HEALTH PROMOTION IN SASKATCHEWAN: INITIATIVES, SUPPORTS, AND BARRIERS

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ABSTRACT

Over the years, health promotion has evolved from an approach focused on medical and behavioural factors to one that addresses broader determinants of health. Research to date has largely focused on medical and behavioural prevention activities of singular health disciplines.

A descriptive, cross-sectional study design was used to explore perceived current and desired health promotion initiatives, supports, and barriers of Saskatchewan general practitioners/family physicians, nurses, pharmacists, and dietitians. The study was based on Labonte's framework for health promotion (medical, behavioural, and socio-environmental practice paradigms). An 80 item researcher-developed questionnaire was mailed to 400 randomly sampled health practitioners (100/professional group under study). Parametric (one-way ANOVAs, Pearson's product moment), non-parametric (chi-square), and multivariate (factorial validity) statistics were conducted.

Response rates of nurses (53%), pharmacists (63%) and dietitians (69%) were impressive; the physician response rate was smaller than hoped (41%) limiting generalizations of physician's results. Reliability and correlation measures determined the 6-point Prevention Activities Scale (PAS) and subscales were highly reliable (r -values ranged from 0.72 to 0.81), linearly related (correlation values statistically significant at $p \leq 0.05$), and highly associated (i.e., respondents did not distinguish between current and

desired prevention activities). Factor analysis did not fully support the use of Labonte's three practice paradigms, yet produced a new PAS scale consisting of three discrete, highly reliable constructs (individual prevention, education, and advocacy initiatives). The reliability assessment of the factor analytically-based PAS suggested the subscales were more reliable than the original (r-values ranged from 0.77 to 092).

The respondents' were largely middle-aged females (between 30 to 50 years of age) working in large urban settings with 0 to 10 years work experience. One-way ANOVAs determined most professions worked primarily within the medical and behavioural paradigms, with infrequent involvement in the socio-environmental paradigm. Approximately 50% of the respondents' most prominent barriers were limitations in time, remuneration, and funds. The respondents' personal belief in health promotion, perceived job responsibilities, multidisciplinary work environments, and the endorsement of colleagues, managers, health authorities, and professional association(s) were considered health promotion enabling factors.

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DEDICATION

I dedicate my thesis to two extremely important people:

Mom...

&

Rod...

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CHAPTER 1

INTRODUCTION

1.1 General Background

Health promotion is generally understood as those activities directed at helping individuals maintain or enhance their health before it is compromised.[1-3] However, over the past several decades, the meaning of health has broadened and so has our understanding of the determinants of health. The key concept of this expanded vision of health is health promotion.[4]

Health promotion initially focused on healthy lifestyles as research revealed links between health status and personal risk behaviours. [3] Early interventions included health education programs and media campaigns designed to influence individual health knowledge, attitudes, and behaviours. Legislative action further reinforced healthy behaviour change (e.g., tobacco legislation, drinking under the influence laws, etc.).[5] By the mid-1980's, there was a growing concern about the limitations of an approach focused primarily on lifestyle.[3] Accordingly, the concept of health promotion and the activities or strategies it employed expanded to include a comprehensive mix of interventions designed to promote change at the individual, community, and policy level. Key interventions included health communication, social marketing, health education, social support, community action for health, creating supportive environments, and developing healthy public policies. [1,3,6]

Within the last 25 years, health promotion has evolved from an approach focused on behavioural factors to one that addresses broader determinants of health.[3,7] Labonte describes this evolution in terms of three approaches: the ***medical approach*** which defines health as the absence of disease with actions based on treating symptoms, eliminating illness, and/or preventing a disease condition from worsening; the ***behavioural approach*** which defines health as a lifestyle choice with actions directed at education, social marketing, and public policy strategies to reduce and/or prevent the development of illness; and the ***socio-environmental approach*** which defines health as an interplay of physical, mental, and social well-being with political measures directing community-based actions.[7-9] Health promotion then forms a new health practice, where medical and behavioural health determinants join broader socio-environmental health determinants defined in social, environmental, and political terms. All three paradigms are considered to complement one another in promoting health, especially in the primary care environment.

The Canadian health care system has played a less central role in health promotion for its primary purpose was to restore health once it has been threatened (i.e., the biomedical model).[10] Continued focus on a biomedical model does not address the primary reason(s) individuals become ill in the first place. Health promotion involves a mix of "upstream" and "downstream" interventions (i.e., "downstream" interventions provided within the context of the health care system to "upstream" interventions such as health protection, disease prevention, and health promotion).[9-11] Few literature sources have discussed the actions taken by health practitioners to integrate health promotion to their work contexts.

Health care practitioners are known to play a less central role in the socio-environmental approach to health, yet they still make important contributions to health

promotion, especially in the area of disease and injury prevention.[7,10] The new health promotion (i.e., socio-environmental approaches to health) encourages health practitioners to become team players in broader health initiatives (i.e., community development, advocacy, education, and politics) with other agencies, government sectors, and most importantly, local community organizations. The extent of these contributions is likely dependent on many factors, including practitioner beliefs and knowledge related to health promotion, and the supportiveness of their organization or employer. Efforts to enhance practitioners' health promotion initiatives must be founded on a solid understanding of their work context. The proposed study aims to increase our understanding of the progress being made by health practitioners towards more broadly conceived health promotion roles.

1.2 Statement of the Problem

We know little about the extent to which health professionals in various disciplines currently engage in health promotion activities and how they integrate health promotion to their practice, if at all. Moreover, we lack information on the factors they perceive to support or inhibit their practice of health promotion. Finally, little is known about how different health disciplines compare on these factors.

1.3 Purpose of the Study

The purpose of this study was to determine the extent to which a selected group of Saskatchewan health practitioners (i.e., general practitioners/family physicians, nurses, pharmacists, and dietitians) use health promotion strategies in their work contexts. This study also examines the factors that ***enable*** or ***impede*** Saskatchewan health practitioners (i.e., general practitioners/family physicians, nurses, pharmacists and dietitians) from engaging in health promotion.

1.4 Conceptual Framework

This study is based on Labonte's framework for health promotion. During numerous consultations with various health disciplines, Labonte discovered they classified health problems into three broad categories: medical, behavioural, and socio-environmental.[8] Categorization of health problems was primarily based on their professional training and their day-to-day work experiences. For example, medical and hospital-based practitioners defined health problems as diseases; public health practitioners defined it in terms of personal behaviours; and community workers defined it in terms of healthy living conditions (e.g., poverty, unemployment, etc.).[9-10,12-14] Labonte realized that within each of these named problems existed a set of assumptions. [9-8,12-14]

The ***medical approach*** is primarily concerned with treating symptoms, eliminating illness, and/or preventing a disease condition from worsening. Health professionals determine the intervention(s). Individual health care (i.e., the biomedical model) has had a dominant position in Canada[15], consequently creating great expenditures and promoting consumerism by those who are labelled as high-risk individuals (i.e., people whose genetic, behavioural, or personal history places them at greater risk of developing a life-threatening disease). [14] The popular domination and costly nature of the biomedical model spearheaded discussion about health restructuring in Canada.[15]

The ***behavioural approach*** moves beyond disease. It is primarily concerned with promoting healthy behaviours in well people. Health practitioners plan programs with actions directed at health education, social marketing, and advocacy for legislation that supports healthy lifestyles early in the life cycle.[12-14] The behavioural approach has its limitations, for it is perceived as "victim-blaming" (i.e., it continues to address "disease" rather than "the condition(s) that causes the disease").[1] Labonte suggests the shortcomings

of the behavioural approach led many public health practitioners to re-examine their practice styles, leading to the socio-environmental approach to health.[8]

The ***socio-environmental approach*** is much more complex. The strategies it employs attempt to create social and physical environments that nurture individual health and well being. [12-14] This approach advocates for community-based actions that are not restricted to health practitioners, subsequently making health no longer the exclusive responsibility of health practitioners and health departments/organizations. Within this framework, health practitioners are encouraged to become team players with other health agencies, government sectors, and local community organizations to create healthy or healthier social, economic, and physical environments. The collaborative endeavours among these players attempt to overcome the historical limitations of the medical and behavioural approaches to health.

Labonte suggested the boundaries among these three practice paradigms are "fuzzy"; health practitioners may find themselves working in more than one approach at different times and for different purposes.[9-10, 13] Also, Labonte suggested these three paradigms represent organizational biases (i.e., hospitals primarily work from a medical approach; provincial and federal agencies from a behavioural approach; and community workers from a socio-environmental approach) which may constrain health practitioners' ability to work within more than one practice paradigm.[9]

This study will attempt to describe the prevention activities of four health disciplines using Labonte's health promotion framework. Furthermore, this study will also determine their supports and barriers to practicing health promotion in the province of Saskatchewan.

1.5 Terms

Health practitioners work in different environments and use different languages. The successful adoption of health promotion begins with the sharing of a common language or terms.[2] The terms listed below were used repeatedly in this document.

Advocacy for Health	A combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or program.[2]
***Barriers**	Factors that impede the health promotion initiatives of health practitioners.
Community Health Dietitians	Health practitioners who work with individuals and communities in order to improve their nutritional well being, prevent disease, increase access to food, and enhance personal control of health.[18]
Creating Supportive Environments	Refers to activities aimed at establishing policies that support healthy physical, social, and economic environments.[2]
Determinants of Health	The range of personal, social, economic, and environmental factors which determine the health status of individuals and populations.[2]
Disease Prevention	Measures taken to not only to prevent the occurrence of disease (or risk factors) but also to arrest its progress and reduce its consequences once established. There are three forms: primary, secondary, and tertiary. Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapse and the establishment of chronic conditions.[2]
Health Communication (or Media Campaigns)	Informs the public about health concerns and keeps health issues on the public agenda. It also reinforces health messages and stimulates people to seek more information.[2]

* Author defined term.

Health Education	Involves learning opportunities designed to influence health knowledge, attitudes, and behaviours. The purpose: to help people improve decision-making and other life skills.[2]
Health Policy	A formal statement or procedure within institutions (notably government) that defines priorities and the parameters for action in response to health needs, available resources, and other political pressures.[2]
Health Promotion	The process of enabling people to increase control over and to improve their health. It embraces action directed towards changing social, environmental, and economic conditions to alleviate their impact on individual and public health.[2]
***Individual**	Terms used to describe patients, clients and/or customers by various health disciplines.
Living Conditions	The everyday environment of people, where they live, play, and work. These living conditions are a product of social and economic circumstances and the physical environment, all of which impact upon health, and are largely outside of the immediate control of the individual.[2]
***Prevention**	Activities that encompass a wide range of strategies aimed at health maintenance and health enhancement of individuals/communities. There are three distinguished levels of prevention: (1) primary prevention, (2) secondary prevention, and (3) tertiary prevention.
Primary Prevention	Essential health care made universally available to individuals and families in the community by means acceptable to them, through their full participation and at a low cost that the community and country can afford. It is the first level of contact of individuals, family, and community with the national health care system. It addresses the main health problems in the community, providing promotive, preventive, curative, supportive, and rehabilitative services accordingly.[2,17]

* Author defined term.

Public Health Nutritionists	Health practitioners working in the area of public health who assess the nutritional needs of populations, identify community nutrition problems, and develop health promotion strategies and nutritional education programs. Through their work in public health, community health and social service agencies, public health Nutritionists/Dietitians provide information and advisory services to other community agencies, professionals, and the public. [18]
Social Marketing	Campaigns using a variety of media mediums to create a social climate conducive to health. [2]
Social Support	The effects of social interaction on health. Activities often take place within communities and are undertaken by voluntary agencies. [2]
***Supports**	Factors that enable the health promotion initiatives of health practitioners.

* Author defined term.

CHAPTER 2

LITERATURE REVIEW

The literature presented concerns the extent to which health promotion is defined and practiced by the following health professions: general practitioners/family physicians, nurses, pharmacists, and dietitians. The health promotion policy statements of each discipline's professional association were identified, as well as literature supporting each discipline's perceived supports and barriers to health promotion practice. Where possible, emphasis was placed on Canadian literature.

2.1 Physicians

The literature suggests health promotion practiced by Canadian physicians largely takes place in primary health care settings[19-20] by ***general practitioners*** (GPs) and/or ***family physicians*** (FPs)[19]. GPs and FPs primarily focus their practice on patient-centred, evidence based, family, and problem-oriented care.[21] Moreover, FPs/GPs are required to develop a broad and varying array of competencies, depending on the needs of the populations they serve, the communities in which they practice, and the environments in which both they and their patients work and live.[21] Although health promotion should not be viewed as any one specialty's responsibility, research regarding the health promotion activities of physicians has primarily focused on these two specialties.[19-45]

The Canadian Medical Association's (CMA) official definition of health promotion is that put forth by the Ottawa Charter, namely "*the process of enabling people to increase control over and improve their health*" with prevention being defined as "*activities and approaches which reduce the likelihood that a disease or disorder will affect an individual, interrupt or slow the progress of the disorder, or reduce disability*".[22] Conversely, selected literature sources suggest physicians view health promotion from a "clinical" perspective.[23] Clinical health promotion is defined as "*applied health promotion with patients in clinical practice, whether it be in the office, hospital or community setting*", a method which "*predisposes, enables, and reinforces patients to take greater control of the non-medical determinants of health*" through patient education and counselling.[24-25]

The CMA's policy statement advises all physicians involved in health promotion and disease prevention to deliver a wide range of services, classified as health enhancement [i], risk avoidance[ii], risk reduction[iii], early identification[iv], and complication reduction[v].[22] Such services are to be guided by the Canadian Task Force Guidelines on the Periodic Health Examination.[22,24-25] These guidelines use scientific and evidence-based methodology to determine the inclusion or exclusion, content, and frequency of a wide variety of primary and secondary preventative measures related to 200 disease conditions. They are meant to

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[i] The routine, daily offering of counselling and information by physicians to encourage healthy lifestyles among all patients (e.g., nutrition, physical activity, and adjustment to life stages).

[ii] Ensuring that people at low risk remain at low risk through the provision of immunizations, and the routine encouragement of breast feeding, moderate exercise, use of bicycle helmets, etc.

[iii] Targeting individuals or segments of the population at moderate or high risk of disease or injury in order to reduce risk by encouraging behaviour change. Physicians will require the education and tools to screen and treat patients for risk factors such as high blood pressure, elevated serum cholesterol, unsafe sex, alcohol, and smoking abuse, etc.

[iv] Screening methods to detect diseases at an asymptomatic stage (e.g., pap smears, mammograms, etc.).

[v] Prescription of therapy to prevent complications in patients with diagnosed conditions or disease (e.g., warfarin in the presence of arterial fibrillation to reduce incidence of stroke).

play an important role in medical care, as well as reduce inappropriate care, prevent geographic variations in practice patterns, and encourage the efficient use of health care resources.[25] Canadian physicians are encouraged to use these guidelines to lead their prevention initiatives in clinical settings[25], yet these guidelines are not meant to address the broad determinants of health.

Much of the current literature based on GP/FP prevention activities focuses on Canadian physicians' adherence to the Canadian Task Force's guidelines, yet little discussion and/or research has addressed their engagement in health promotion activities. Several literature sources suggest the existence of the prevention guidelines (i.e., primary, secondary, and tertiary prevention) does not guarantee physicians will use them. [20,25-26] Therefore, one may assume GPs/FPs are experiencing a number of barriers in their practice of prevention or that their prevention activities are not always based on hard-core science. In 1992, Bass suggested few FPs in Canada were "*wholeheartedly behind all recommendations on preventative care*".[20] Ross supported Bass's statement by suggesting there is ample evidence North American physicians insufficiently used preventive care guidelines.[26] The following studies were found to support these allegations.

In 1993, Smith and Herbert studied the preventive practices of 186 primary care physicians in British Columbia.[27] A random sample of 300 general practitioners and family physicians were mailed a self-reported questionnaire, which examined the respondents' preventive practices with respect to four common types of cancer (i.e., breast, cervical, colon, and lung), demographic characteristics, professional training, practice profiles, and geographic settings. A 65% response rate was received (186/300). The author's found over 90% of the respondent's performed these preventive manoeuvres, yet less than 50% of the respondents performed two Task Force recommendations for patients who smoke

(i.e., advice to follow a diet high in beta-carotene (reported 10%) and scheduling of follow-up visits to reinforce antismoking counselling (reported 46%)). The most frequently offered reasons for not implementing these two guidelines were as follows: counselling was time consuming; patients were non-compliant with follow-up visits; and no provision in the provincial medical services fee schedule to bill for preventive services. The author's also found there was a discrepancy between knowledge of new preventive procedures and the number of physicians performing such activities, and preventive procedures were primarily carried out as a general examination rather than incorporated into all types of patient visits, as recommended by the Task Force. Smith and Herbert concluded that the respondent's failure to adopt the Task Force's recommendations may be due in part to how the recommendations were disseminated. At the time of this study, the Canadian Task Force Guidelines were not dispersed in packages but summarized through many issues of the Canadian Medical Association Journal. The author's recommended more efficient methods of dissemination to ensure all physicians are aware of these guidelines. The author's concluded that GPs and FPs were not complying with the CMA recommendations for prevention counselling. This conclusion was primarily based on the respondents' method of practicing prevention initiatives (i.e., general check-ups vs. all types of patient visits). This conclusion is somewhat puzzling, for at the same time the author's commended the respondents' sufficient use of preventive practice patterns for the four cancer manoeuvres under study.

In 1995, Weingarten et al. conducted a similar study in which the primary care initiatives of 48 Southern Californian primary care physicians were assessed by a self-administered questionnaire.[28] An impressive 100% response rate was received. Health records were also reviewed to assess physician compliance with practice guidelines set forth

by the U.S. Preventative Services Task Force. This study concluded that most of the respondents 'agreed' or 'strongly agreed' the guidelines would improve their quality of medical care (88%) and had caused them to change their patient care practices (75%), yet their general attitudes about the guidelines did not consistently correlate with their use. The author's suggested those respondents who claimed the guidelines had changed their preventive practices were more likely to follow certain preventive guidelines, but not all.

In 1999, Ewing et al. surveyed the use of clinical preventive practices (CPS) delivered by a national sample of U.S. primary care physicians.[29] The relationship between self-reported CPS delivery, demographics (i.e., gender, age, practice setting, and area of practice), and specialty characteristics was examined. A 60% (5400/9079) response rate was received. This study suggested most primary care physicians were not providing adequate clinical preventive services to their patients (inadequate was defined as < 80% of the time). Physicians < 50 years of age reported providing more preventive services involving smoking, alcohol/drugs, seatbelts, sexual activity, and family planning. Older practitioners (i.e., > 50 years of age) were more likely to deliver vaccines and screening procedures. Practitioners from metropolitan areas (i.e., > 1 million population) reported more preventive services involving drugs/alcohol and family planning while respondents in rural areas (i.e., < 50,000 population) reported fewer immunizations and screening procedures. When analyzed by specialty, the type of preventive care practice(s) varied suggesting that American primary care physicians inadequately and inconsistently provided preventive care.

Health promotion's popularity has grown over the last twenty-five years and so have the public's need for lifestyle counselling and the government's desire to improve its nation's health. GPs/FPs are in an excellent position to provide such services; however,

some literature sources suggest they are not adequately fulfilling their professional roles.

McAvoy et al. surveyed 430 GPs in the United Kingdom (U.K.) to determine if they were providing adequate behavioural counselling and risk reduction assessments.[30] A 68% (279/430) response rate was received. Despite recent increases in workload, GPs reported spending approximately 16% of their practice time on prevention (i.e., disease prevention and lifestyle risk counselling). Moreover, respondents spent 79% of their prevention practice time on lifestyle risk counselling (e.g., smoking cessation, alcohol consumption, use of prescription drugs, exercise, diet/nutrition, stress, and illicit drug use). Respondents, nonetheless, reported low confidence in perceived effectiveness of these types of interventions. The author's suggested further training and support would help GPs continue counselling lifestyle interventions.

Lawlor et al. further assessed the lifestyle advice of 36 UK GPs using a semi-structured interview guide in focus group discussions.[31] The main themes that emerged suggested GPs preferred a high risk approach to prevention (i.e., tertiary prevention activities) and doubted their ability to be effective in a population health approach despite their belief that social, cultural, and environmental factors were the most important determinants of population health. Respondents suggested a multi-agency, centrally coordinated approach was required to improve population health and that their role should be limited to secondary prevention activities.

Slatt et al. obtained much the same results when assessing the attitudes and prevention practices of California-based FPs.[32] A questionnaire was distributed to 165 community FPs to explore the level of patient counselling, the types of prevention services offered, and the level of physician success in modifying patient behaviour. The overall response rate was 70% (112/165). Over 60% of the respondents 'almost always' offered

services in smoking cessations, exercise, diet, and nutrition. Over 50% felt 'very prepared' to counsel patients regarding smoking cessation, sexually transmitted diseases, depression, exercise, alcohol use, and age-specific services. The respondents, however, were pessimistic about their abilities to change unhealthy behaviours of their clientele. This pessimism did not override respondents' confidence in their knowledge and skills to provide such services. The author's suggested further study was required to assess why FP's continued to offer a variety of prevention services while feeling ineffectual in their efforts to modify patient behaviours.

American and Canadian physician's have identified a number of factors that have hindered their practice of health promotion: (1) improper dissemination of the Canadian Task Force recommendations, (2) time constraints/competing priorities, (3) inadequate reimbursements for preventative care, (4) organizational issues, (5) administrative support, (6) patient non-compliance, (7) lack of counselling skills, (8) improper implementation of the Task Force interventions, (9) territorial considerations with other professionals, (10) conflicting guidelines between health promotion and primary prevention practices contributing to physicians' confusion, (11) scepticism concerning the value of prevention, (12) fear of losing dollars needed for primary prevention activities to health promotion initiatives, and physicians' (13) over-dependence on scientific data and outcomes as proof of effectiveness, (14) uncertainty about who should receive services and how often, (15) insufficient or outdated clinical education about preventative services, (16) lack of office or system organization to facilitate the delivery of primary care guidelines, and (17) attitudinal factors related to acute care focus. [25,27,29,3-34]

European physicians have experienced similar barriers to those of North American physicians. Coulter and Schofield studied the health promotion initiatives of 1014 U.K.