POLICY IMPLICATIONS ON POPULATION HEALTH THEORY AND PRACTICE AMONG HEALTH WORKERS

By

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> "It is too easy to be caught up in the tyranny of the urgent. We try to address the demand for greater and greater medical services or acute care services and the problem is the true gains to improving population health lie in those population health strategies. There is the example of the baby floating by in the river and we need to work upstream, we need to find out where they are coming from and solve the source of the problem as opposed to getting better at dealing with the baby baskets."
> (Participant Response in Research Data collected for a Master of Science Degree)

POLICY RELEVANT QUESTION

How do health workers understand a population health component within the design and delivery of services? This was the over arching thesis question for a Master of Science Degree in Community Health and Epidemiology. This paper will examine the results of that research and describe how these results have helped to inform policy considerations with respect to population health.

INTRODUCTION

There are programs in health regions that have a population health component described as being an essential element of the work delivered in that program. The extent to which staff understands the meaning and the breadth of population health issues is not

practices, and attitudes is not especially well known. In order to address this gap, I decided to explore these issues further. I am particularly interested as:

- population health arose in Canadian health system policy discourse during the 1990s
- it embodies some of the same principles, if not the same language, as health promotion, which also exerted influence on health systems during the 1970s and 1980s
- health systems in Canada, notably regional health authorities, have reorganized to incorporate population health concepts, and are now being accredited, in part, on their ability to ensure its practice
- at the same time, both the concept and its practice remain somewhat contested.

I consider it important to examine how the concept of population health and its practice are understood by health systems, particularly in light of accreditation standards for population health. Further, I thought it was important to examine whether the accreditation standards are adequate, when comparing them to what the literature suggests are important criteria for population health.

PURPOSE OF THE STUDY

The purpose of this study was to explore the extent to which health region staff understands population health and to determine how the accreditation process of the Canadian Council on Health Services Accreditation (CCHSA) addresses population health perspectives.[1]. The goal was to ascertain the knowledge, practices, and attitudes of the staff with respect to population health and its accreditation process in order to see how a health region integrates a population health component into its services. Throughout this paper the term “health systems workers” will be used to describe people who are employed

CONCEPTUAL FRAMEWORK

A case study of the Saskatoon Health Region (SHR) was used to determine how a health region can integrate a population health component into the design and delivery of its services. The case study was comprised of a literature review, secondary data review from the 2001 Accreditation Survey Report, and primary data collection from people involved in the 2004 accreditation self-assessment which took place in the health region from March through June, 2004, facilitated by the Canadian Council on Health Services Accreditation (CCHSA).[1] Primary data was captured through the use of key informant interviews of twenty employees in the health region. The participants were selected from the accreditation teams most connected to a population health perspective. This selection of teams was by no means exclusive as many other teams in the health region consider themselves to have some population health perspective in their programs. Not all programs with an identified population health component were surveyed, but there was a deliberate attempt to capture those with the most population health relevance. Thus, there was a total of six teams, with three participants per team: a Team Sponsor, a Team Lead, and a Front Line Worker. Team Sponsors were people who worked in upper management levels in the health region. Team Leads were usually middle managers, and front line workers were workers who were involved in delivering the program that was being accredited. Seeking input from three levels in the Saskatoon Health Region triangulated the responses. In addition, key informants representing senior management, such as the medical health

In total there were twenty key informant interviews conducted. The process and rationale are described in the methodology section of this thesis.

LITERATURE REVIEW

I examined the literature around population health. The definition of what constitutes population health was explored, as was the history of population health. Various tensions that exist within population health theory and practice, both historically and currently were also identified and explained.

RESULTS

This section will examine the data that had been gathered in the semi structured interview process in order to answer the original question with respect to how a health region integrates a population health component into the design and delivery of services. The key research question of this study reads: How do health regions integrate a population health component in the design and delivery of services?

To accomplish this task the research sub questions were addressed. They are:

How do senior management, middle management and front line health staff with a population health mandate understand population health as a concept and as a practice?

How well has this concept and practice been put in place by the region as a whole?

How well has this concept and practice been put in place by teams with specific mandates for population health?

What evidence is there of change in integrating population health within the region and

To answer them I examined the data in the following way. I first looked at how each stratum of employee responded to the key informant interview, irrespective of which accreditation team they happened to serve on. Some upper management participants did not serve on an accreditation team; they were selected in order to capture the point of view of the visionaries and leaders of the health authority. By assigning various codes to the dialogue provided by the participants using the Atlas ti tool (as described in the methods section of this paper), I was able to ascertain the knowledge and view points of the participants.

I examined how upper management responded to the interview questions regarding population heath as a concept. I then wrote about how they viewed population health as a practice. Finally I looked at the strengths and challenges discovered through the semi structured interview process and highlight those concerns from an upper management perspective. I then did the same from a middle management perspective and followed with a front line worker's point of view with respect to these issues.

The next step in the process was to examine the results from an accreditation team specific point of view. I explored how each team viewed population health as a concept, as a practice and strengths and challenges that the teams identified. I examined how each accreditation team as a whole responded to the interviews irrespective of each member's position of employment within the health region, i.e. it did not matter whether they were upper management, middle management, or front line worker for this portion of the analysis. The differing strata responses were addressed in part one of the results. It is the

ability to implement population health initiatives, and any ideas they have with respect to forwarding a population health approach.

A SUMMARY OF RESULTS AND SOME DISCUSSION

In this section of the paper I will attempt to make some sense to the results that I had analyzed in the thesis to offer some recommendations as to what I see that would further a population health approach. I will briefly synthesize some of the points made from the research writing in order to encapsulate those responses that answer the sub questions. The section will conclude with a discussion on what the discoveries from the interviews might lead to by way of education or policy opportunities for health regions and for the CCHSA.

DISCUSSION OF ANALYSIS A

Concept, Practice, and Policy Implications

How do senior management, middle management, and front line health staff with a population health mandate understand population health as a concept and as a practice?

Concept:

Upper management presented a clear understanding of the concept of population health, middle management less so, and some front line staff said they don't know how to describe it, yet later in the interview described the idea of at least the non medical determinants aspect of population health quite well. However, as well informed as many of

upper management level, that were able to articulate the importance of population health to broad societal concerns and how population health initiatives would further a more robust community. However, there were many health workers who did not understand population health well and thus much room for increasing knowledge about a population health approach.

This leads to the question: Is there an opportunity here for the health region to provide some in-service with respect to population health training across disciplines? All of these people who were interviewed in this piece of research sat on an accreditation self-assessment team, yet some of them are struggling to come up with a definition or a way to express their understanding of population health. I see this as an opportunity for the health region to provide the in-service mentioned. I would like to see an in depth education component provided to all staff within a health region that would address a population health approach. I think everyone working in the health region would profit from in service workshops that not only outlined what population health is but how, if properly implemented, it would have a positive impact on all programs that are delivered within the health region.

The case study explored in this paper examined the views of population health across teams and people that have a specific population health component identified as a part of their program design and delivery. This selection of teams was by no means exhaustive as many other teams in the health region consider themselves to have some population health perspective in their programs. Not all programs with an identified population health

even acute care and critical care programs would profit to some extent by an in-service education around how upstream interventions throughout the community would have an impact on the number and severity of patients/clients that those programs would need to attend to. Further, the more people who understand a population health approach the greater the spread of that understanding throughout the community. A broad based understanding would ultimately lead to a society that would welcome more broad based non medical determinant interventions and initiatives within the community. This would lead to a healthier society and a more robust community.

As mentioned above, upper management and middle management described the streams of population health such as population health surveillance and the non-medical determinants of health. There were some comments that spoke to the non-medical determinants of health in a way that privileged medical health services and were not really about the broader aspects of health. These types of comments revealed the tension between medical care and the importance that it receives and the non-medical determinants of health, a tension noted throughout the literature review.[2]

There was another comment that was quoted in the results that spoke to the non-medical determinants of health in terms of keeping the population strong and healthy so that they would not need treatment in a hospital setting. This is what the CIAR spoke to in their view of population health and which other writers critiqued as being too medically and capitalistically based and not sufficiently focused on society.[3] [4] Many participants drew attention to this ‘side’ of population health. While their arguments make sense

that can provide for a more inclusive society; a society where the community comes first and individual needs, while addressed, are not the most important consideration. Butler Jones (1999) offers:

> The pursuit of health should, therefore, include an increasing understanding of other contributors to a broadly defined 'good health', of aspects over which the individual and the community have influence in a constructive way. These include among others, 1) the development of supportive communities, what some have termed "civic society", 2) involvement in arts and music with creative and health enhancing benefits to both participant and observer, 3) an active lifestyle, both physically and mentally, to whatever extent individuals are capable, 4) voluntarism and the giving of oneself to others, in the process receiving the intangible benefits that contribute to well-being, 5) friends and family, who provide support and counsel in both good and bad times, and 6) spirituality and faith, which represent having a belief in something greater than oneself and a supportive faith community, both of which may encourage health. (p.S63) [6]

Other writers also describe this as an important element of population health. Hayes and Dunn (1999) write:

> A population health framework situates the importance of social relations centre stage. Social structure is recognized as a crucial factor in shaping health and well being, which moves the focus of discussion away from obsession with individual biology and/or personal choice. (p. S9) [7]

They go on to describe how many factors such as housing, global capitalism, gender, power and other considerations are considered important and have been assigned as numerical variables but not enough attention is devoted to understand how or why they are important, and are often ignored completely from the research arena.[7]

This is important to policy since all of those variables have an impact on health and societal outcomes. It is important to write and implement policy that will address and serve

> Of course population health prompts many more policy challenges as well. Among them is that a relative lack of public currency and understanding of a population health perspective provides precious little political motivation or public appetite for developing an integrated policy framework dedicated to promoting just and equitable social relations. (Hayes and Dunn 1999 p.S9) [7]

In closing the discussion around how people viewed population health as a concept I want to focus on the following: Knowledge of population health as a concept varied from participant to participant and across the strata of employee. While upper and middle management understood it best, there is still the need for an in-service education session that would not only describe the non-medical determinants of health to the employees but would also stress the fact that policy pertaining to these determinants greatly influences why these determinants are important. It is not enough to simply know that poverty, education, and other social determinants have an impact on health outcomes, it is also vital to understand how policy impacts on those determinants. Through a broad education component delivered in the health region as well as provincially and nationally, all health workers, their friends, and their families will have a better understanding of what it will take to achieve a better community and therefore better health and social outcomes. It is up to all of us to speak about this whenever and wherever we can.[8, 9] Informing staff of the importance of these considerations will help to further the word about population health.

Another point that needs to be mentioned is upper management stratum's responsibility to work with funding authorities and the governments to ensure that policy with respect to working toward a more egalitarian society is written and delivered. It is important that they

Practice:

As a practice both upper management and middle management understood the population health components of the programs that they delivered. They were quite cognizant of efforts that had been made in the community to strengthen relationships but saw the need to do even more. Many spoke to the need for an increase in the number of relationships with all levels of government and with community based organizations. They recognized the importance of partnerships to deliver the programs more effectively and to use the partnerships to spread the word about population health. This is an important consideration when discussing ways to further population health. From the results associated with practice I learned that this is another area where all strata have an important role to play in influencing the way in which policy is written. But if upper management and middle management have a better understanding of a population health approach and how that knowledge needs to help inform policy, it is also important to note that the front line worker stratum has a lot of information about practice in the programs that needs to be captured to help influence policy development. They see the impact that the current policies have on the programs they are delivering.

Members of the front line staff have a wealth of input to offer. They bring a great deal of valuable information to the policy setting arena due to their hands-on involvement in programs with a population health component. To ignore the contribution that this stratum of employees offers would be foolish; they are invaluable in providing direction to programs and in determining whether the interventions are having the desired effect. They

population health interventions to the people who most need it. The in service education sessions would not be simply a one way flow of knowledge, but rather, would utilize the experience, understanding, and information that front-line workers and indeed all strata of worker would have to offer. This flow of information from bottom to top could be useful in providing policy writers with hands on information and could influence the direction that policy would take. Also, it is important that all strata of employee are cognizant of a population health approach so they are able to better articulate its importance in their work place and in their community as advocates and community organizers. A comprehensive in-service education session regarding population health would go a long way to strengthening this stratum of employee in their knowledge about the importance of population health, the importance their work brings to a population health approach, and the benefit we can all derive from involving them and their valuable experience in the decision making process. The in service education sessions would not be simply a one way flow of knowledge, but rather, would utilize the experience, understanding, and information that front-line workers and indeed all strata of worker would have to offer. This flow of information from bottom to top could be useful in providing policy writers with hands on information and could influence the direction that policy would take. Also, it is important that all strata of employee are cognizant of a population health approach so they are able to better articulate its importance in their work place and in their community as advocates and community organizers.

I have discussed the need for a more comprehensive view of society when writing

discussed the need to include a variety of workers to inform the direction of the policy development.

Discussion of Analysis B

Teams' Responses to Accreditation Questions about Population Health

How well has this concept been put in place by teams with specific mandates for population health?

Much of this question has been answered in the previous chapter. However, I think it is important to note that of the criteria with a population health mandate, as described in the four core teams (especially in the Leadership and Partnerships Standards), there was a very strong indication from all teams around the importance of interdisciplinary and cross sectoral teams. Another area that was identified as important was that of Information Management; people felt their programs could be delivered more effectively with a better vehicle to disseminate data and share knowledge and information. Human Resources staffing to address the needs of the community was rarely mentioned, opting instead to focus on Occupation Health and Safety Issues of the facility in which they worked. The Environment Standard most often referred the facility in which the workers were working, not the community in which they were delivering services. The standards for the four core team areas all received some comments as mentioned. All of the core standards do provide for an avenue to make some comment with respect to the community and the need to share information, provide sufficient resources to deliver programs, and identify the environment

discussing these criteria but it was mainly because they had some knowledge of a population health approach and found a way to fit the conversation into the criteria. The CCHSA, health workers, governing authorities and other partners would all benefit from CCHSA writing a more population health focused set of standards. With a more comprehensive component of population health written into the core standards, more agencies would be able to grasp an understanding of population health because more health workers would be able to describe it more completely and recognize the effect of cross sectoral work.

With respect to the direct question (Question 11) regarding the CCHSA and whether the standards adequately address a population health perspective the results were mixed. Some participants thought that the standards were acceptable, while others felt that there was an opportunity for improvement in how the standards addressed population health. There was at least one member of each team who felt that the standards did not address population health well. The need to identify more community concerns was articulated across the teams.

As I identified above, most participants spoke at length to the need for networking, partnering, interdisciplinary and cross sectoral work. Since this is what most of the discussion focused upon and since this networking represents the best single way to advance a population health initiative[8], I will now discuss the results presented in Analysis B to identify the concerns that have policy implications and ways in which improving partnering and networking will impact that policy discussion.

interdisciplinary teams was mentioned. This was identified in the 2001 Accreditation of Saskatoon District Health. However, in that accreditation the opportunities for improvement suggest that these relationships needed to become broader, stronger, and that there be more of them.[10] This is consistent with what was identified across the teams I interviewed, irrespective of program. This came through as one of the most important considerations. All teams recognized the value of the partnerships. This has policy implications that health regions and the CCHSA need to consider. By identifying that cross sectoral partnerships involve more people in the community than just the health region, it lays the ground for population health programs to be delivered. I see this as the impetus for CCHSA to write a more population health focused self-assessment tool.

Hayes (1999) offers:

> The population health framework makes it clear that health is most robustly a shared responsibility. Issues of social justice and equity never go away, but they may be responded to in prudent, less violent, more humane ways. Sharing the responsibility for bringing this about involves advocating for the broader kinds of change in social welfare policy that will most improve health and well-being. It involves having the courage to speak out to share the information assembled within the population health framework. It involves having the wisdom to understand and respect our connections with distant others. And it involves having the strength to act upon the information in a way that is consistent with the ultimate objectives: improved health and well-being and reduced health inequalities. (p.S17) [8]

Other writers describe the importance of partnering. They suggest that a multi pronged approach to address the needs of the community. Butler Jones describes ways to collaborate:

> To address the determinants effectively, we require a broad intersectoral

> significant policy or program changes, working together complements strengths and maximizes effectiveness. (p.S64) [6]

The points described above are consistent with what many writers describe as an important consideration when considering policy regarding population health.[5, 7, 12,] However, difficulty in implementing such partnerships may be encountered until clear expectations and definitions of responsibilities are understood. Frankish et al.(1999) explains:

> The involvement of non-health sectors in population health decision making suggests both a shift in the role of traditional government stakeholders and health professionals, and an emergence of new partnerships. With a shift to greater intersectoral participation, the role(s) of health professionals in population health may become unclear. Tensions emerge as health professionals feel threatened by an uncertain future and a reduction in their influence, analogous to the changing role of academic researchers involved in participatory research within communities for example.(p.S74) [12]

In the same paper they write that there will be challenges with respect to understanding the information if there is to be involvement by program planners and policy makers charged with addressing the broad determinants of health. They also mention how it will be important to ensure that resources are equitably distributed across the various levels of government (provincial/state, regional, municipal).

While there will likely be some “growing pains” in the formation of such partnerships as is suggested, I think it will be well worth the effort. Population health professionals will still be required to provide input to the policy arena. Their input is valuable because they as much as any group who have studied the impact of the social determinants of health and

They would also be made aware that governments are very much a partner in policy development that affects how these partnerships will work.

The Leadership and Partnerships set of standards elicited the most response, almost all of it from all strata and all teams speaking to he need for increased networking across the communities at multiple levels, from community based organizations to governments. The other core team areas of Human Resources, Information Management, and Environment did not yield as much discussion regarding the community. To me that is an important point. In order for more discussion to take place in these other core team area, there needs to be a more complete picture of community needs built into each of these standards. Some of the participants were able to identify some of the issues associated with these standards as they related to the community because of the work in their program. A criterion that addresses sufficient personnel to do work in the community would be of benefit in the standards for Human Resources. A criterion that addresses having data that represents the situation in the community, so those needs could be addressed, would benefit the standards for Information Management. Only criterion 6 of the Environment Standards actually addresses the community per se. Because there is so much more attention given the facilities throughout this set of standards, comments on the community itself were often scarce by interview participants. A more specifically community focused set of criteria would be beneficial in addressing community needs in the standards for Environment. Some of the participants were able to identify some of the issues associated with these standards as they related to the community because of the work in their program. However,

CONCLUSION

Through this research I wanted to learn what understanding of population health exists in a health region and how that level of understanding has an impact on the way programs are informed and delivered. I also wanted to know if the CCHSA “Achieving Improved Measurement (AIM)” self assessment tool had a population health component that was meaningful to people who were involved in the accreditation of a health region. Further, I wanted to analyze the findings to see what policy implications arose from what I discovered. To accomplish these tasks I conducted a case study of the Saskatoon Health Region and interviewed health workers in the region who served on accreditation teams. I did notice some differences among the teams which could be related to discipline and seems to be related to their primary orientation. If population health is to be part of the core function of a health system then understanding better what those differences are and whether they in fact are tied to disciplines or specific functions and not simply tied to individual differences is something that merits some more consideration or work as an area of further inquiry.

I learned that although there is a fairly good understanding at the upper management and middle management levels about what a population health approach is, there is room for improvement at the front-line stratum. As good as the understanding with respect to non-medical determinants of health was at in the upper strata, there was also room for improvement here. Very few participants spoke to how the social determinants of health need to be addressed. As mentioned they were able to articulate the importance of them

in the literature review regarding the differences not only in practice, but also as it pertains to the understanding of community involvement and the structural social inequalities being the two least understood pieces around population health. There is room for growth in the understanding about what effect a policy will have on a society and how that translates into improved or worsened health outcomes.

I was encouraged by the ample discussion by almost all participants with respect to the need for increased partnering and networking across various organizations in the community. However, their inability or reluctance to speak to the other core standards revealed that CCHSA has an opportunity to improve the way in which the core standards are written. In their next iteration of the "Achieving Improved Measurement (AIM)" a more community and policy focused set of standards ought to be developed.

With respect to policy implications the opportunity here is at once exciting and somewhat daunting. To conclude what I opened in the discussion portion of this chapter, there is some concern with respect to partnering. There is a real concern over what will be possible and whether it can be achieved because of all of the competing interests. Hayes explains:

> Implementing population health approaches to public policy presents innumerable challenges to both politicians and public servants. By definition, the "big picture" is complex and whatever is held up as "the framework" is contestable. The timeframe of a life course perspective greatly exceeds the temporal horizon of political mandates, and it is extremely difficult to muster support for policy options that make sense from a longer term perspective but are at present unpopular or threatening to specific interest groups or advocate on behalf of marginalized groups that are not politically/economically powerful. (p. S15) [8]

> their accountability for health. Given health's dominance in government budgets and a relative lack of collaborative action with other sectors, such imperial assertions are sometimes greeted with resentment and scepticism. For example, those in a non-health sector who have been trying to address social determinants for decades, while hospital ate up the budget, might say, "where have you been?" (p.S63) [6]

Yet, even though the above concerns are important, it remains equally and maybe more important to continue to strive to work in partnerships as described by other writers and brought to light by the participants in this research. There is a need to step out of the silos and move toward a new way of writing policy and delivering programs. It must include a wide variety of participants. Ruger (2004) offers:

> A capability approach to the social determinants of health thus recognizes the importance of addressing health needs on multiple fronts, in multiple domains of policy that affect all determinants of health (not just socioeconomic inequalities). It emphasizes the integration of public policies into a comprehensive set of health improvement strategies delivered through a plurality of institutions. (p.1092) [13]

This is important as outlined earlier. Through research focused in this direction, hope exists that agencies will work together to achieve more equitable social and health outcomes. Frankish et al provide:

> Population health research is concerned with whole communities or populations, not just individuals or groups, generally more distal rather than proximal determinants of health; greater intersectoral action beyond only the health sector; and with making populations more self-sufficient and less dependent on health services and professionals. The population health perspective is concerned with explaining differences in health and has the intent of doing so at the population rather than individual level. It describes the analysis of major social, behavioural and biological influences upon overall levels of health status within and between identifiable population groups and subgroups, attempting to identify aspects of the social and cultural milieu that affect differences in health status. (p.S71) [12]

is considered ‘sacrosanct’. Anyone who disagrees with this assessment is often challenged. Yet, other capitalist economies that exist in the world have far better health and societal outcomes than we experience in North America. Coburn and Denny (2003) write:

> We need research that will help us understand why some capitalist countries with strong social democratic political parties and resilient welfare states, such as Sweden and Norway, have much lower health inequalities and better average population health than Canada or the United States. (p.394) [14]

Perhaps with sufficient input from a variety of research efforts changes to the current model can be realized and hope for a more egalitarian society can be achieved.

I have written a great amount in the above pages about the importance of understanding population health as more than a tool for measurement and that it is more than just recognizing the non- medical determinants of health. I have also written that it is important to understand why those social determinants have an effect on health outcomes. It is important to inform the policy writing process that these determinants need to be addressed through a variety of methods through many organizations. Therefore I conclude that education about measurement, the non-medical determinants, and policy affecting those determinants be offered to health region employees.

As much as I think that a broad based education in-service is required to inform staff about the different aspect about population health, I also think that since there is no common consensus as to its definition or the way in which policy needs to be written. Yet, I remain hopeful that if sufficient knowledge about all aspects of population health is afforded staff, including considerations for the policy realm, there can be an improvement

The need to have the accreditation instrument be more reflective of a population health perspective was identified in the CCHSA section of this work. Broad partnerships were considered very important and the challenges and promises of writing policy with respect to partnering were identified.

I am optimistic that population health initiatives can yield better health outcomes that will be realized by our communities. Through the combination of research, partnerships, and broad based stakeholder input, policy can be written that will have the desired effect. In spite of the challenges presented with respect to partnerships and networking, I still think it offers our greatest chance for success. Programs do not operate in isolation from each other. The participants in this research spoke to the need for more partnering across many sectors. Perhaps Rudolf Virchow was correct all those years ago when he stated, “medicine is a social science, and politics is nothing more than medicine in larger scale” (quoted in Waitzkin 1983:74).[15] If we accept that this assertion is at least partly correct and that there are policy implications across all or nearly all policy realms then it is important to include a vast variety of stakeholders in the policy decision making process. It is through the combined efforts of many spheres that I believe we have the best chance of improving the knowledge, practice and attitudes of health workers and all people with respect to population health.

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