Implementation and Impact of Public Health Policies: A Comparison of BC and Ontario

Marjorie MacDonald

On behalf of the RePHS Team

University of Victoria
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<tr>
<td>Bernie Pauly – Co-PI</td>
<td>Ruta Valaitis – Co-PI</td>
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<td>Trevor Hancock Co-PI</td>
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<td>Diane Allan</td>
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<td>Karen Dickenson-Smith</td>
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<td>Warren O’Briain</td>
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Overview of RePHS

Renewal of Public Health Systems/Services

**Principal Investigators:** Marjorie MacDonald, Trevor Hancock, Bernie Pauly, and Ruta Valaitis

**BC Decision-maker Lead:** Warren O’Briain

**ON Decision-maker Lead:** Heather Manson

**Funder:** CIHR Emerging Team Grant

**Time Frame:** January 2009 – March 2015
Purpose

• To examine the implementation and impact of public health renewal policy interventions in BC and ON (Core Public Health Functions Framework & Guiding Framework in BC, and the public health standards in ON)

• Using two public health programs as exemplar cases - chronic disease prevention/healthy living and sexually transmitted infection prevention
Research Questions

• What factors/contexts influence or affect the implementation of these policy interventions?
• What have been the impacts/effects on staff, the organization, the populations served, other organizations, and communities?
• How is an equity lens applied in the core programs/standards?
• What are the implications of these policy interventions for PH human resources?
• How do public health and primary care collaborate and with what impact?
Data Collection & Analysis

- Qualitative semi-structured interviews and focus groups, two concept mapping studies with PH directors, managers and staff participants
- 4 Phases (2010-2014)
  - Phases 1 and 3: implementation, impact, evidence, partnerships
  - Phases 2 and 4: equity, public health human resources, public health/primary care collaboration
- Constant comparative coding, situational analysis
- Concept mapping – MDS, cluster analysis
Findings – High Level

• Structure and organization of public health has a strong influence on implementation and impact of public health policies and interventions

• Systems level factors (e.g., leadership, place of PH in the system, accountability) intimately intertwined with local level implementation so it is difficult to separate out the local level influences
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<td>• Phase 1 limited knowledge of many managers and FLS about CF</td>
<td>• Overall, more awareness of OPHS in ON, particularly managers vs FLS</td>
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<td>• Early implementation in HAs limited and variable</td>
<td>• History of mandatory guidelines made new OPHS more salient with better early implementation</td>
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<td>• Phase 3 – much more awareness of CF, particularly as foundational to Guiding Framework and informing current practice</td>
<td>• Phase 3, much more awareness and more concrete evidence of impl.</td>
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Implementation

BC
• General sense that “we already do that”
• Communication from MOH and within HA not seen as effective
• CF Coordinators seen as central to and very important to both communication about CF and implementation effectiveness

ON
• Also sense of “we already do that”
• Internal communications used to inform manager and staff with variable effectiveness
• More reliance on external networks and groups for communication about OPHS than on MOHLTC
Overall

• Better implementation in Ontario
  – Staff more likely to know about OPHS and associated protocols and guidelines
  – Communication mechanisms more effective in a “contained” organization (i.e., health units) than in the more diffuse and disconnected PH structures in BC
  – History of Mandatory Program Guidelines, although some felt OPHS did not provide as much specificity
  – More significant involvement of Managers and FLS in various stages of development and implementation
• OPHS was a stable policy intervention, with new elements added to the OPHS seen as enhancing and supporting OPHS in contrast (e.g., guidance documents, accountability agreements). This contrasts with BC.

• Positive support for OPHS overall
  – seen as providing important direction,
  – necessary for ensuring appropriate program decisions by Boards of Health,
  – useful for advocating for new programs or shifting emphasis to Boards and municipalities
  – Resulted in enhanced program planning and evaluation
Evidence

BC

- ERs very useful, mostly of high quality (although variable) but go out of date and need to be renewed
- Diverse views of what constitutes evidence and support for “multiple ways of knowing”
- Support for practice-based and experiential evidence (especially by FLS)

Ontario

- BC’s ERs viewed as excellent model and ON envious
- Diverse views but more emphasis on field knowledge
- Access to evidence an issue initially, but some HUs made efforts to develop their own evidence reviews at high cost
- Phase 3, Other sources of evidence have been identified and used extensively
Evidence

BC
• Issues with access to appropriate data for planning for some program areas
• Variable across HAs
• Between Phase 1 and 3, more availability of population-level data for planning in some HAs

Ontario
• Similar issues in Ontario
• Also variable across HUs with larger HUs more likely to be able to have the data available
• Similar findings, formation of Evidence Informed Practice Working Group
Resources

BC
• MCPPs not viewed as being as useful, do not provide sufficient guidance, and do not indicate priorities
• Guiding framework viewed very positively, but not providing sufficient guidance on priorities
• “You’ve told me what, now tell me how”

ON
• Guidance documents viewed very positively, seen as providing excellent support
• Additional guidance documents would be very helpful (harm reduction, implementation, priority populations)
**BC**

- Importance of specific roles for supporting implementation (e.g. CF coordinators - formal, program champions, local level practice leaders, informal)

**ON**

- Appears that there may be more likelihood that specific and more formal roles/positions were created to support OPHS (e.g., SDOH nurses, Chief Nursing Officers)
- Access and equity officers
Accountability

BC
- Phase 1 – limited accountability – few mechanisms and no consequences for not implementing
- Lack of accountability seen as lost opportunities for PH
- Limited buy-in at all levels
- Belief that HAs must be accountable for PH

ON
- Phase 1 – history of accountability agreements in ON, but participants did not perceive any consequences for not implementing OPHS
- less concern to participants because “they were already doing what was in the OPHS”
Accountability

**BC**
- Phase 3 – increased accountability with newer initiatives like NFP, Stop HIV/AIDS, KRA 1
  - Clear expectations for timelines, deliverables and report on outcomes
  - Funding attached and re-allocated
- Emphasis on accountability to MOH, not internal to HA

**ON**
- Accountability agreements viewed positively and seen as essential to ensure Boards meet targets
- Mixed views about whether accountabilities stronger now
- Strong sense that HUs should be accountable
RePHS BC
Accountability Issues

Standardization
- Not all programs are a good fit everywhere (particularly more rural areas)
- Loss of programming tailored to community needs in contrast to Ontario

Indicators
- Difficulty identifying outcomes
- Difficulty measuring outcomes
- Concern about what HAs can be accountable for
PH needs to be more accountable

Seen as broad, societal based, helpful for prioritization

Need to be evolving

Generally built into internal planning and evaluation activities

Some health units still in the process of building internal accountability mechanisms
Public Health and Primary Care Collaboration

BC
- Significant increase in collaboration in Phase 3 overall, but variable within and between HAs
- Divisions of Family Practice influential
- MHOs taking strong leadership role
- Resources to support collaboration needed

ON
- Collaboration is occurring in a few HUs, but much more progress being made in BC
- Also require tools to support collaboration (some suggest guidance documents but aware of other resources)
Collaboration in General

**BC**
- Some HAs demonstrating leadership in collaborating across the health system on public health programs (e.g. STOP HIV/AIDS)
- depends very much on organization of PH in the HA but increase since phase 1
- External collaboration much better in some programs than others

**ON**
- Much better collaboration within the HUs across PH program areas, but much less with larger health system
- Strong community collaborations across programs
- Closer collaborations with municipalities
Public Health
Human Resources

**BC**
- Loss of positions with budget constraints
- Shifting responsibilities with new initiatives (e.g. NFP)
- Staff identify need for competencies in applying an equity lens, using evidence and data, and evaluation
- Very low morale in some HAs with long recovery time

**ON**
- Budget constraints also in ON - less impact on staff
- Staff identify need for competencies in identifying and developing programming for priority populations
- Evaluation capacity seems to be stronger in ON (more reliance on NCCMT)
Public Health
Human Resources

BC

• Few new roles created at manager – front line to implement CF/Guiding Framework
• Some HAs identify new planning processes in which some staff were involved in some HAs (PDSA cycle)
• More resources needed, including prof-development

ON

• New roles created in most HUs to address new standards (e.g., SDOH, evaluators, epidemiologists to provide local data)
• Increased focus on planning viewed very positively by staff
• Also identified need for more resources
## Equity

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<td>Broad range of views among HA staff about meaning of health equity – not always same as MOH definitions</td>
<td>Defined primarily as equal access to PH services, particularly for priority populations</td>
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<td>More emphasis on notion of unfair health outcomes and access to determinants of health than in ON</td>
<td>Some emphasis on SDOH (increasing in Phase 3 with SDOH nurses)</td>
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<td>Need for shared understanding of term</td>
<td>Equity is being incorporated into planning frameworks</td>
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• BC appears to be somewhat ahead of ON in application of an equity lens, and in having a broader understanding of health equity, not solely linked to priority populations

• BC has identified significant increase among HAs on extent to which health equity is a priority, not just in public health but in health care system at large
Conclusions

• Population health outcomes cannot be achieved without effective policy implementation

• Ontario’s organization of public health and greater stability within the system promoted better policy implementation than BC’s health authority structure in which PH functions are dispersed and disconnected
Conclusions

• Successful implementation of major policy interventions requires significant system and local level supports as well as local level involvement in, development of, and acceptance of the policies.