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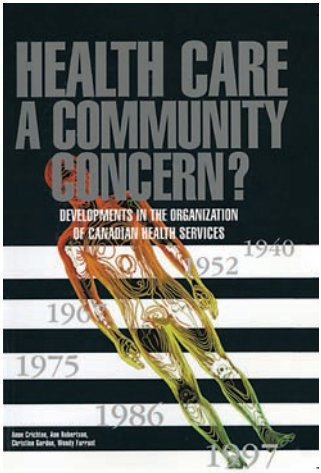

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 12

Evolution of Public Health Departments

With the reduction in the significance of infectious diseases in Canada over the last twenty-five years, public health, like other sectors of the health care system, has been seeking to carve out new territory and a new role for itself within the overall context of the provision of community-based services. Several histories of the development of public health services in various jurisdictions in Canada exist (e.g., Lewis 1984). While a full exposition is beyond the scope of this chapter, a number of points are relevant to the present discussion.

In a very general way public health could be said to comprise those activities which are undertaken with collective responsibility for the protection of the health of the public, primarily through primary prevention measures.[1] Public health activities generally are directed toward particular population groups who are basically "well" but who could be considered to be "at risk" for health problems (well-baby programs and school immuni-

1 Primary prevention refers to those activities which are believed to prevent the onset of disease, for example, immunization, prenatal education, well-baby clinics, etc. Secondary prevention refers to those activities which are believed to minimize the effects or slow the course of existing disease, for example, screening and monitoring programs, nutrition counselling for diabetes, etc. Tertiary prevention refers to those activities which are believed to promote recovery from a disease, for example, cardiac exercise programs, back pain programs, etc. Generally, primary prevention is the domain of public health; secondary and tertiary prevention services are sometimes provided by public health agencies, but may also be provided by other jurisdictions in the health care system, such as other primary care settings (doctors' offices and community health clinics), and outpatient clinics of hospitals.

zation campaigns), or are directed at the protection of the public at large, as with environmental controls for clean air and water and food inspection.

Structural Arrangements

Public health in Canada had its earliest established structures in local communities towards the end of the nineteenth century (Manga and Muckle 1987). Prior to this there had been sporadic activity by local communities during the cholera epidemics of the mid nineteenth century (Bilson 1984). Representing one of the earliest attempts to establish an organized locally-based system of public health, the Ontario Public Health Act of 1884 required all municipal councils to elect a local board of health. This local board's powers included the control of "nuisances" (e.g., a badly situated privy), the prevention or control of the spread of epidemic disease, and the regulation of the conduct of certain businesses such as tanneries. These later evolved into the twentieth century public health activities of sanitation control, communicable disease control, and environmental and occupational health control. Initially power rested entirely in these local boards of health (Powell 1981).

In her analysis of how local municipalities in Ontario gradually lost control over local public health activities, Powell (1981) concludes that issues of provincial control and professional dominance were directly related. District medical health officers, who were provincial government employees, were effective in establishing provincial administrative control over local municipalities because of their power to enforce professional norms on local medical officers of health. Thus provincial policy was largely set by public health professionals whose objective, which became the objective of the provincial government, was to ensure that local public health activities were "conducted to the norms and scientific standards of the public health profession" (p. 26). According to Powell all subsequent provincial policy has been directed towards securing that professional control through a series of administrative and financial (as opposed to legal or judicial) controls over local municipalities. For an excellent review of the shifting administrative and financial role of local governments on the provision of health and social services see Manga and Muckle (1987).

Lewis (1984), in a comparative look at the role of medical officers of health in Great Britain, Ontario and Quebec, observed that community physicians, in general, see themselves first and foremost as physicians with a firm allegiance to the medical profession and the medical model of health and disease. This orientation of such a major player in the field of public health services has undoubtedly had a significant impact, not only on the

nature of services delivered, but also on the way in which they are delivered, that is, on the organization of public health activities.

Public health services have emerged in the other Canadian provinces in a variety of ways (Manga and Muckle 1987). For example public health in British Columbia was initially organized not as a municipal but as a provincial concern because of the sparse population and the late development of municipalities (Ewan and Blatherwick 1980; Green 1984). However, for the greater part of the twentieth century, public health services in Canada have been delivered out of provincially or municipally administered health units with medical officers of health in the top administrative position, and with other public health professionals in subordinate positions.

There have been efforts on the part of some provincial or municipal governments to shift this organizational arrangement. Vancouver has gone through three different ways of structuring its public health service — under its different disciplines, under its different programs, and under geographic divisions into health units headed by administrators, not professional experts (Altman 1991). The Province of British Columbia also put the administration of health units under a non-medical director in the mid 1980s. Quebec, as part of the Quiet Revolution of the 1970s, brought all public health services under the jurisdiction of Départements de santé communautaire (DSCs), which themselves were put under the jurisdiction of designated hospitals; recently there has been a move to return some public health responsibilities to local community health centres, Centres locaux des services communautaires (CLSCs). In designated geographical areas, Ontario has established District Health Councils (DHCs) under non-medical directors. Although not part of the public health system, DHCs have a health planning and advisory role, and work primarily with the institutional sector and community agencies in order to rationalize resource allocation for health care services within a designated area. This is significant to the extent that changes in other health care sectors affect the role of public health.

Alberta, British Columbia and other provinces have recently moved towards regionalizing health care delivery. The impact of these structural changes on public health services is as yet undetermined.

The "New Public Health"

After the release of the Lalonde Report (Canada 1974b), public health began to focus more on "lifestyle" issues and risk assessment activities. Through the 1970s public health began to shift more and more of its resources towards identifiable "risk groups," that is, those population groups who were believed to be more "at risk" for compromised health, for example, women at risk for delivering low birth weight babies, adolescents at risk for drug and

alcohol abuse, elders at risk for contracting influenza, etc. This orientation in the delivery of service towards designated population groups was still consistent with the organization structures of the public health units and agencies which delivered services.

By the late 1970s and early 1980s, fundamental changes in the definitions of health and recommended directions of health care efforts (WHO and UN 1978) prompted many in the public health field in Canada to question the nature and role of public health within a rapidly changing health care field. Sparked largely by the World Health Organization (WHO) European office on Health Promotion (1984), a social model of health was replacing a clinical or medical model of health, at least in theory and in discussion papers emanating from all health jurisdictions in Canada.[2] The main feature of the social model of health is that many of the determinants of health lie outside of the health care sector and are produced by the social, political and economic context within which people live, for example, poverty, inadequate housing, unemployment, etc. (Toronto 1988a).

What this has meant for public health practice and the organizational arrangements for the delivery of public health services has been a subject of discussion and debate for most of the last decade. Generally it has meant a shift, at least in the discussion within public health circles, away from the provision of traditional professionally determined public health services based on a scientific/clinical model towards provision of services based on a community-based planning and implementation approach.

One of the first jurisdictions to recognize the need for structural change in order to accommodate the new definitions of health, and hence the "new public health," was the City of Toronto (Toronto 1978, 1983, 1984, 1985, 1988a,b). With the publication of *Public Health in the 1980s* (Toronto 1978), the Toronto Board of Health, in addition to recommending a greater advocacy role for the Department of Health in a number of "non-health areas" (income, housing, etc.), also recommended a departmental structure which would allow its services to be provided by "service delivery teams." The make-up of these teams would be determined in a number of decentralized health units which would serve specific geographical areas of the city, thus providing for maximum flexibility and innovation in responding to local needs.

Throughout the 1980s, several initiatives in Canada were instrumental in reshaping the dialogue over what constituted public health (Canadian Public Health Association 1985, 1987; World Health Organization 1984; Canada 1986d). Of particular significance to public health was a series of

2 The health promotion movement is discussed later in Chapter 20.

nationwide collaborative workshops and meetings around the theme "Strengthening Community Health," co-sponsored by Health and Welfare Canada and the Canadian Public Health Association (Canadian Public Health Association, 1987). As a result of these workshops, many public health units and agencies are participating in the healthy communities movement.

These initiatives are dealt with in more detail in the discussion of health promotion research (see Chapter 20). What is significant here is the extent to which these initiatives have had an effect on the organization and practice of public health. Reviews of the more recent annual reports of several public health jurisdictions reveal earnest attempts to incorporate some of the notions of the "new public health." The 1989 *Annual Statement* of the City of Toronto Department of Public Health (Toronto 1989) has documented ways in which community development initiatives have been incorporated into public health services. However, it is difficult to determine how the daily practice of the public health professional has been affected.

The Health Department of the Capital Regional District in British Columbia has created a community development position; however, when the activities of this person are examined they appear to be similar to traditional health education activities, indicating that there remain gaps between the theoretical discussion of the "new public health" and its implementation at the level of public health practice in this and other public health jurisdictions.

Barriers to Implementing the "New Public Health"

The barriers to implementing the "new public health" are primarily structural. At the macro level, public health departments/agencies are legally constrained to deliver statutory services, many of which are based on a clinical/scientific model of public health. In addition existing administrative and financial arrangements at the provincial and local level structure the organization of public health services and their delivery.

Extensive interviews (for this project) with public health professionals in various public health jurisdictions across Canada provide further evidence for a disjuncture between rhetoric and practice at the service delivery level. This dissonance appears to result from attempts to graft a new rhetoric onto old structures, structures which originated in early public health efforts to deal with infectious disease. This is revealed in structural concerns, which were generally expressed as:

1. What will the lines of authority be, that is, who will report to whom?
2. Related to no. 1, but not identical, who will be accountable?

3. What about quality standards: what will they be and how will they be measured?
4. What will public health practice "look like" on a day-to-day basis, that is, what will public health professionals do?

On this last issue, there have been recent attempts to re-examine the role of public health professionals, especially public health nurses (Besner 1988; Canadian Public Health Association Task Force 1990; Mid-Main Community Health Centre 1991). Several attempts have also been made to articulate, not only the educational preparation of the public health professional for a changed role (Smithie 1990), but also the educational role of the "teaching health unit" in preparing public health professionals for a role more oriented towards community-based prevention and health promotion approaches (Calgary 1990a).

However, preliminary examination of these proposals reveals that there remains a confusion between the notion of community-based (that is, community driven) and community-oriented (that is, professionally driven) approaches.[3] This is similar to the confusions between the concepts of community development and community participation. These confusions may exist in part because of the traditional organization of public health activities around mandated services and programs as indicated above. For example, while the 1989 Ontario Ministry of Health's *Mandatory Health Programs and Services Guidelines* (Ontario 1989e) attempts to incorporate the new dimensions of health that have been discussed above, it is clear that public health practice is constrained by the necessity for meeting statutory requirements as laid out in the Health Protection and Promotion Act of 1983.

There have been several pilot projects to explore whether different financing arrangements would enable health units to develop innovative approaches to providing public health services. One such project was the Global Funding Pilot Project in the Milburn-Vermillion Health Unit in Alberta (Hancock 1990). One of the four barriers which prevented the project from meeting its stated objectives was identified as the organization of the health unit along program and discipline lines, representing "a hierarchical structure allowing little flexibility." On this issue the evaluators concluded: "When an organization moves towards monitoring its progress by results, the organization must be able to assign responsibility for the results to one manager. The traditional hierarchical pyramid organization does not facilitate this process" (p. 3).

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3 See Appendix A for definitions.

Summary

Public health could be said to comprise those activities which are undertaken with collective responsibilities for the protection of the public primarily through primary prevention measures. These activities are directed towards particular population groups which are considered to be "at risk."

This chapter considers how public health departments have been restructured over the years. They became professionally controlled in the nineteenth century. The medical officers of health continue to have a firm allegiance to the medical profession and the medical model of health. Some efforts have recently been made to restructure under administrators but these efforts are still being tried out.

By the early 1980s there had been a shift in thinking away from the biomedical to the social model of health care. For the public health departments this meant the need for conceptual change from a clinical model of care to a community-based planning and implementation approach. This has resulted in much discussion about suitable structures for implementing the changes in orientation, but it is not yet clear whether changes are being made.