who was the leader of the project (and a Canadian) went on to become the Dean of Public Health at John's Hopkins University

Dr. Korn then related two of his personal experiences of health promotion in the health care system; one a success and one a failure. The success was his experience at The Donwood Institute. The Donwood was a highly successful prevention and clinical treatment centre for addictions. At the Donwood, it had been possible to incorporate health promotion principles into a hospital setting with, Dr. Korn felt, great success. The hospital was able to address determinants and harm reduction, as well as introduce alternative treatments. They were also able to implement policies to support health. For example, The Donwood was one of the first smoke-free hospitals, long before any other institution felt it was possible to do such a thing and in spite of the fact that most of the hospital's clientele smoked.

Next, Dr. Korn discussed his experience with a failed health promotion project within "Health Net North". This initiative of "Health Net North" was a coalition of 12 Toronto-area hospitals and the public health department in North York. This project of "Health Net North" was two years long and eventually fell apart due to hospital restructuring, fiscal constraints and turf issues. Dr. Korn noted that this failure was perhaps a reminder that health promotion is a long-term process that requires a philosophical 'buy-in' by the leaders involved. He noted that firm commitment of resources is key to the success of health promotion projects and that in some cases, systems change may be necessary.

In the final part of his lecture, Dr. Korn discussed current issues, projects and challenges for health promotion.

The first issue Dr. Korn discussed was that of health promotion terminology. He cautioned that there is a great need to be perfectly clear and very careful about language. Various terms have similar but distinct meanings, such as "risk factors", "determinants", "health promotion and disease prevention", and "health promotion and population health". This is confusing. Each of these terms can be a philosophy, principle, a program or a framework. As Dr. Korn pointed out, there is a great difference between a principle and a program. People are receptive to the concepts of health promotion, but they need to understand the language. We need to be clear about what we are talking about, and use language that everyone involved understands.

Secondly, Dr. Korn discussed the issue of biases of leaders in the health care field. Dr. Korn stated that many health care leaders do not "believe" in the effectiveness of health promotion. Health promoters must realise that decision-makers need to see evidence,

which they are competing for limited resources. Health promoters must use rational strategies with rational people.

Thirdly, Dr. Korn discussed the fact that currently we are dealing with a very uncertain environment in health care – health services restructuring Phase I has resulted in the closure of a range of hospitals. Dr. Korn mentioned that the Health Services Restructuring Commission would soon be progressing to phase II of its mandate. Since phase I of the health care restructuring did not speak about health promotion at all, it is to be expected and hoped that in phase II (the community phase) there will be opportunities for health promotion.

Dr. Korn's final remarks were a series of challenges to the health promotion field.

Be Strategic – PLAN. Health promoters need clear vision, clear values and clear strategies. They need to be clear about what they want to achieve. Dr. Korn noted that health promotion is a process, but that it needs to be a process with outcomes. He remarked that health promotion has a powerful role to play in health reform. There are also many opportunities for health promotion to reduce inequities with vulnerable or marginalised populations by investing in child and family health and development.

Be a Role Model. Dr. Korn discussed the need to believe in your "product". We need to be supportive of each other in a caring sense. Modelling supportive behaviour is important. Health promoters need to use mutual support and mentors to help manage the change and heavy expectations of the current situation. He also cautioned that health promotion practitioners need to practice their own good personal health habits - as Mahalia Jackson said, to "live the life you sing about".

Be Where the Action is. Be Relevant. Dr. Korn cited three areas where he thinks the "action" will be and these were the fields of Biomedicine, Information Technology and Molecular Biology. The example of antibiotics to decrease the risk of heart disease was given. He mentioned the field of behavioural genetics where genetics and neurosciences are investigating the relationships between genes and behaviour. He also discussed that health information can (and does) makes use of potentially powerful technology like the Web or even the telephone.

Dr. Korn told a story to end his talk. This was the story of the shtetl in Eastern Europe where, in preparation for Passover, the rabbi asked each family to make a bottle of wine that would be poured into a large communal vat to be used for the Seder. On the day of the Seder, however, the rabbi uncovered the vat only to discover that it was filled with water. He asked the question: "who is responsible for this?" and the answer to the question was "all these families".

Dr. Korn said that health promotion is a kind of community, where everyone must participate fully. He felt that health promotion has been watered down because not everyone is participating, that conferences like this one would help things and that at the end of the day there would be a better wine or "health promotion product".

PANEL RESPONSE TO KEYNOTE:

PANEL:
David Butler-Jones, Saskatchewan Health
Hy Eliasoph, Ontario Hospital Association
Carol Kushner, Health Care Consultant
Camille Orridge, Toronto Community Care Access Centre

HY ELIASOPH:

Mr. Eliasoph introduced himself as Director of Hospital Relations and Health Policy with the Ontario Hospital Association. He asked people in the audience to show hands to let him know where they worked (e.g. hospital, government, and private industry). Mr. Eliasoph commented on the fact that he looked around the audience and found that he knew very few people. This highlighted for him the solitudes in the health sector – that he could come to a conference such as this, and find he knew almost none of the people working in health promotion.

Mr. Eliasoph felt that more opportunities were needed for networking, collaboration, and to create synergy between the various fields in the health sector. He suggested that we determine what the forums are that are available. He stated that he was willing to commit that the Ontario Hospital Association could and would work with the Centre for Health Promotion to prepare a broader conference on health and health care, which could be used to include hospital people in the discussion of health promotion.

Mr. Eliasoph commented on the fact that the Federal Budget has provided for a lot of money to go to health care. He suggested that, perhaps, the new Federal money should be spent on health promotion and prevention. He noted, that he believed Lalonde's assertion that only 10% of health are health care.

Mr. Eliasoph discussed how health promotion would fit into integration (i.e. an integrated health system). He said that some people think that health promotion doesn't fit into the new system, but that he felt that health promotion should be out in front of the new integrated system, not left behind. Mr. Eliasoph then used a hockey analogy in which he said that health promotion and health promoters were like the offensive forwards of a hockey team – that they should be out in front of primary care (the defence) and urgent care (the goalie). Mr. Eliasoph felt that, unfortunately, the defensive positions of the health care team were currently getting more funding than the front lines. He suggested that right now we put most of our money into the "goalie".

Mr. Eliasoph communicated that the OHA is trying to look at a broader vision of health. He felt that the problems in the system now are that the cuts to the system were done before other supports were put in place.

CAMILLE ORRIDGE:

Ms Orridge opened her comments by noting that, unlike Mr. Eliasoph, when she looked around the room she knew many people, probably because she is, as she said, "community". In discussing the health care system, Ms Orridge said that she found the best aspects of the health system were the community health centres and public health units where attempts are being made to approach the other 90% of the contributors to health aside from health care (lifestyle, environment, biology). She noted that she hasn't seen health reform yet – she has only seen institutional reform.

Ms Orridge pointed out that Health Net North, Dr. Korn's example of a failed [health promotion] project, failed because it was trying to use hospitals for a community purpose. She was not surprised at all that it had failed.

Ms Orridge said that generally she had trouble identifying with health promotion because she found it very sterile – removed from her experience. That it is not "real". She felt that health promotion was too entrenched in the sick care system, too disease-based. For health promotion to really have a place she felt that it needed to come out of the sick care system. Health Promotion needs to be advocating for housing and income.

Ms. Orridge commented on her frustration with the hold that the sick care system has on health promotion. She felt that if there is money in health promotion, they'll grab it and run with it.

CAROLE KUSHNER:

Ms Kushner addressed herself to Dr. Korn's presentation, noting that Dr. Korn had been asking what has to happen next for health promotion to be successful. Ms Kushner posed the question that if health promotion were effective, wouldn't the new (Federal) budget have mentioned housing? Ms Kushner discussed her feeling that health promoters needed to work harder to get information to the public and transform the public's perspective, because elected decision-makers would, ultimately, follow the public's lead.

Ms Kushner commented that she was struck with Dr. Korn's mention of language and clarity in health promotion. She related that when she had been doing research for her books on the health care system, she had found a lot of health promotion material difficult to understand. The reason for this overuse of difficult language, she felt, was that health promotion needs a theoretical academic background, which it has not yet achieved. She noted that ParticipAction was one success, as it was recognisable and easy to understand.

Ms Kushner felt it was important to recognise the inevitability of conflict in shifting attitudes and actions towards a health promotion perspective. This is a struggle for power. She used the example of the tobacco industry versus the efforts to regulate tobacco.

She also discussed the issue of scale in the health care system. Ms Kushner mentioned that a health system without a geographical or regional organisation really couldn't work. She noted that Ontario is the only province without regional health authorities. Ms Kushner felt that regional health authorities are necessary for an effective health system, in order to be able to plan and to be accountable.

Finally, Ms Kushner called attention to Dr. Korn's "political" comment. She responded with the comment that information, while essential, is never enough and that timing is critical as well. She made reference to Ann Golden's recent report that was not responded to by the Federal government, because it was "too late".

DAVID BUTLER-JONES:

Dr. Butler-Jones, who has worked in both the West and the East of Canada commented on the different language used to refer to the solitudes that we work within. Ironically, in Toronto we refer to "silos", and in the West they talk about "smokestacks".

Dr. Butler-Jones noted that most health care systems in other parts of Canada (outside Ontario) have gone to structural responses (i.e. regional divisions). Dr. Butler-Jones remarked that the health care system is like a hungry elephant that constantly needs feeding, at the expense of the baby (health) which is being starved. Not that institutional care isn't important, but that we can never meet all the needs of illness and disadvantage. He mentioned one caveat – that technology always falls short. The fact that people are healthier in this age is, as he pointed out, 90% *not* due to health care technology. He noted that each wave of technology widens the gap between rich and poor, for a period of time. Dr. Butler-Jones called for a balanced strategy for health care.

Dr. Butler-Jones commented that he sees health promotion as working on what makes the community healthy. What are the indicators? How do you know if a community is healthy and functioning? He noted that problems occur not just because of cost restraints. He suggested that we need to avoid a deterministic view. we don't need to focus on not being poor. But, how can we live well if we are poor? He noted that he had just returned from a visit to the U.K. where he found that the poor in post-Thatcher Britain are actually less healthy, while the rich are healthier than ever before. He felt that no one sector has the answer. That we need to look at how systems can work together better to help people to get to where they need to be.

Dr. Butler-Jones reminded the audience that today's problems are yesterday's solutions and that things are constantly changing, but that we need to deal with the present as it is and avoid thinking "when I win the lottery I will...". There is no one answer to these complicated questions and Dr. Butler-Jones advised that it is important to recognise the existing power structures and work to change them. He cited the example of unemployment/employment – that there are two policy options. The first says "we (as a society) need these things done, while you are not working it might be of benefit to you

(and to us) if you would do them". The second says "you lazy so and so, get to work – here's something you have to do".

Dr. Butler-Jones closed his remarks by commenting on the following about how health promotion has been "mis-sold":

- We must work towards having the healthiest people possible by emphasising that life has inherent well being.
- Resources are not unlimited
- Greatest health often comes from outside the health system.
- Health promotion needs to be clear about what it can and cannot do. It has advantages and trade-offs.
- There is an expertise involved in practising good health promotion, and that it is easy to do health promotion badly.

Ultimately, Dr. Butler-Jones felt that the goal of health promotion should be to build an infrastructure for healthy communities. He closed by saying that sometimes, it is important to do things for no other reason than that it is right to do them.

QUESTIONS AND COMMENTS FROM THE AUDIENCE:

The following are questions and comments from the audience, in response to the panel:

- What he had heard was the same old story and very frustrating. The real opportunity is at the community level. We can't wait for other sectors – we need to do what we can at the local level. Share what does work and what does not.

- We need to move from building resources for hospitals to strengthening communities. Will believe hospitals are serious about health promotion when they start talking about poverty. Hospitals should look inside themselves for the source of some problems – should ask themselves if they are healthy places to work in or to get well in.

- Health promotion is calling for a revolution, but that one has to work incrementally. In terms of Hy Eliasoph's hockey analogy, health promotion is not even on the ice at present. One way to get on the ice is through community motivation. Technology could be used to narrow the gap and health promoters need to be more sophisticated in their communications. As an example, it was suggested that an excellent business case could be made for health promotion values (e.g. the cost of disability). If a business case could be made a political case could be made after that.

- A conference attendee from said that he was newly hired as a health promoter and that he needed suggestions for how to proceed in his new position.

- One of Premier Mike Harris's favourite words is "accountability". It is not very accountable to put 90% of the health care dollars to something that contributes only 10% to the state of health. OHA should not just hold a conference – they need to go with us and lobby government for more money for health promotion.

- The example of an agency for the blind that was losing its funding from MCSS was given. MCSS told this agency that they need to go to the Ministry of Health for funding. These agencies need help in finding ways to get sources of funds in this new health care system.

- What role does health promotion have in the private sector?

- The environment and its fundamental importance to health was raised – this includes the food we eat, the water we drink and the air we breathe. A conference to be held in March on "Everyday Carcinogens: Stopping Cancer Before it Starts" was announced.

- A workshop coming up with the Centre for Health Promotion on "What Works in Health Promotion in Ontario" is possible because of the skills, ability, and expertise of the people working in the field.

- Question was raised regarding the lack of connection between business and the hospital sector. How do we address individuals in the workplace?

- Pleased to hear that David mentioned injury prevention. This is an area where there can be savings.

- Everything is connected to everything else, and that as long as the people with the money see a label, they will use that label. Maybe it was time for a new name to describe something dealing with more than just health.

THE PANEL RESPONDS:

David Butler-Jones: Dr. Butler-Jones described how in the U.K. they are introducing legislation that will allow health authorities to transfer money to social agencies, which will allow the health care system to address other areas of life which contribute to health (e.g. unemployment). Dr. Butler-Jones said that health promotion needs to be at the table while changes are going on. He used an example from the Province of Saskatchewan where 50% of new money that was about to be given by the government to WCB, was earmarked for health promotion use, because health promoters were there at the table when discussions were going on. Finally, in response to the question about injury prevention, Dr. Butler-Jones acknowledged that the linkages between injury prevention and the health system are still in their infancy.

Camille Orridge: Ms Orridge commented that if you take the example of AIDS education, the most successful education and teaching may have started with academics and health care organisations but ended up with grassroots community groups. She cited the example of handing out condoms in bathhouses and hairdressing shops on Eglinton Ave. to members of the black community. Ms Orridge warned that no one sector can own the information or delivery, but all sectors must come together. Further, Ms Orridge commented that she would like to see a study done on just how much workplace productivity was being lost by people who have to stay home to care for the sick.

DAVID KORN RESPONDS:

Dr. Korn commented that given the complexity of the health care system and the nature of change, that one must expect conflict in the system – that's part of it. Dr. Korn next picked up on Trevor Hancock's comment about hospitals versus communities. He pointed out that we tend to think in dichotomies, but that it can be dangerous to think of hospital versus health promotion, for example. Dr. Korn said that people need to learn to think in circles or a continuum. With regard to the issue of the focus on hospitals and doctors in the health care system, Dr. Korn reported that, ironically, when he had tried to find out where Marc Lalonde was presently he had located him as the Chair of the Board of Hotel Dieu Hospital. As Dr. Korn pointed out, this apparent irony was a great example of the fact that we all have to work with the systems and institutions that are currently in place in order to change the health system into something better.

CONCURRENT SESSION

LONG TERM CARE – CAMILLE ORRIDGE

Highlights of Camille Orridge's discussion of health promotion in long term care in a reformed health system are as follows:

- There is a health care revolution going on – no matter where you live or what terminology you use (e.g. regionalisation, restructuring, centralisation or rationalisation). This is resulting in:
  - a profound impact for consumers
  - a corresponding shift for health care management and staff as they serve their clients, and
  - continuing stress and turmoil in the health care environment that will carry on through the next millennium.

- Before health care reform:
  - The hospital was regarded as the centre of the health care universe – virtually all services provided there.
  - Since much of the patient's convalescence and rehabilitation was provided in-hospital, much of the teaching component, including health promotion, also took place in the hospital.

- After health care reform we see:
  - Shift of in-patient procedures to ambulatory care and day surgery.
  - Dramatic shift of convalescence and rehab into the community.
  - Long term care continues largely within the institutional walls, but the emphasis is focussed on maintaining the client in their own home (i.e., the community).
  - Teaching and health promotion (e.g. cardiac care, diabetic teaching, breast-feeding teaching/assistance) are sharply curtailed or eliminated.

- Impact of Health Care Reform on Home Care:
  - *Policy vacuum* – Canada Health Act does not cover care obtained outside hospital/doctor environment. There is no National and in most cases no Provincial policy that governs who pays the cost of services outside of institution. There is a lack of consistency, uniformity and portability of entitlement and eligibility of services in the community. Since costs are not covered, and health care dollars are not following patients, individuals and families are bearing the burden of costs.

  - *Increase in community expenditures* – Home Care expenditures in Canada have increased by 3000% from 1975 (from $62M in 1975 to $2.1B in 1997) but this is still less than 6% of total health expenditures. The increases are a great direction, but the rate of home care spending is not matching the rate at which patients are leaving the institution for care in the community. In the short term, some patients

and their families can incur additional costs without too much negative impact. However, for others with chronic illness or disability or lower incomes, the diversion of resources results in sacrifices of other preventative measures such as proper diet and in some extremes, giving up on their housing.

- *Increased role/burden of family and friends as caregivers* – Many more chronically ill patients who require long term care are being cared for at home by family and friends. Women shoulder most of this burden. Three types of female caregiver are at risk: the woman at home caring for a severely ill child and other children; the woman who is 'sandwiched' caring for two generations at the same time; and the elderly woman who cares for her ill spouse. All of these caregivers are at risk of compromising their own health as well as the health of other family members who do not receive sufficient care. Respite care needs to be part of the health promotion agenda.

- *Community Care Access Centres (in Ontario)* – The role of CCAC's are to determine eligibility for, and the provision of in-home services, information/ referral and the placement of individuals into long term care facilities. The shift of community care to the privatisation of service delivery and the managed competition model has led to the importance of "the best quality services at the best prices possible". This competition has the ultimate effect of emphasising treatment and then teaching the client to do the care. Teaching for prevention or health promotion is not built into the CCAC mandate or the provider's mandate either. While we keep advocating for it, we've not seen a lot of support for this role.

- Primary prevention and addressing the determinants has great relevance to long term care. Future populations and health consumers will be different than today. In Toronto they will be more ethno-racial and less European origin. They will have less money, less opportunity for well-paid work and less education upon arrival.

- Meeting the long-term care needs of a changing community will require changes in the way we provide services. It's not clear exactly what those changes will be – there is no roadmap or "bible".

- From a health promotion perspective, the Health Department at the former City of Toronto provides a good example. They have developed programs in response to the community's needs, with a heavy emphasis on primary prevention and health promotion. Harmonisation, regionalisation and integration of health services or municipalities all have their strengths. But the biggest potential loss is the health prevention, health promotion and services targeted to specific populations.

- Meeting the challenge:

  - *Advocacy* – Needs to be done around primary prevention, the maintenance of public health's role in primary prevention or the cessation of funding for public housing, or for cuts to social programs, welfare or disabled – a distinct advocacy strategy seems to be in order.

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  - *Research* – there is no shortage of research but research priorities need to shift – to be driven by community and its needs, not by academia.

- Health promotion crosses a myriad of domains (housing to education to nutrition to income to prevention of disease) but funding largely comes from sick-care system. Health promotion may have more of an effect if it were funded and established as an independent unit outside of the sick-care system, and became a truly influencing force on other agendas such as housing, education, environment, and social justice, in addition to the sick care system.

CONCURRENT SESSION

POLICY – DAVID BUTLER-JONES

Highlights of David Butler-Jones' discussion of policy and health promotion in a reformed health system are as follows:

- The question driving policy in health system reform is "How much do you put where?". This is the dilemma of policy makers. Governments are torn.

- Every region in Canada except Ontario has devolved services to their regional boards. This allows the community to look at indicators within a certain geographic area. It also allows for public participation and accountability – providing the opportunity to discuss local issues and develop plans to meet the needs.

- Tensions in health system policy are the result of the "hungry elephant" (i.e. not all needs can ever be met). This creates the dilemma between immediacy versus investment.

- Media has a strong influence in driving the public demand for services. In order for action to be taken on the determinants of health, the media needs to reflect these issues. The media typically picks up on sickness issues. They are not as interested in the determinants issues. Dr. Butler-Jones' region has done some work with media, but the stories change for about a month. It is not an easy road.

- "Determinants of health" is not a concept understood by the public. People tend to know about and demand sick care services from the health system. Need to frame issues in a way that people can understand links between determinants and their health.

- Barb Kahan did research with decision-makers (key informants) in Saskatchewan regarding population health. Her findings included the following:
    - Internal contradiction – differences between belief and actions
    - There is consensus around beliefs about health and determinants
    - Less consensus on what to do about it.

- An integrated system is important to be able to address a health issue in the most appropriate way. An example was given of a nursing home that had a heavy door where people were falling. They were able to fix the door, instead of beefing up emergency services to treat the injured residents.

- Health promotion needs to work at the community level. It can't be top down. The individual needs to be empowered. Sometimes hospitals have enough funds in their budgets that they can make money available for health promotion. They do it, but they don't do it well. Then they say that health promotion doesn't work.

- In order to influence the determinants of health, you need to work with boards of health to understand the issues and also do the following:
  - Partner
  - Advocate
  - Cheerlead
  - Enable
  - Mitigate – minimise the effects of the determinants while you are working on addressing them

- From the audience, the Medical Officer of Health for York Region commented that in her region they pick one determinant of health a year to address, such as “Food, Hunger, and Health”. This theme got very good press and media coverage.

- In response, Dr. Butler-Jones noted that it is important to go to specifics, even if that means disease. He ended his remarks highlighting the importance of making even small victories.

CONCURRENT SESSION

PRIMARY CARE – CAROL KUSHNER

Highlights of Carol Kushner's discussion of health promotion in primary care within a reformed health system are as follows:

- It is difficult to talk about the new, integrated health care system because it's not really here yet.
- The fit between primary care and health promotion is embodied in the question "who does what?" This question is one of the most contentious one's in health care.
- Some of the players in primary health care are family medicine, public health, governments (provincial and federal) and social activist groups. Social activist groups involved in health care tend not to be very political or particularly powerful. Most of these activist groups have actually grown from inside the health care bureaucracies and Ms Kushner suggested that they might take a lesson from the more independent environmental activist groups or consumer advocacy groups.
- Current priorities in primary care funding do not currently support a health promotion perspective. For example, a medical treatment that costs $5,000 - $10,000 per quality adjusted year of life saved is considered efficient, but at the same time, public health nursing for new mothers has been cut back or phased out.
- Very few models of primary care actually deliver any type of community-based care (e.g. healthy public policy, community development) or even many important aspects of individual or family care (e.g. self-care/management, disease prevention, etc.). The new health care system, public health services have been cut back to the point where they provide very few non-population based individual services such as new mother contact.
- The discussion then turned to the various delivery models for primary care, including Fee for Service (FFS), Health Service Organisations (HSOs), Community Health Centres (CHC), Community Care Access Centres (CCACs), public health and telephone advice. Ms Kushner talked about the fact that primary care delivery models had been developed haphazardly as part of our "one value" focus on sick care, and as a trade-off between physicians and Medicare.
- The power and transformative potential of the telephone and Internet as methods of delivering health care information were discussed, noting the potential for mis-information on carriers like the Internet. Ms Kushner acknowledged that mis-information will be, in some cases, corrected by other users of that information, either professionals or non-professionals and that this function of health professionals had the potential to be greatly transformative.

- Ms Kushner described the characteristics of CHCs: they serve a defined population (by geography), they use multidisciplinary teams, they emphasise health promotion and disease prevention, they provide their workers salaried reimbursement and they participate in the community and in community development. Ms Kushner discussed CHCs as being an excellent method of allowing primary care providers to deliver health promotion. She used the example of the South Riverdale CHC, where she attends, and mentioned that CHCs role in helping the community to get rid of a rendering plant that was causing health problems. She also cited the well-known Abelson and Lomas study (CMAJ 1990, 142(6): 575-581) which suggested that CHCs used a greater variety of health promotion programs and a greater tendency to use non-physician health care personnel to carry out both prevention and health promotion activities.

- The Primary Care Reform Pilots being carried out by the OMA and the Ministry of Health were discussed. These operate on two basic options (reformed fee for service or global funding) and are being piloted in 5 Ontario communities (Chatham, Paris, Hamilton, Wawa and Kingston). Ms Kushner felt that positive aspects of these projects include the fact that they are geographically based and have some specific incentives re: preventive services. Overall, however, Ms Kushner felt that these reforms are not going to be a good way of delivering primary care overall. One problem is that the Primary Care Reform Pilots are not multi-disciplinary - affecting only doctors and nurse practitioners and not other health care providers. Also there is no emphasis in the pilots on community development. Ms Kushner also commented that the evaluation process for these projects is very slow (up to 5 years).

In conclusion, the following challenges and implications for health promotion in primary care were expressed:

1. The challenges that Ms Kushner anticipates with regard to implementing health promotion into primary care include:
    - The political nature of social and economic determinants
    - Cultural barriers (re: individual/group/community and population perspectives)
    - The demise of Inter-sectoral initiatives
    - Reduced support for public health
    - A weak consumer health movement
    - Absence of critical mass

2. The implications of this discussion of health promotion in primary care are as follows:

    For Policy:
    - The importance of geographic responsibility
    - Funding by population re: needs
    - Development of more multidisciplinary delivery models
    - Appropriate reimbursement incentives

For Research:

- Research on efficacy and cost-effectiveness of interventions
- Research on alternative delivery models
- Lessons from other sectors re: community participation

For Training:

- Training for teamwork
- Clarity re: role of community development

CONCURRENT SESSION

THE HOSPITAL SECTOR – HY ELIASOPH

Highlights of Hy Eliasoph's presentation on health promotion in the hospital sector in a reformed health system are as follows:

Opening remarks:

- Reiterated his interest on behalf of the OHA (Ontario Hospital Association) in organising a larger joint conference on the topic of this conference and the need for continuing dialogue and collaborative effort.

- Health promotion work goes on in a variety of health care settings. Asked where health promotion was in the system, i.e. was it in, out or in-between? Suggested the need for health promotion to make its case better.

- For the time being at least, the idea of Integrated Health Systems or Integrated Delivery Systems was off the government's agenda. Suggested that what is likely to work is a bottom-up approach.

- The run-up to the election is an opportunity to influence the government

- Expressed the view that throwing money at the problem won't solve it, but rather there was a need to reorganise the system. He presented an environmental scan overhead with the following points on it:
  - Ministry attempt to develop provincial policy framework on hold or off altogether (i.e. IDS/HIS will not be implemented
  - Role, scope, mandate and likely impact of new ADM (Integrated Policy and Planning) still far from certain
  - Primary Care Reform focused on physician remuneration
  - OMA-Ministry agreement severely limits new funding arrangements
  - Ontario health Providers Alliance not constituted to lead reform/integration
  - Impact of HSRC directives still substantive; second phase of mandate unclear
  - Federal (health care) budget
  - Provincial Election looming.

Discussion:

- Health promotion work in hospitals is marginalised. An example of this is the way in which budgets are structured so that health promotion activities can't be counted. Community development and other health promotion activities consequently are not considered as being part of "good health care".

- There are a number of models of collaborative approaches, which appear to be working well. One example is the model in Ottawa, which involves the Children's Hospital of Eastern Ontario, and many other community agencies in co-ordinating services for children and youth.

- There is a role for hospitals to take the lead but not assume complete ownership of collaborative activities.

- The "Partners for Health" initiative in East Toronto was described. It was noted that the partnerships were exclusionary because they were restricted to programs funded by the health sector. There was a need to include the social services and other sectors.

- There is no incentive for primary care services to come together.

- There is a need for more pilot projects.

- We are all in this together and have to work with one another.

- We must develop "business plans" for the work that we do together.

- There is a lot of innovative work happening that we need to share knowledge about with one another.

- The government has "butchered" rather than "reformed" the health care system. Ontario is the only province that hasn't become regionalised. Where does the OHA sit and what leadership are they prepared to take?

- Hy indicated that the OHA was willing to take leadership. There was a need to integrate the system by starting functionally and going from the ground up. There are systemic barriers that we have to negotiate with the government about. This includes the fee-for-service system. It needs to be recognised that 90% of the factors that determine health are outside of the health care system.

- Health promotion represents basic values. We need to share our visions.

- Health promotion is everywhere – that is, the values of health promotion such as "empowerment" need to be played out in all components of the system. In addition, health promotion needs to be part of each component to varying degrees in terms of programs and policies.

- It is time to move. OHA needs to show leadership. We do have a common vision but don't have common paths.

LUNCHEON

KEYNOTE ADDRESS –The Hon. Elizabeth Witmer

Good afternoon. It's a tremendous pleasure to be here today to discuss health promotion and disease prevention in Ontario within a reformed health system.

I want to thank Ted Mavor, Chairperson of the Hospital Health Promotion Network in Southern Ontario, and Co-ordinator of Health Promotion at Grand River Hospital in Kitchener, for his kind invitation.

I also want to take this opportunity to congratulate Ted who has accepted the World Health Organisation's invitation to be its Canadian Partner for the Organisation's International Health Promoting Hospitals newsletter.

And, apart from his work as Co-ordinator of Health Promotion at Grand River Hospital – work which has been intrinsic to the hospital's significant reputation for innovation in promoting good health habits – Ted is also initiating the Health Promoting Hospitals concept across Canada.

Clearly, health promotion and disease prevention are a significant component of any good health system. Indeed, it's the cornerstone of our plan for the future of Ontario's health system. Prevention is a key strategy in the MOH 98/99 Business Plan that states "we will expand previous programs designed to reduce people's health risk. These programs are designed to encourage people to change the types of behaviour that may place their health at risk. We will also help them by identifying problems early on for effective early intervention".

Let's focus on children first since the government has a strong commitment to the well being of children. The Healthy Babies, Healthy Children Program, for example, provides: screening, prenatally and at birth, for all Ontario new-borns; assessment of families potentially at risk, linking them to community supports and services; and public health nurses and lay home visiting for high risk families.

The program has been enhanced with increases of $10M in 1998/99, $20M in 1999/2000 and $10M in 2000/2001 for a total program commitment of $50M by 2000/02. New dimensions are being introduced to the program that reflect the government's responsiveness to current research and field consultations. These include:

- broadening the catchment area of vulnerable children to include children up to age 6
- provision of lay home visiting from prenatal to age 3
- increased intensity of lay home visiting
- ability to augment lay home visiting with professional public health nurse visitation

Advantages – self-esteem, fewer health, academic and problems with the law. Ability to reach potential.

The Pre-school Speech and Language Initiative, has provided $20M enhanced funding to create a system to serve children, from birth to their fifth birthday, who have speech and language disorders. It is providing services to over 30,000 pre-school aged children this fiscal year and will provide services for close to 70,000 children when it is fully implemented in 2002.

As well, the "Better Beginnings, Better Futures" program helps women with their parenting skills and helps protect children from neglect or abuse.

So far, more than four thousand families with young children in eight economically disadvantaged communities have received ongoing support to improve their children's capacity to grow into healthy adults, thanks to our funding of $4.6 million for Better Beginnings, Better Futures.

Hand in hand with programs for Ontario's children go our health promotion and disease prevention initiatives for women –- particularly in the areas of breast and cervical cancer, violence against women, midwifery, women's health centres, mental health and substance abuse programs, and support programs for HIV-positive women.

With funding of some $210 million annually, these initiatives include the expansion of the Ontario Breast Screening Program to allow five times as many women to be screened. It's expected that deaths from breast cancer can be reduced by as much as thirty per cent in women between the ages of fifty and seventy-four through such screening.

As well as focusing on instituting health promotion and disease prevention initiatives for children and women we're launching the Heart Health Program for all Ontario.

The provincial Heart Health Program is providing local health promotion and prevention services to Ontarians by addressing three key lifestyle factors: eating, physical activity and preventing tobacco use which are linked to reducing the risk of both heart disease and cancer. Specific targets have been set to decrease the rate of smoking in young people and adults, increase the level of physical activity in the entire population, and decrease the level of fat intake in adults.

Heart Health funding to Ontario's 36 public health units totals $17 million over five years ($3.4 million per year).

Public health units have joined community partners including local chapters of the Heart and Stroke Foundation, Canadian Cancer Society, Ontario Lung Association, school boards, recreation centres, local businesses and community volunteers. Across Ontario, over 700 groups are members of local heart health partnerships.

These efforts to reduce the risk of heart disease go hand in hand with our efforts and strategy to prevent smoking, support quitting smoking and protect the public from environmental tobacco smoke.

Treating tobacco-related illnesses and disease in Ontario costs over $1 billion in direct health care costs, plus an additional $2.6 billion in lost productivity. In 1998 a total of $470 million was collected in provincial tobacco taxes.

Since January 1998, we have announced $900,575 to support five initiatives to prevent and reduce tobacco use. The initiatives and funding allocations include:

- Community Education Campaign ($500,000)
- Ontario Tobacco Strategy Dissemination Services ($48,266)
- Ontario Tobacco Strategy Research Projects ($29,310)
- 1-800 Quit Smoking Telephone Support 8.HHH

children and youth is a priority, with each project being asked to allocate one third of their budget to activities directed at young people.

Another of our top priorities is diabetes, with a strong emphasis on prevention initiatives. We are constantly increasing our efforts to educate the public and to help people manage life in the shadow of this disease.

While diabetes may not be curable yet, proper education and treatment can go a long way in controlling it. And I'm proud to say that "Ontario's Diabetes Strategy" was one of the first to be developed in Canada.

In 1996, as part of that Strategy, we made a commitment of almost $6 million over three years for diabetes-complication prevention.

This is money to enhance education programs and services, and create four new regional diabetes networks in southwest, central west, central east and eastern Ontario.

Education manuals for front-line workers are being developed, as well as a critical path for diabetes treatment and management for use by long-term care facilities. And last November, I announced $2.5 million for thirty-three community-based diabetes education programs.

Few things have a more profound influence on a community's quality of life, prosperity and productivity, than the health of its people.

A vibrant and health-conscious culture is the foundation on which the general well being of Ontarians rests. And the development of such a culture in our province will derive from a health system that promotes wellness and personal responsibility.

Thanks to the combined efforts of organisations such as the Hospital Health Promotion Network and our government's health-promotion initiatives, we can see our health services evolving into a system providing a more equitable balance between the prevention and treatment of illness.

And our investment in health promotion and disease prevention will have a double dividend. Not only can we expect to see Ontarians live longer in better health but we can expect to see health-system resources put to optimal use for all Ontarians.

By working together on these health promotion strategies and programs, we can enable individuals and communities to take control over and improve their health.

As you can see, health promotion is a key strategy within our reform of the health system. Thank you for the part you play in making that happen.

CONCURRENT SESSION

INTEGRATED HEALTH SYSTEMS – ELIZABETH BIRSE, HEATHER GRAHAM & WALTER WEARY

Highlights of Elizabeth Birse's and Heather Graham/Walter Weary's discussion of integrated health systems are as follows:

Elizabeth Birse – Theoretical Perspective

Elizabeth Birse is a recent graduate of the MHSc Program in Health Promotion at the University of Toronto. The framework she presented for integrated health systems was initially developed as part of her graduate work. She has continued to develop and refine the framework in her work with Quantum Solutions (a private health care consulting firm). The full paper that outlines the framework is available through the Centre for Health Promotion. A shorter version was developed for the Toronto District Health Council. Both are available on-line at the Centre for Health Promotion's web-site at:

http://www.utoronto.ca/chp/ihs.htm#Publications.

- An Integrated Health System (IHS) is a network of organisations that provide or arrange to provide a co-ordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.

- The characteristics of an IHS are:
  - Non-profit
  - Single point of accountability
  - Meets broad range of health needs through provision or purchase
  - Rostered population
  - Capitated funding
  - Strong core primary care services

- Three approaches need to be balanced in an IHS that is health promoting: Medical (treating illness, rehabilitation, and preventative medicine), lifestyle/behaviour, and socio-environmental factors.

- Foundation of an IHS needs to be based on the core health promotion values of :
  - Empowerment
  - Public Participation
  - Intersectoral Collaboration
  - Broader Determinants of Health
  - Equity and Justice

- In her Toronto DHC paper "Nine Steps to a Health Promoting IHS", Ms. Birse suggests that both top-down and bottom up (grassroots) strategies can happen simultaneously. But a health promoting IHS won't just happen. It needs to be nurtured. The nine steps are as follows:

  1. Develop a mission based on health promotion values.
     - This is especially important for rostered populations, so that those are high risk or high cost (need a lot of medical services) are not "dumped".
  2. Develop a governance structure that reflects health promotion values.
     - Should adopt a model similar to Finland's, where citizens have seats on a municipal health board.
  3. Allocate a minimum percentage of the budget for health promotion.
     - As IHS's evolve, they should eventually allocate 10% of their budget to health promotion.
  4. Develop a health promoting service culture, roles and responsibilities.
     - Emphasise community care, as appropriate.
  5. Take a health promoting client-focused approach to services.
     - The Ministry of Health should develop a province-wide, comprehensive Client Bill of Rights for all IHS members. This would be similar to what has been done in the Netherlands.
  6. Develop a work environment/culture that promotes health.
  7. Identify and support partnerships in health promotion.
     - Intersectoral collaboration is needed, so that health promotion is not limited to the health care sector.
  8. Set targets and standards for health promotion.
     - Important to set targets and standards so that you can measure whether the health of the population has been improved, or if inequities in social indicators have improved.
  9. Adopt strategies that promote health.
     - Make sure strategies and tools are evidence based, not just principles.

- It is clear that IHS's are off the Ontario Ministry of Health's agenda. But, Ontario is the only province without regional or integrated health services. Integration is part of a worldwide phenomenon. When it does happen, they will need to have a model that promotes health. That's why it's important to develop and refine this model now.

Heather Graham and Walter Weary – What an IHS might look like on the ground.

Ms. Graham and Mr. Weary shared their experience with the Community Health Network of West Toronto.

- An initiative of 18 agencies coming together to begin to integrate, in the absence of a formal IHS system. These agencies include health, social, community and recreational agencies. They have worked together for three years. Individual representatives on the steering committee may change, but the agencies involved have remained constant.

- Health promotion needs to be made more visible. It lacks presence (i.e. there are no satires of health promotion on Seinfeld!). It's invisible. It needs to be integrated into every job in an organisation from the secretary to the Executive Director.

- Community Health Network of West Toronto began in 1986 because of a desire by the agencies involved, to work in an integrated way, supporting principles of health promotion and community development.

- One of their first activities was that they produced a discussion paper on how they could form an IHS. They received good feedback on this from the bureaucrats, but were not funded as a program.

- They continued working together and formed three working groups – seniors, mothers & children, homeless/under-housed individuals.

- They developed a mission: "To work better together to improve the health, well being, and quality of life for all members of our community". They also developed shared values, which included: a broad definition of health, flat leadership within the group, non-profit values, and community controlled.

- They established their view of a community health system that is integrated. They believe it should be:
  - Health promoting
  - Comprehensive
  - Supportive of self efficacy and client empowerment
  - Effective and efficient
  - Committed to continuity of care.

- Hard to sustain this type of collaboration without any core funding, as it does take resources to work together. There is no government funding available for this type of work.

- Early challenges were:
  - Fear of loss of autonomy
  - Loss of key partners due to restructuring
  - Large bureaucratic systems can be remote and unresponsive
  - Trust – didn't know if they could trust each other
  - Engaging physicians and other providers
  - Confidentiality and access to information
  - Structure of organisation (realised later on that function is more important than structure)

- Current challenges are:
  - Sustainability of the network (funding, maintaining staff support (without core funding) and keeping membership engaged.
  - Monitoring erosion of partner agencies
  - Developing a structure and process that supports identified goals
  - Maintaining communication between Steering Committee, Working Groups and Community Boards
  - Collective approach to needs-based planning.

- Will be in a good position to direct any future effort of government legislated IHS's, and would be well prepared to work in that way.

- Critical success factors for health promotion in a reformed health system:
  - Structure, process and resources that support a co-ordinated, collaborative model.
  - Goals and objectives that bring added value to individual organisations, the network as a whole, and the community at large.
  - Broad definition of health (more than absence of disease)
  - Membership that reflects range of partners & individuals whoa are committed to contributing to improved community health
  - Defined community (e.g. geographic population focus)
  - Incentives aligned (e.g. funding mechanisms in sync with desired outcomes).

CONCURRENT SESSION

HEALTHY COMMUNITIES – FRAN PERKINS, CLINT ROHR & JOY FINNEY

The presenters for this session on healthy communities in a reformed health system were Fran Perkins, Clint Rohr and Joy Finney. Highlights are as follows:

Fran Perkins – The Macro Perspective

- The world has always viewed Canada as a leader in health promotion. The 1974 Lalonde Report brought health promotion into the world perspective.

- The 1980s saw a change in the focus of public health to areas other than communicable diseases.

- Following Canadian (primarily Toronto) leadership, the healthy communities movement picked up momentum in Europe.

- In 1984, the first international conference on health promotion was held. The 1986 international conference on health promotion culminated in the Ottawa Charter for Health Promotion. It is a framework that is still widely used today in the field – anywhere you travel the world, the Ottawa Charter is the standard and is what the world community sees as Canada's significant contribution to health promotion.

- WHO became interested in healthy cities in 1996, when a network of healthy cities priorities was established and formalised. A "healthy city" had to have several characteristics that can be clearly identified. These characteristics included: convivial, liveable, viable, equitable, sustainable, and adequately prosperous as they relate to the realms of community, economy and the environment.

- There are four main characteristics of the Healthy Community Process:
  - Wide community participation
  - Broad involvement of all sectors in the community
  - Local government commitment
  - Creation of healthy public policy

- Healthy cities sits in the environmental sector of WHO World – but North America and South America see healthy cities in a different sector from the European view.

- Politicians like the idea of healthy communities because the groups involved step back from the political issues and work on solutions. These efforts either save money or do not cost much money. Healthy communities groups like that politicians are willing to either step back from their community involvement process or are willing to help.

- The concept of healthy communities is about trying to get everyone out of "their silos" and to work in a more integrated fashion – getting people to move through systems and departments. At one time the Toronto Healthy City Office produced a State of the City Report. It is more like a bulletin today – organisations, etc., are continually changing the way they collect data. In some cases, the groups are not collecting the data any longer.

Clint Rohr & Joy Finney – The Micro Perspective

- An example was given of the Woolwich community – a community that had a chemical factory with toxic substances leaking into the water table. In this community, a lot of people use wells. The community had a strong reaction – as do most cases where there is a technology disaster and blame can be focused. The issues become divisive for the community.

  This gave rise to the idea that the community needed to work together and look at the larger picture. The community decided to set up an inter-sectoral group, and had a healthy communities visioning day facilitated by Trevor Hancock. The ideas that came to the forefront were: enhancement of nature trails, sustainable development, well water issues group and stream rehabilitation. There was solidarity amongst diverse community groups for the ideas presented. A working group was formed on each of these issues.

- They held a second day with local politicians and staff of the municipality to get them on board. The strength from this was that they got government endorsement and inter-sectoral involvement and commitment. The drawback was that the issues were too broad or too specific for community groups and politicians to use.

- It became clear that when we're healthy, we don't think about health issues – they only surface when there is a "disaster" or other strong issue that becomes a rallying point for community members.

- As next steps, they hired a student from the University of Waterloo to interview town councillors and community groups to come up with indicators for each area and discover what (if any) information was available. This data was used to compiled a report. The guiding principles that came out of the report have been useful in allowing everyone to stand back and look at the issues holistically – rather than looking to specific issues such as runway expansion, water, air and tourism. The

people involved have also learned new skills such as coding and compiling data and reports.

- To use Fran's image of eating an elephant, the group realised that when you start eating the elephant, you realise that it is a lot bigger than it seemed at first to be. For example, with stream rehabilitation, you start pulling out garbage and realise that there are larger issues than just garbage, such as soil erosion, water levels, and wildlife that rely on the stream, etc.

Questions & Discussion

Q. How do we sustain this kind of involvement?
A. Strong health units, strong CHCs, strong volunteer base. Healthy City movement does not diminish when governments change because the groups are not necessarily political themselves. Liberals like it because it involves community, PCs like it because it doesn't cost money (and sometimes saves money). Lisa Caton (Ontario Healthy Communities Coalition) pointed out that their network used to be funded by the Ontario Ministry of Health. They had to rebuild because the Ministry of Health says that they are multi-sectoral. They've had to break down all of their work, as no one government wants to take ownership.

This brought up a discussion on the benefits and drawbacks of decentralisation of services. Lisa pointed out that in Quebec, decentralisation added vitality to the movement. But in B.C., decentralisation killed the movement. It depends on how services are carried out and downloaded

Q. Has the decision to not align the project entirely with the health centre [Woolwich Community Health Centre], imposed any restrictions or limitations?
A. In the long run they feel that the project is better off – they don't want to build an empire. The concept of one place taking ownership didn't fit with the notion of empowering the community to take responsibility for the project themselves.

Q. Will the downloading of public health produce an adverse effect?
A. Hard to say at this point.

Q. Have they had any private sector funding/involvement?
A. Yes to some degree. You have to proceed carefully - there is a lot of discomfort to fund a group that might be involved in advocacy – don't want to lose the activists but you don't want to alarm potential allies.

CONCURRENT SESSION

MENTAL HEALTH – BONNIE PAPE & GLENN THOMPSON

Highlights of Bonnie Pape's and Glenn Thompson's discussion of mental health promotion in a reformed health system are as follows:

Bonnie Pape:

- Mental health promotion is distinct from "regular" health promotion.

- The mandate of the Canadian Mental Health Promotion is to promote the mental health of all people, but even within the CMHA itself, the activity of mental health promotion can be perceived of as "soft".

- The key elements of mental health promotion are:
    - control
    - participation
    - resilience
    - equity/social justice
    - social cohesiveness

- Mental health promotion lends itself to a range of setting and issues, such as: transitions, crisis events, chronic situations and disability/disorder settings. Mental health promotion is carried out through actions and strategies such as: healthy public policy, reorientation of services, individual skills, supportive environments, and advocacy and community action. Positive mental health outcomes of mental health promotion include: resiliency, empowerment, self-efficacy and coping.

- The interconnectedness of mental health services in improving the mental health of all people was highlighted. A diagram entitled "The Community Resource Base" illustrated the interconnectedness of the individual with the four (4) cornerstones of Family and Friends, Mental Health Services, Generic Community Services and Consumer Groups and Organisations. These elements are embedded in the four (4) cardinal points of Housing, Work, Income and Education.

- A discussion ensued after the comment was made that the problem in mental health promotion is in deciding what it is you are trying to promote. The question was raised whether tax dollars ought to be spent in improving an individual's mental health from the 85th percentile to the 95th percentile. Another comment was made that since mental health is a part of what everybody is, perhaps as the health care system becomes more "integrated" the mental health care system should become integrated with it.

Glenn Thompson:

- Do we think differently about mental health now? Why change now? Things have changed. The media has helped a lot. People seem to have a serious interest in mental health issues which 20 years ago were kept almost a secret.

- The important issue is how to make mental health promotion make sense to policy makers. For example, the CMHA has been waiting 4.5 years for funding ($250,000) for a stigma-reducing project. We need to convince the Ministry of Health that they should be spending 20% of the mental health budget this year (and every year) on mental health promotion.

- Mental health promotion could be preventing some of the "logjam" that is occurring in the (partially) restructured system. If mental health promotion was fostered with children, young people and adults who are currently not suffering a mental illness needing treatment, perhaps those people could be kept out of the mental system altogether. If, for example, stress reduction could be put into effect in people's lives and workplaces through mental health promotion, perhaps many people would be able to avoid needing direct mental health services. The example of the Homewood Behavioural Health Corporation in Guelph, Ontario, which has opened a centre focused on improving the workplace environment was noted.

- We need to find out where the system is at in terms of health change and then to propose things that health promotion can do to help. The field of mental health promotion needs to do a lot of persuading. People in the mental health field do not have their numbers down very well, and they don't use the information they have available to them enough.

  The comment was made that on the contrary, the numbers have been available, in some cases, for decades to show that, for example, unemployment affects the mental health of the population, but that politicians have a vested interest in keeping things the same. You can't sell health promotion at the cabinet table.

  Another conference participant noted that mental health promoters could make better use of media advocacy. Mr. Thompson agreed that people working in mental health often do not do a good job at working in partnerships. He said that mental health promoters have to get the findings of the academic world out and communicate them to the public.

- Bonnie Pape made the comment that the best way to change attitudes is by proximity (this is backed up by a study done by the University of Manitoba). The CMHA is working to bring mentally ill people into the proximity of other members of the population.

CONCURRENT SESSION

BROKERING RELATIONSHIPS – ROB SIMPSON

Highlights of Rob Simpson's discussion of brokering relationships for health promotion in a reformed health system are as follows:

- Health promotion has changed over the recent past and will continue to change over the foreseeable future. Although not necessarily consistent with much of the conventional wisdom about how health promotion will and should evolve, the observations and suggestions in this presentation represent a genuine attempt to reflect the realities that will be faced by the health promotion field.

- Brokering relationships will be central to the effective participation in the health promotion field over the next decade. Clearly, much of the field is moving from a "cottage industry" profile built around well-meaning local initiatives to one that is sophisticated, technologically-supported, and outcome driven. To understand these dynamics and to adapt accordingly is key to retaining a role in health promotion.

- Brokering relationships begins long before you first sit down with another party to undertake a particular set of negotiations. And it continues long after the negotiations have been successfully concluded. It is about achieving a state of readiness – one that results from developing an intense understanding of the following five areas:

    - the dynamics of the health promotion field
    - where payer demand will be
    - the core competencies of your organisation
    - which problems you can solve
    - which partners you will need

Within this schema, three types of relationships will be central to your ability to maintain your relevance:

- between payers and providers
- among collaborating providers
- between providers and service recipients

Characteristics of a Reformed Health System

1. There will be new payers and new perspectives on reimbursement:
   - Systems are very much shaped by payers.
   - Government share of funding will drop from 70% to 50%.
   - Non-government funders will have a new perspective on reimbursement.
   - Government funding for health promotion will shift from a "funding of activity" model to "purchasing of outcomes".

2. Non-government and, to some extent, government payers will adopt Return-on Investment (ROI) models:
   - Primary focus on reduction/containment of existing costs (loss management).
   - Secondary focus on containing increases in existing costs (loss prevention).
   - Willingness to adopt integrated delivery models/solutions.

3. There will be aggressive competition for payer reimbursements:
   - Outcome measurement and cost-per-outcome analyses will be required.
   - Rigour of thought and conceptualisation will be critical to the ability to deliver.
   - Customer/service recipient satisfaction will be a priority.

4. Technology and overall efficiency will be differentiates:
   - Local initiatives and therefore local planning, will become increasingly less relevant.
   - Conventional wisdom (e.g. the virtues of group delivery) will be challenged.
   - R&D, start-up investment, and business cases will become facts of life.
   - Technology and content providers will form alliances.

Relationships between Payers and Providers

1. Health promotion initiatives must solve problems for payers:
   - define the cost of doing nothing
   - define the outcome of your initiative and its impact on costs
   - define the cost per outcome.

2. Health promotion initiatives must meet a range of new standards:
   - new heights of customer satisfaction (convenience, flexibility, service)
   - broad and equitable access
   - integration into parallel/related initiatives.

3. Health promotion initiatives must include:
   - impressive marketing/sales support
   - built-in program management/evaluation capabilities
   - rigorous QA mechanisms

Relationships among Providers

- Partnerships will be necessary in order to deliver outcomes, realise efficiencies, and meet standards.
- Each provider should define and develop its core competencies (differentiated uniqueness).
- Partners fill in capabilities beyond your core competencies.
- The right partner will bring capability and efficiency, neither of which you could achieve on your own.
- PPP's (public-private partnerships) are an emerging worldwide phenomenon.
- Partnerships are established by sharing business case analyses and matching strategic directions.

Relationships between Providers and Service Recipients

- Conduct target group/market segmentation analyses to better understand your service recipients.
- Design your intervention around your knowledge of the target group and its segments.
- Approach recruitment with integrity.
- Address issues of convenience, flexibility, and individualisation from the service recipient's perspective.
- Form a contract-like relationship between yourself and the service recipient through communication.
- Preserve the dignity of the service recipient – assume the larger responsibility for failures.

PANEL DISCUSSION: WHERE DO WE GO FROM HERE?

Panel:

Murray Mackenzie, CEO & President North York General Hospital
Lorne Zon, Executive Director, Toronto District Health Council
Peter Cole, M.D., Medical Officer of Health, Peel Region
Pegeen Walsh, Health Promotion and Programs Branch, Ontario Region, Health Canada

MURRAY MACKENZIE

Mr. Mackenzie addressed the question "Where do we go from here", meaning "How do we reorient the health system?" "How do we introducve»È /Pro1 1Ìal 12 Ä ¾ ¾

the next few years, as it may become possible to test for any one of hundreds of genetic diseases. The issues for health promotion around the area of genetics are very interesting. For instance, it is very expensive. And, do people always want this information?

North York General Hospital provides multidisciplinary primary care based on nine "Core Principles" which, among other things, reflects the need to bring physicians to the table in a meaningful way. Among the nine core principles are: (1) that primary care at NYGH is provided by 26 community care teams made up of nurse practitioners, social workers, family physicians and possibly paediatricians; (2) each Family and Community Care Team co-ordinates and integrates health services for patients; and (9) the governance of primary care must be focussed on the health status and needs of the community. Mr. MacKenzie outlined a continuum of care spectrum that ranges from Health Promotion to Primary Care to Hospital Acute Care, to Rehabilitation to Long Term Care to Home Care to Palliative Care.

The rising age of the population will cause health costs in general to increase in the next years. Health promotion is an integral part of the health care system with the potential to reduce long term health care costs. No health system can be effective without co-ordination of all facets. Health promotion is just on of the areas that is weak. An increased interest in health promotion is needed. Mr. MacKenzie finished by commenting, "let's invest in what we know how to do well and find new ways to do what we don't do well". We need to find better and more effective ways to improve the health of the population.

LORNE ZON

Mr. Zon began his presentation with the question "where do we go from here?". He commented that indeed, this is a very profound question. He suggested that his comments may sound a touch cynical but, that he preferred to call his approach 'lessons learned from the trenches'. He outlined two key interactions.

The first consideration was that he was not sure where the health system is going. Are we headed for integrated systems, co-ordinated services, a narrower treatment focus or a broader, more inclusive definition of health? He suggested that it has been said that "if you don't know where you are going than any road will get you there." The downside risk, he offered, is that you may not end up where you thought you were headed.

The second consideration he outlined was how to harness the health promotion field to champion their beliefs and positions as part of the changes taking place. He suggested that we look at these issues from four different vantagepoints:

1. Firstly, what is the likely future of the health care reforms taking place?
2. What are the key challenges in the next while for putting health promotion on the front burner of these reforms and more integrated into mainstream health services?

3. What do health promotion practitioners and advocates need to do to influence the change process?
4. And finally, what are the levers that need to be utilised?

Mr. Zon suggested that while changes in health care agencies – hospitals, CCACs, mental health – are occurring at a frenzied pace, the system as a whole is changing far more slowly and subtly. Relative expenditures on treatment versus promotion show a widening gap. The power structures in health remain relatively unchanged. The public's attitudes and understanding of our health system are not very different than they were a decade ago.

So, he asked, how do you influence changes in health's culture and beliefs in such an environment?

Mr. Zon related that over the last two years or so, there was a groundswell of interest in integrated health systems. This interest represented not just a change in health organisations but the organisation of health services themselves. IHS as a concept held out the potential to represent much of what health promotion has been saying for some time. It talks about a continuum of client focussed services including wellness and population health issues. It offered the ability to demonstrate that health promotion can reduce utilisation of health care services by keeping people healthy.

However, over the past six months the enthusiasm has waned. The momentum has gone. The lack of government policy support and direction is a contributing factor. Mr. Zon suggested that it is his belief that IHSs if they ever come into existence are at least 10 years down the road. So where are we going?, asked Mr. Zon. To where we are is the most likely scenario, he suggested. Mr. Zon then outlined the key ingredients in the 1999 health care recipe. You start with:

- One cup full of federal money
- Stir in a very full cup of waiting lists and ER back-ups
- Add a liberal helping of patients – cancer patients, pregnant mothers and babies – being sent to the United States for care
- Gently stir in a provincial election
- And add poll after poll of 'fix the problem'

The most likely result is a plate full of more hospital funding, more home care funding, more long-term care beds and some expansion of physician and nursing programs. Mr. Zon suggested that the emphasis is clearly aimed at more treatment and relatively little attention to health promotion services. Even more importantly, it may represent a time of more calm and a lessening of the pressures for system reform, he cautioned – a period of stability and status quo. That is what many providers want. It is most definitely what the public wants. And that is certainly what the government – any government – wants.

That is not to say that some very positive changes, coming from health promotion, have not occurred, Mr. Zon suggested. We have seen recent initiatives like healthy

babies/health children, pre-school speech and language programs and a widening understanding of primary care. Conceptual leadership by the Centre for Health Promotion and public health have also been important.

Mr. Zon noted that while we are here talking about health promotion, system reform and integrated systems, the people who need to become health promotion supporters are meeting in the Minister's, the Premier's and the senior civil servants boardrooms. They are making excellent and very powerful cases for an infusion of the newly allocated Federal money. They are pointing out why they must be given more resources or people will go without necessary treatment. They have captured the front page and lead story of every media in this province for many weeks.

The challenge in front of us today, Mr. Zon asserted, is to make an equally strong and meaningful case for health promotion. We need to convince the public and the politicians and boards of health care agencies that health promotion has just as much to contribute. Health promotion must be seen as mainstream and as necessary as treatment services.

It feels right sometimes to be the social conscience of the health system, but history tells us that if you lay claim to the periphery, then the periphery is what you'll get. But this isn't the only outcome possible. The periphery can and has become the centre.

Mr. Zon asked, "how many health journals and articles in the 60s and 70s talked about determinants of health?" But now this belief and understanding is mainstream. In the 1970s or 80s, "how many people thought that smoking would be banned to the extent it is today? The challenge is to make continuous strides in turning health promotion strategies and health promoting values mainstream. This will not be accomplished easily. The accomplishments so far have not directly challenged the power structures of health care. Health promotion has not led to major re-allocations of funds. It has not changed the decision-making processes in most health care agencies or governments.

Becoming mainstream means that you must challenge the status quo. You must challenge not with rhetoric but with facts, with public opinion, and with media support. A tall challenge indeed. Where to next? It is indeed a profound question. Health promotion supporters must learn from success. Success from elsewhere in the health system and from the health promotion field itself.

Mr. Zon related, that coming from the DHC system, he can honestly say we have not always been our own best advocates. We believe in the need for and the benefit of planning for health services. Many of us are taken aback when some people say planning is a waste of time or that we don't live in the real world. Too often our response has been, "yeah, that's what you say!" or something a little less polite. The outcome is you feel good for about five minutes and then realise that unless you can change that person's beliefs or attitude then you have lost a key opportunity.

Mr. Zon suggested that when he came to the TDHC in 1989, the agency was in trouble. Not financially, not because of the quality of the board or staff. Nor was it due to the quality of the work. It was in trouble because it had a bad image. To the local health providers, it was seen as an obstacle or at best a necessary but useless step on the way to the Ministry's chequebook. To other DHCs it was the big, bad stuck-up sibling. In reality, neither was true. The DHC did some very good niche planning and did not see itself as better than its colleagues. Turning the situation around meant changing people's mind set about us. It meant making ourselves meaningful to the community – public and professional – and making other DHCs see us as an asset.

He noted that through strategic leadership, actions and constant evaluation and re-evaluation of our actions, they have been successful in changing attitudes. It's slow, it's hard and it's effective. That is the challenge for health promotion. Get strategic. And make yourself an asset to those whose support you need to leverage change.

Health promotion has had many successes and has had significant impacts on our health philosophies. It has led the change in values from health care to health. From treatment to determinants of health. It has directly effected changes in lifestyles. For us at the District Health Council it has had a major influence on our approach to planning and is now reasonably integrated into everything we do. The base is there to build on.

Mr. Zon suggested that we need to look at the key levers available. "What can health promotion offer to dealing with socio-demographic changes?" "How can it lower demand through more effective primary care services?" "How can it assist keeping people in their homes and healthy?" These are the change levers of the next few years. To influence the change agenda you have to adopt the agenda.

CHCs have a great deal to teach us about primary care, community development and these directions can improve people's lives and therefore relieve the pressures on the health care system expected from a growing elderly population. Public health can look back at over a hundred years of experience that is relevant and reliable. The question is how to market the benefits and the strategies. How to move from the fringe to the boardrooms. How to become key partners in any policy, planning and change agendas.

Mr. Zon concluded his remarks with stating that health promotion has had a very real and measurable impact on our beliefs and understanding of health. It can help shape the future of health services in Ontario but only if the supporters and champions of health promotion can lead the way.

PETER COLE

Dr. Cole addressed the question: where do we go from here, versus the questions where is the system going? He also asked the question "where is here?"

Dr. Cole pointed to the lack of vision for health. He stated that there is no governmental focus, no comprehensive vision and therefore no present articulation of health goals from Federal or Provincial government to embrace illness care, health promotion and the infrastructure for service delivery

Regarding the issue of population health vs. health promotion, Dr. Cole stated that there was no conflict as long as population health includes a partnership with community in the health planning process. He felt that there must be evidence-based planning for disease prevention and health promotion which must include qualitative data derived from participatory/action research as valued evidence.

Dr. Cole equated the nature of true health reform with social justice and social change. He stated that there must be an interconnection between health reform and reform in other sectors e.g. income, education and training. Dr. Cole cited the cost effectiveness of health promotion strategies, pointing out that they are highly effective. He talked about the primacy of the role of community and the need for commitment to community responsibility for achievement of on-going change.

The importance of complementary therapies/health care modalities was addressed. Many time-honoured modalities are re-surfacing from Eastern and indigenous cultures, which are acquiring legitimacy through research. He noted that there is a new acceptance of holistic health practices. The increasing importance of spiritual health, especially non-religious spiritual health, was noted.

Finally Dr. Cole discussed the need for sharing responsibility for health promotion. He felt that there was a certain degree of chauvinism in the health care field, in that many other people/organisations do health promotion. He called attention to the need for the integration of human services, which must be balanced with the need for autonomy.

In answer to the question "where do we go?", Dr. Cole then outlined six directions for health:

1. A well articulated, shared vision for health
2. Rational restructuring of the health care system, including integration of human services, i.e. restructuring 'across and up and down'
3. Leadership and effective communication, including partnerships and strategic alliances at all levels
4. An optimal degree of local autonomy to determine and meet needs
5. Emphasis on disease prevention and health promotion
6. A strong volunteer component for service delivery

Dr. Cole then described some actions he felt could be taken for the future of health promotion. These included:

1. Local action – in response to the sense he has that governments will never get it right. Dr. Cole suggested creating a local vision for health with the broadest, most inclusive definition of health. He suggested creating a populist argument using the negative determinants of ***illness*** not health to discuss healthy public policy. In order to make a strong case for disease prevention and health promotion, Dr. Cole recommended adopting the "health hazard" approach to increase the marketing potential of health promotion initiatives. He suggested identifying the "top 10" health hazards in your community, establishing indicators of success and reporting annually (a "report card") on your progress as part of this accountability process. He also recommended the development of a strong volunteer component to the health care delivery system in your community – organised labour does not have a monopoly on service delivery. Finally, Dr. Cole suggested developing a framework for accountability that has at its core the best interests of the health of the community. Health promoters need to take responsibility for failures – to drop it or change it and to "never mind the lords and masters".

2. Advocacy – Dr. Cole felt that we must continue to advocate for a strong, shared vision and goals for health, especially to continue to advocate for expansion of the mandatory programs to include violence prevention, mental health promotion and prevention of alcohol and drug abuse. He also felt there needed to be advocacy around the issues of the inclusion of complementary therapies as a strong component of our health care system and for spiritual health as a natural and basic requirement for health care training and practice

3. Personal health – this should be a priority for providers/practitioners. Dr. Cole said you should consider yourself to be a role model in your health and ethical behaviours. He suggested "be a pilot project" and "be a model", and, he said, that is how to move in to the future. He encouraged participants to fulfil your job responsibilities by honouring your noblest principles and your faith in community at all times.

PEGEEN WALSH

Pegeen Walsh introduced herself as an insider in social policy and programming who can act as a catalyst for change through the Health Canada's Health Promotion and Programs Branch in Ontario. She said that she would like to return to several themes raised by others through the day and offer her "insiders" view about what could work at the Federal level.

1. **Language** – this is a real stumbling block at the Federal level – don't forget the importance of language. Cannot get ahead without using the right language. New words: "horizontality" – this suggests work groups across sectors; "partnership" –

can't get ahead unless you can partner with others, you need to show that you are addressing an issue "holistically" (although, the word "holistic" is not a politically strong word); "citizenship engagement" – this is critical – we need to engage the public – without their support you can be stopped.

2. **Political Strategies** – Ms Walsh presented an example of the Community Action Program for Children where there are many who have been vocal from both the top and the bottom about keeping funding in this area. Other examples are the Prenatal Nutrition Program and the National AIDS Strategy for Literacy. Very astute groups market all these programs. They have credible spokespeople, and know how to use the media. They also have evidence to show what happens without these type of interventions.

3. **Accountability** – measure, measure, measure. There is greater scrutiny of projects and initiatives than ever before due to the public's demand for accountability.

4. **Opportunities** – The Federal Minister for health sees health promotion as part of an integrated health system that could stitch together health promotion, disease prevention, treatment and care. There is an opportunity to bring forward a business case for IHS provincially.

Ms Walsh finished her comments by talking about making the "business case". She commented that the health promotion field contained lots of "doers" who often don't take the time to make a compelling business case for health promotion strategies and to draw qualitative and quantitative information together. She suggested that health promoters go where the action is – that there are opportunities out there, and she urged everyone to seize the available opportunities.

CLOSING REMARKS – IRV ROOTMAN AND LORI WILSON

In closing, Irv Rootman commented that after planning for a year, it was heartening to see so many people interested in the focus of the conference. He suggested that if people wanted to become involved in further activities, to contact the Centre for Health Promotion. Lori Wilson thanked all the presenters for the day. She noted that it's important that the work begun to today is just the beginning, and that we can build on this day.

List of Conference Participants

Note: This list of conference participants is provided for networking purposes. The list is not complete. We apologise for any omissions or errors.

Ms. Nina Acco Weston, Centre for Addiction & Mental Health
Ms. Joan Andrews, The Willett Hospital
Ms. Peggy Bayley, Toronto Public Health Department
Ms. Josee Bourdages
Ms. Jane Brown, Simcoe York Region District Health Council
Mr. Don Buchanan, Hamilton Health Sciences, Corporation
Ms. Rishia Burke, Association of Ontario Health Centres
Ms. Freda Burkholder, Health Canada
Ms. Evelyn Butler, Durham Region Health Department
Ms. Lisa Caton, Ontario Healthy Communities Coalition
Ms. Maureen Cava, Toronto Public Health
Dr. Catherine Chalin, Department of Public Health Sciences, University of Toronto
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Ms. Diane McBride, ParaMed Health Services
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