SENATE SÉNAT

POPULATION HEALTH POLICY: FEDERAL, PROVINCIAL AND TERRITORIAL PERSPECTIVES

Third Report of the Subcommittee on Population Health
of the Standing Senate Committee on
Social Affairs, Science and Technology

Chair
The Honourable Wilbert J. Keon

Deputy Chair
The Honourable Lucie Pépin

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ORDER OF REFERENCE

Extract form the *Journals of the Senate* of Tuesday, November 20, 2007:

The Honourable Senator Keon moved, seconded by the Honourable Senator Watt:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population — known collectively as the social determinants of health — including the effects of these determinants on the disparities and inequities in health outcomes that continue to be experienced by identifiable groups or categories of people within the Canadian population;

That the Committee examine government policies, programs and practices that regulate or influence the impact of the social determinants of health on health outcomes across the different segments of the Canadian population, and that the Committee investigate ways in which governments could better coordinate their activities in order to improve these health outcomes, whether these activities involve the different levels of government or various departments and agencies within a single level of government;

That the Committee be authorized to study international examples of population health initiatives undertaken either by individual countries, or by multilateral international bodies such as (but not limited to) the World Health Organization;

That the papers and evidence received and taken and work accomplished by the Committee on this subject since the beginning of the First Session of the Thirty-Ninth Parliament be referred to the Committee; and

That the Committee submit its final report no later than June 30, 2009, and that the Committee retain all powers necessary to publicize its findings until 180 days after the tabling of the final report.

After debate,

The question being put on the motion, it was adopted.

MEMBERSHIP

The following Senators have participated in the study on the inquiry on the issue of *Population Health Policy: International Perspectives* of the Subcommittee on Population Health:

The Honourable, Wilbert Joseph Keon, Chair of the Committee
The Honourable Lucie Pépin, Deputy Chair of the Committee

The Honourable Senators:

Bert Brown
Catherine S. Callbeck
Ethel M. Cochrane
Joan Cook
Joyce Fairbairn, P.C.

Ex-officio members of the Committee:

The Honourable Senators: Céline Hervieux-Payette, P.C. or (Claudette Tardif) and Marjory LeBreton, P.C., or (Gérald J. Comeau)

Other Senators who have participated from time to time on this study:
The Honourable Senators: Art Eggleton, P.C., Jim Munson, and Hugh Segal

EXECUTIVE SUMMARY

- This report describes and compares the efforts of federal, provincial and territorial governments to develop and implement population health policy in Canada.

- The concept of population health was elaborated in Canada in 1974 with the Lalonde report; it then evolved from a focus on improving overall health status to an emphasis on reducing health disparities.

- Both the federal and provincial/territorial governments have devoted considerable attention to population health. However, there is no national plan in Canada to reduce health disparities and improve overall population health status.

- In 1997, the federal government endorsed a Memorandum to Cabinet on Population Health; the proposal involved 18 departments and identified Health Canada as the lead. Yet, it did not succeed in coordinating the activities of the different departments concerned. It failed because significant funding cuts impeded its implementation. Only Health Canada moved forward to apply a population health lens to its programs and initiatives.

- In 2001, Health Canada developed a template that provides guidance to successful implementation of population health policy in both the health and non-health sectors. Though useful, this document has not convinced the non-health sector to embark on an ambitious population health agenda.

- Aboriginal populations bear a disproportionate burden of ill health and social suffering in Canada. The federal government can play a key role in addressing these health disparities. Currently, 30 federal departments and agencies deliver some 360 programs and services at a cost of $8.2 billion to all Aboriginal peoples. These programs and services, however, are not coordinated and integrated in a way as to reduce health disparities.

- In Newfoundland and Labrador and Québec, population health policy emanates from the health department, but the two jurisdictions also have separate policies on poverty and social exclusion. In other provinces, current whole-of-government approaches tend to be structured around singular health determinants, such as ActNow BC's focus on personal health practices and early childhood development by Healthy Child Manitoba.

- Each province implemented health goals between 1989 and 1998, but by the end of the 1990s they were no longer being used. In 2005, Federal, Provincial and Territorial Ministers of Health established health goals for Canada but, to date, they have not evolved into a national strategy or translated into measurable actions. Moreover, national targets have not been set for reducing health disparities.

- The 1997 Memorandum to Population Health submitted to the federal Cabinet recommended that Health Impact Assessment (HIA) be used to assess health impacts of federal policies and programs. Similarly, the use of Health Impact Assessment tools has been promoted in numerous provinces and a number of provincial reports have recommended that HIA be part of all Cabinet submissions. To date, only Quebec has passed legislation to ensure that the health impacts of proposed laws and regulations are assessed.

- Canada has sound data on population health status by health determinants and on health disparities. At the national level, reliable information is provided by the Canadian Population Health Initiative, Statistics Canada and the Public Health Agency of Canada, while several useful sources of health indicators and health disparities are available at the provincial level including, to name of few, the Manitoba Health Data Repository, the Community Accounts in Newfoundland and Labrador, and the B.C. Health and Wellness Survey.

- Canada plays an important role in population health research with the work funded or performed at the national level by the Canadian Institutes of Health Research, the National Collaborating Centres on Public Health, the Canadian Population Health Initiative, Health Canada, and the Public Health Agency of Canada, as well as at the provincial level by the Manitoba Centre for Health Policy, the *Institut de la santé publique du Québec*, the Ontario Institute for Work and Health and the Saskatchewan Population Health and Evaluation Research Unit, among others.

- Between 1994 and 2004, one of the main vehicles for intergovernmental coordination and dialogue in population health was the Advisory Committee on Population Health, which advised the Federal/Provincial/Territorial (F/P/T) Conference of Deputy Ministers of Health. This advisory committee played a key role in taking a long term and integrated view of the health of the population and ensuring policy coherence across issue areas. In 2004, with the publication of *Reducing Health Disparities*, the Advisory Committee addressed, for the first time in Canada, health disparities from a systemic perspective as opposed to addressing specific populations experiencing health disparities.

INTRODUCTION

The Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology has been mandated to examine and report on the broad determinants that influence the health of Canadians. We are particularly interested in identifying the actions that would have to be taken by the federal government to implement a population health policy. In our study, "population health policy" or "population health approach" refers to public policy that aims to reduce health disparities and improve the overall health of the population by addressing, in a coordinated fashion, the range of factors that influence health. Such an approach requires intersectoral action – coordination among different government departments, collaboration among all levels of government and the participation of different stakeholders from non-government organizations, industry and communities.

In its 13 chapters, this report deals with the efforts of the federal, provincial and territorial governments to develop and implement population health policy. Chapter 1 reviews the efforts of the federal government, while chapters 2 through 12 summarize those undertaken in each province and the territories. Finally, Chapter 13 provides a comparative review of the approaches used to develop and implement population health policy in the various jurisdictions in Canada.

CHAPTER 1: THE FEDERAL GOVERNMENT

1.1 MAIN FINDINGS

- The federal government has been recognized as a leader worldwide in elaborating the concept of population health. Health Canada has played a key role in promoting population health at the federal level and has officially adopted a population health framework for its programs and initiatives.

- In 1997, Cabinet ministers formally agreed to adopt a whole-of-government approach to population health involving 18 departments, with Health Canada as the lead. However, funding initially committed to implement the population health policy was subsequently significantly curtailed and, as a consequence, the federal government did not move forward with a comprehensive approach to population health.

- The work of the Federal/Provincial/Territorial (F/P/T) Advisory Committee on Population Health led to intergovernmental consensus and collaboration on advancing population health in Canada. The approach advocated by the Advisory Committee was officially endorsed by all F/P/T Ministers of Health.

- Documents prepared by Health Canada as well as the F/P/T Advisory Committee provided guidance on the design and implementation of intersectoral action by the health and other sectors to improve population health and reduce health disparities. Though useful in the health sector, these documents have not convinced sectors other than health to embark on this ambitious agenda.

- Over the years, the federal government has played a key role in the development of a sound population health information infrastructure. It has also made significant investments in research on population health and health disparities. Key players in these fields include Statistics Canada, Canadian Population Health Initiative, Canadian Institutes of Health Research, Public Health Agency of Canada, and National Collaborating Centres for Public Health.

- In 2005, an important step toward the development of population heath policy was reached when the F/P/T Ministers of Health agreed on a set of health goals. Each government is to put them into effect in meaningful and relevant ways. But, to date, the goals have not been converted into concrete actions nor have they evolved into a pan-Canadian population health strategy.

- Also in 2005, the F/P/T Ministers of Health also approved the Integrated Pan-Canadian Healthy Living Strategy, an intersectoral strategy with the goal of increasing the proportion of Canadians who are physically active, eat healthy food and maintain healthy body weights over a ten-year period. The Strategy has the potential to address health disparities significantly .

- Major health disparities exist both among Aboriginal populations and communities and between Aboriginal and other Canadians. The federal government can play a key role in addressing these health disparities. Currently, 30 federal departments and agencies deliver some 360 programs and services to Aboriginal peoples but they are not coordinated and integrated in ways to reduce health disparities.

1.2 DEVELOPMENT AND IMPLEMENTATION

Some three decades ago, the federal government was recognized as a leader worldwide in elaborating the concept of population health. Since then the concept has evolved from a focus on improving overall health status to one of reducing disparities in health.

In 1974, the then federal Minister of Health, Marc Lalonde, issued a working document entitled *A New Perspective on the Health of Canadians*. This report, which legitimated the idea of developing a broad population health policy, argued that good health is not the result of medical care alone and that changes in lifestyles and to social and physical environments would likely improve in the health status of Canadians more than would spending more money on health care delivery. The Lalonde report identified four major health determinants: human biology, environment, lifestyle and organization of health care.[1] Following the public release of the Lalonde report, the federal department of health created community programs and issued specific social marketing campaigns aimed at health promotion (such as ParticipACTION, "Dialogue on Drinking" and the Canada Food Guide).

In 1986, the then federal Minister of Health, Jake Epp, released *Achieving Health for All: A Framework for Health Promotion*. Like the Lalonde report, this report recognized the broader social, economic and environmental factors affecting health and advocated development of a population health policy. More importantly, the Epp report conceptualized a population health approach not only as a complement to the health care system but also as a means of reducing health disparities among Canada's various socio-economic populations. It recommended that all policies bearing directly on health be coordinated, including, among others, income security, employment, education, housing, business, agriculture, transportation, justice and technology.[2] Federal programs based on such an interdepartmental approach that were initiated during that period include Canada's

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(1) Marc Lalonde, Minister of National Health and Welfare, *A New Perspective on the Health of Canadians – A Working Document*, Ottawa, April 1974. http://www.hc-sc.gc.ca/hcs-sss/com/fed/lalonde_e.html

(2) Jake Epp, Minister of Health and Welfare, *Achieving Health for All: A Framework for Health Promotion*, Ottawa, 1986. http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/1986-frame-plan-promotion/index_e.html

Drug Strategy, the Heart Health Initiative, the Family Violence Initiative, a National AIDS strategy, etc.[3]

In 1989, the Canadian Institute for Advanced Research (CIFAR), an academic think tank, provided empirical evidence that the health of populations is the result of a complex interaction among several health determinants. In their seminal collaborative book, *Why are Some People Healthy and Others Not?*, CIFAR's researchers demonstrated convincingly that social and economic conditions exert a major and potentially modifiable influence on health through their impact on biological mechanisms (i.e. the nervous, endocrine, and immune systems) that were just beginning to be understood. Moreover, they identified early childhood, during development of fundamental neuronal pathways, as a critically important window for the development of intelligence and coping skills.[4]

The empirical evidence provided by CIFAR on the link between socio-economic factors and the health of both individuals and the population as well as on the relationships between early childhood experiences and health had a major influence on public policy. In 1993 the Federal/Provincial/Territorial (F/P/T) Conference of Deputy Ministers of Health established the F/P/T Advisory Committee on Population Health to provide national and intergovernmental policy advice on how to improve overall health and reduce disparities within a population health framework. A year later, the Advisory Committee published *Strategies for Population Health: Investing in the Health of Canadians*. This report summarized what was known at the time about the broad determinants of health and proposed national action to create greater understanding among the public about the population health approach as well as among government partners outside the health sector and to develop comprehensive intersectoral population health initiatives for a few key priorities.[5] The F/P/T

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(3) It is interesting to note that, also in 1986, *The Ottawa Charter for Health Promotion* insisted on the need for intersectoral action in tackling health disparities. The Charter, which was adopted at the First International Conference on Health Promotion organized by the World Health Organization, identified five priorities for action: 1) building healthy public policy; 2) creating supportive environments; 3) strengthening community action; 4) developing personal skills; and 5) reorienting health services. It also recognized the fundamental conditions and resources for health to be peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. (World Health Organization, *The Ottawa Charter for Health Promotion*, First International Conference on Health Promotion, Ottawa, 21 November 1986. http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)

(4) *Why are Some People Healthy and Others Not? – The Determinants of Health of Populations*, Editors Robert G. Evans, Morris L. Barer and Theodore Marmor, 1994

(5) Federal/Provincial/Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*, Ottawa, 1994. http://www.phac-aspc.gc.ca/ph-sp/phdd/approach/linked.html

Ministers of Health officially endorsed the approach advocated by the Advisory Committee. Around that time, several programs were developed to improve the well-being of Canadian children, including National Child Benefits, Canada Prenatal Nutrition Program, Aboriginal Head Start Program, etc.

In 1996, Health Canada published *Towards a Common Understanding: Clarifying the Core Concepts of Population Health*, which described twelve determinants of health (income and social status; social support networks; education; employment and working conditions; social environments; physical environments; biology and genetic endowment; personal health practices and coping skills; healthy child development; health services; gender; and culture) and identified five underlying assumptions of the population health approach: 1) Health is determined by the complex interactions between individual characteristics, social and economic factors and physical environments; 2) The health of a population is closely linked to the distribution of wealth across the population; 3) Strategies to improve population health must address the entire range of factors that determine health; 4) Important health gains can be achieved by focusing interventions on the health of the entire population (or significant sub-populations) rather than individuals; and 5) Improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional health care system. One of the key actions identified was a long-term, sustained investment and commitment within Health Canada as well as its promotion in other departments responsible for policies that impact on the health of Canadians. To help achieve this goal, Health Canada established an Interdepartmental Reference Group on Population Health made up of representatives from 18 government departments. The group shared information about programs and policies of member departments and identified opportunities for collaboration on common areas of concern.[6]

In 1997, the Interdepartmental Reference Group significantly advanced the cause of population health within the federal government by presenting a Memorandum to Cabinet on Population Health. Importantly, Cabinet formally agreed to adopt a population health approach to guide its policy and Health Canada was confirmed as the lead department. Cabinet Ministers also agreed to work with Health Canada in developing tools and mechanisms to assess the health impacts of

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(6) Health Canada, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health*, Discussion Paper, 1996. http://www.phac-aspc.gc.ca/ph-sp/phdd/docs/common/index.html

federal policies and programs. Due to fiscal restraint, however, the funding initially committed to implement the federal population health policy was subsequently significantly curtailed.[7]

Despite the reduction in financial resources, in 1998 Health Canada formally adopted a population health framework for all its programs and initiatives. To address the conceptual and organizational challenges posed by the transition to the population health approach, the department developed information and tools to assist its staff, including *Taking Action on Population Health*.[8] Health Canada also published the *Blueprint to Promote a Population Health Approach in Canada* which identified six action areas – theory; policy; evidence; marketing; mobilization and institutionalization; as well as the outcomes expected – to facilitate the integration of a population health approach within the department. These following areas were defined:

- Theory – develop further the theoretical framework for population health to integrate evidence supporting policy and program interventions and provide a knowledge base for developing tools needed to apply the population health approach;
- Policy – incorporate the population health approach into the public policy process in all sectors with tools for priority setting and accountability, such as population health reporting and health accounts;
- Evidence – encourage research agendas that address population health priorities and health information systems that capture population health data;
- Marketing – inform and influence decision makers, stakeholders and the public about population health through communication campaigns, workshops, presentations and publications;
- Mobilization – develop tools, partnerships and approaches that support implementation; and
- Institutionalization – strike joint committees, establish appropriate policies and structures within organizations, and provide organizations with clear mandates for reporting and evaluating population health approaches.[9]

In 1999, the F/P/T Advisory Committee on Population Health released *Intersectoral Action… Towards Population Health* which stressed that improving the health, well-being and quality of life of the population and reducing persistent health disparities requires the involvement of many sectors. It emphasized that intersectoral action – cooperation and collaboration within and between organizations and sectors – must involve the public and government sectors, the voluntary sector, the

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(7) Barbara Legowski and Lindsey McKay, *Health beyond Health Care: Twenty-five Years of Federal Health Policy Development*, Discussion Paper, Canadian Policy Research Networks, October 2000. http://www.cprn.org/doc.cfm?doc=131&l=en

(8) Health Canada, *Taking Action on Population Health – A Position Paper for Health Promotion and Programs Branch Staff*, 1998. http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/tad_e.pdf

(9) *Ibid*.

private sector, businesses, professionals and consumers in the fields of health, justice, education, social services, finance, agriculture, environment, and so forth.[10] The report was not a detailed guide for designing and implementing intersectoral action, but it did, however, enunciate conditions for successful intersectoral collaboration, including:

- Seek shared values and interests and alignment of purpose among partners and potential partners.
- Ensure political support, building on positive factors in the policy environment.
- Engage key partners at the very beginning; be inclusive.
- Ensure appropriate horizontal linking across sectors as well as vertical linking of levels within sectors.
- Invest in the alliance building process; work for consensus at the planning stage.
- Focus on concrete objectives and visible results.
- Ensure that leadership, accountability and rewards are shared among partners.
- Build stable teams of people who work well together and have appropriate supports.

Intersectoral actions that were initiated around that time included, among others, the National Tobacco Reduction Strategy and the Vancouver Agreement.

In 2001, Health Canada published *The Population Health Template* which outlined the procedures and processes required to implement a more comprehensive population health approach involving both the health and other sectors. The Template identified eight key elements for successful implementation of the population health approach (see table 1.1).[11]

(10) Federal/Provincial/Territorial Advisory Committee on Population Health, *Intersectoral Action… Towards Population Health*, Ottawa, June 1999. http://www.phac-aspc.gc.ca/ph-sp/phdd/collab/linked.html

(11) Health Canada, *The Population Health Template: Key Elements and Actions That Define A Population Health Approach*, July 2001. http://www.phac-aspc.gc.ca/ph-sp/phdd/approach/index.html

TABLE 1.1: POPULATION HEALTH KEY ELEMENTS

Key Element	Actions
Focus on the Health of Populations	▪ Determine indicators for measuring health status Measure and analyze population health status and health status inequities to identify health issues ▪ Assess contextual conditions, characteristics and trends
Address the Determinants of Health and Their Interactions	▪ Determine indicators for measuring the determinants of health ▪ Measure and analyze the determinants of health, and their interactions, to link health issues to their determinants
Base Decisions on Evidence	▪ Use best evidence available at all stages of policy and program development ▪ Explain criteria for including or excluding evidence ▪ Draw on a variety of data ▪ Generate data through mixed research methods ▪ Identify and assess effective interventions ▪ Disseminate research findings and facilitate policy uptake
Increase Upstream Investments	▪ Apply criteria to select priorities for investment ▪ Balance short and long term investments ▪ Influence investments in other sectors
Apply Multiple Strategies	▪ Identify scope of action for interventions ▪ Take action on the determinants of health and their interactions ▪ Implement strategies to reduce inequities in health status between population groups ▪ Apply a comprehensive mix of interventions and strategies ▪ Apply interventions that address health issues in an integrated way ▪ Apply methods to improve health over the life span ▪ Act in multiple settings ▪ Establish a coordinating mechanism to guide interventions
Collaborate Across Sectors and Levels	▪ Engage partners early on to establish shared values and alignment of purpose ▪ Establish concrete objectives and focus on visible results ▪ Identify and support a champion ▪ Invest in the alliance building process ▪ Generate political support and build on positive factors in the policy environment ▪ Share leadership, accountability and rewards among partners
Employ Mechanisms for Public Involvement	▪ Capture the public's interest ▪ Contribute to health literacy ▪ Apply public involvement strategies that link to overarching purpose
Demonstrate Accountability for Health Outcomes	▪ Construct a results-based accountability framework ▪ Ascertain baseline measures and set targets for health improvement ▪ Institutionalize effective evaluation systems ▪ Promote the use of health impact assessment tools ▪ Publicly report results

Source: Health Canada, *The Population Health Template: Key Elements and Actions That Define A Population Health Approach*, July 2001, p. 7. http://www.phac-aspc.gc.ca/ph-sp/phdd/approach/index.html

In 2002, the F/P/T Advisory Committee on Population Health established a Health Disparities Task Group with the mandate of providing advice on the role of the health sector in addressing health disparities. The Task Group, which included policy-makers and researchers from the health and social sectors, both within and outside government[12], identified four roles for the health sector in the reduction of health disparities:

- make the reduction of health disparities a health sector priority (establish a national leadership capacity; set goals and targets; use Health Impact Assessment; collaborate with jurisdictions, develop priority areas);
- integrate disparities reduction into health programs and services;
- engage with other sectors in health disparities reduction;
- strengthen knowledge development and exchange activities (develop indicators to measure the impact of health disparities; continue to support research; improve health information systems; share evidence on health disparities).[13]

In 2005, the F/P/T Ministers of Health approved the Integrated Pan-Canadian Healthy Living Strategy following three years of consultations and input from a wide range of people and organizations across all sectors. This Strategy presents a framework for sustained action based on a population health approach; its goals are to improve the health of the population overall and to reduce health disparities. The Strategy is intersectoral and involves federal, provincial and territorial government representatives, regional networks, the private sector, non-government stakeholders and national Aboriginal organizations. Consensus was achieved that initially the Strategy would address physical activity, healthy eating and their relationship to healthy weights, with a special focus on children and youth, Aboriginal peoples and other vulnerable groups. A target was set to obtain a 20% increase in the proportion of Canadians who are physically active, eat healthy food and maintain healthy body weights over a ten-year period.[14] The Strategy has the potential to make a significant contribution to addressing health disparities.

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(12) Health Canada, Canadian Institutes of Health Research, Canadian Population Health Initiative, Statistics Canada, provinces, universities, Canadian Council for Social Development and Caledon Institute of Social Policy.

(13) Health Disparities Task Group, *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper*, and *Recommended Policy Direction and Activities*, December 2004. http://www.phac-aspc.gc.ca/ph-sp/disparities/ddp_e.html and http://www.phac-aspc.gc.ca/ph-sp/disparities/dr_policy_e.html

(14) Secretariat for the Intersectoral Healthy Living Network, FPT Healthy Living Task Group and FPT Advisory Committee on Population Health and Health Security, *The Integrated Pan-Canadian Healthy Living Strategy*, 2005. http://www.phac-aspc.gc.ca/hl-vs-strat/index.html

1.3 MONITORING AND EVALUATION

Over the years, the federal government has played a key role in the on-going development of a sound population health information infrastructure. It has also provided significant investment in research on population heath and health disparities.

Statistics Canada, for example, maintains solid population health databases obtained from excellent population health surveys. In 1994, it initiated the National Population Health Survey to improve the information available to support the development and evaluation of health policies and programs in Canada.[15] In the same year, it undertook the National Longitudinal Study of Children and Youth, a long-term study to monitor the development and well-being of Canada's children from infancy to adulthood. Data collection occurs at two-year intervals from a representative sample of Canadians.[16] And in 2000, the Canadian Community Health Survey was initiated to provide regular and timely cross-sectional estimates of health determinants, health status and the utilization of health services for 136 health regions across the country.[17]

In 1998, the Population Health Fund was created following Health Canada's adoption of the population health approach to further its continuing mandate to maintain and improve the health of Canadians. The goal of the Fund is to increase community capacity for action on or across the determinants of health.[18]

In 1999, the federal government launched the Canadian Population Health Initiative (CPHI) within the Canadian Institute for Health Information. CPHI focuses specifically on population health. Its mission is twofold: 1) to foster a better understanding of factors that affect the health of

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[15] Statistics Canada, *Information About the National Population Health Survey*, http://www.statcan.ca/english/freepub/82F0068XIE/82F0068XIE1997001.htm

[16] Statistics Canada, *National Longitudinal Study of Children and Youth – Overview*, http://cansim2.statcan.ca/cgi-win/cnsmcgi.pgm?Lang=E&SP_Action=Theme&SP_ID=20000

[17] Statistics Canada, *Canadian Community Health Survey*, http://www.statcan.ca/english/concepts/health/cchsinfo.htm

[18] Public Health Agency of Canada, *Population Health Fund*, http://www.phac-aspc.gc.ca/ph-sp/phdd/funding/index.html

individuals and communities and 2) to contribute to the development of policies that reduce health disparities and improve the health and well-being of Canadians.[19]

In 2000, the federal government established the Canadian Institutes of Health Research (CIHR). Part of CIHR's mandate is to harness research to improve the health status of vulnerable populations and, as a consequence, most of its 13 virtual research institutes fund population health research. In 2005, CIHR established the Reducing Health Disparities Initiative – a multi-institute strategic research initiative to address the reduction of health disparities and the promotion of equity for vulnerable populations.[20]

In 2001, in collaboration with its provincial/territorial counterparts the federal government created Canada Health Infoway with the goal of accelerating the creation and use of electronic health information systems and electronic health records (EHRs) across the country.[21] There is a huge opportunity to use data generated by emerging EHRs for population health purposes if they are designed appropriately.

In 2004, the federal government created the Public Health Agency of Canada and appointed Canada's first Chief Public Health Officer (equivalent to Deputy Minister of Health). One responsibility of the Chief Public Health Officer is to report annually to Parliament on the state of public health in Canada.[22] The first report, to be tabled in May 2008, will focus on health disparities.

Along with the creation of the Public Health Agency of Canada, the federal government established six national collaborating centres to promote the use of evidence to support better decision-making in public health. Four of these centres focus on population health and health disparities.[23] The National Collaborating Centre for Determinants of Health (Atlantic Canada) studies how the

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(19) Canadian Institute for Health Information, *About the Canadian Population Health Initiative*, http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_about_e

(20) Canadian Institutes of Health Research, *Health Disparities Reduction Initiative*, http://www.cihr-irsc.gc.ca/e/25703.html

(21) http://www.infoway-inforoute.ca/en/Home/home.aspx

(22) Public Health Agency of Canada, *About The Agency*, 2008. http://www.phac-aspc.gc.ca/about_apropos/index-eng.php

(23) Public Health Agency of Canada, *National Collaborating Centres for Public Health*, Information, May 2004. http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_01bk2_e.html

various determinants of health inform health policy and practice.[24] The National Collaborating Centre for Healthy Public Policy (Québec) examines the impact of public policy, both health-related and in other areas such as transportation and urbanization, on Canadians' health and well-being.[25] The National Collaborating Centre for Environmental Health (British Columbia) explores environmental factors that can affect human health and identifies evidence-based interventions to reduce risks from environmental hazards.[26] The National Collaborating Centre for Aboriginal Health (British Columbia) focuses on means and strategies to improve the health status of Aboriginal Canadians.[27]

In 2004, another important step to advance the population health agenda was reached when Canada's First Ministers agreed to commit to the development of "goals and targets for improving the health status of Canadians through a collaborative process". A set of health goals was agreed upon by the F/P/T Ministers of Health in 2005. These were divided into four areas: basic needs in the social and physical environment; belonging and engaging; healthy living; and, a system for health (see Table 1.2).[28]

(24) http://www.stfx.ca/research/ncc/about-us.htm

(25) http://healthypublicpolicy.ca/513/The+Centre.htm

(26) http://www.ncceh.ca/en

(27) http://www.unbc.ca/nccah/

(28) *Health Goals for Canada – A Federal, Provincial and Territorial Commitment to Canadians*, October 2005. http://www.phac-aspc.gc.ca/hgc-osc/home.html

TABLE 1.2

HEALTH GOALS FOR CANADA	
Basic Needs (Social and Physical Environments)	• Our children reach their full potential, growing up happy, healthy, confident and secure. • The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy – now and for generations to come
Belonging and Engagement	• Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities. • We keep learning throughout our lives through formal and informal education, relationships with others, and the land. • We participate in and influence the decisions that affect our personal and collective health and well-being. • We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.
Healthy Living	• Every person receives the support and information they need to make healthy choices.
A System for Health	• We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world. • A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

Source: *Health Goals for Canada – A Federal, Provincial and Territorial Commitment to Canadians*, October 2005. http://www.phac-aspc.gc.ca/hgc-osc/home.html

The Health Goals for Canada are broad directional statements that provide a tool to guide further action on the determinants of health and help to strengthen the management of horizontal or intersectoral issues. It is up to each government, however, to put them into effect in meaningful and relevant ways. To date, these goals have not evolved into a pan-Canadian strategy nor have they resulted in any measurable actions.

1.4 ABORIGINAL HEALTH

The federal government has a key role in addressing health and socio-economic disparities affecting Aboriginal peoples. Currently, over 30 federal departments and agencies deliver some 360 programs and services to Aboriginal peoples. More than half (190) of these programs/services are available to all Aboriginals, while the rest are available to particular groups. In 2004-2005, $8.2 billion were allocated to these programs/services under seven broad strategic

objectives: health ($1.8 billion); lifelong learning ($1.9 billion); safe and sustainable communities ($2.5 billion); housing ($0.5 billion); economic opportunity ($0.2 billion); land and resources ($0.2 billion); and governance and relationships ($1.1 billion). Indian and Northern Affairs Canada was responsible for 61.5% and Health Canada for 21.0% of the total.[29]

In addition, the federal government funds pan-Canadian programs, including transfer payments to the provinces/territories, that benefit all Canadians, including Aboriginal peoples. The provinces and territories also have their own suite of programs and services to improve the quality of life for Aboriginal people living off-reserve and in the North.

Yet major disparities remain both between Aboriginal peoples and other Canadians and between Aboriginals living on reserve and those living off-reserve, primarily in cities.

The continued pressing health challenges faced by Aboriginal peoples led to a process of policy negotiations between First Ministers and national Aboriginal organizations in 2004 and 2005. This process, unique in Canadian history, resulted in the Kelowna Accord, an ambitious ten-year plan to "close the gap" between Aboriginal and non-Aboriginal Canadians in education, housing and infrastructure, health and economic opportunities – all key determinants of health. The federal government pledged $5.1 billion over five years to improve the socio-economic conditions of Aboriginal peoples, with the goal of bringing their standard of living up to that of other Canadians by 2016.[30] It is unclear whether the Kelowna Accord will be implemented and, if so, how.

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[29] Treasury Board of Canada Secretariat, *Aboriginal Affairs: Spending and Programs*, 2004-2005. http://www.tbs-sct.gc.ca/aaps-aapd/intro.aspx?Language=EN

[30] *First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap*, Kelowna, British Columbia, November 24-25, 2005. http://www.scics.gc.ca/confer05_e.html

CHAPTER 2: ALBERTA[31]

2.1 MAIN FINDINGS

- In the early 1990s, the government of Alberta established an advisory committee with the mandate of developing health goals. In the early 2000s, it enunciated new health goals and targets within a clearly-articulated population health framework. It failed, however, to translate that framework into a set of concrete actions to address the broad determinants of health.

- Currently, Alberta's message on population health lays primary responsibility on each member to maintain his/her personal health and wellness. Provincial non-governmental networks carry the major responsibility of bolstering awareness of and promoting action in population health.

- While little reference is made to population health in the documents from Alberta Health and Wellness, three of Alberta's nine regional health authorities have opted to incorporate the determinants of health in their annual health reports.

- A report in 2004 by the International Board of Review for the Alberta Heritage Foundation for Medical Research (AHFMR) advised Foundation to increase its emphasis on funding population health research to an extent comparable to that it places on biomedical research. The Foundation was also urged to encourage the province to provide increased access by researchers to provincial health data.

2.2 DEVELOPMENT AND IMPLEMENTATION

In 1987, the Premier's Commission on Future Health Care for Albertans was established with the mandate of examining the challenges to health care. From the outset, however, the Commission determined that health, as broadly defined by the World Health Organization, would be its over-riding focus. Its report in 1989 stressed that a more coordinated approach was needed, on a much broader scale and with specific goals and targets. In addition to a series of recommendations to reform health care, the Commission made three recommendations pertaining to population health: 1) that an Advocate for a Healthy Alberta be appointed to set broad priorities, monitor health status and report its findings on a regular basis to the Legislative Assembly; 2) that health impact assessment (HIA) be

[31] The information contained in this chapter is based on a paper commissioned by the Subcommittee and prepared by Laura Corbett and entitled *Population Health Policy in Alberta*.

required of new legislation, regulations and procedures; and 3) that additional funding be invested in population health research.[32]

In its response, the government announced its intention to develop health goals and objectives, additional funding for health promotion and disease/injury prevention, increased investment in population health research, and that consideration would be given to the feasibility of implementing HIA.[33]. It did not, however, support the creation of an Advocate for a Healthy Alberta; this was considered a responsibility of the Minister of Health.

After establishment of the Advisory Committee on Health Goals in 1991, *Health Goals for Alberta* was published in 1993, setting out nine goals supportive of a population health approach:

1. To increase the number of years of good health by reducing illnesses, injuries, and premature deaths and improving well-being;
2. To make decisions based on good information and research;
3. To include a health perspective in public policy;
4. To have appropriate, accessible and affordable health services;
5. To live in strong, supportive and healthy families and communities;
6. To live in a healthy physical environment;
7. To recognize and maximize individual potential in spite of biological differences;
8. To choose healthy behaviours;
9. To develop and maintain skills for facing the challenges of life in a healthy way.[34]

A few years later, another review by the Premier's Advisory Council on Health for Alberta resulted in *A Framework for Reform: Report of the Premier's Advisory Council on Health* in 2001.[35] The predominate message, indeed what the Council considered the best long-term answer to health care reform, was to encourage Albertans to stay healthy and well. Support incentives needed to encourage Albertans to stay healthy were set out, including rewards and penalties for their use of health care.

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[32] Premier's Commission on Future Health Care for Albertans, *The Rainbow Report: Our Vision for Health*, Final Report, December 1989.

[33] Government of Alberta, *Partners in Health, Government's Response to the Premier's Commission on Future Health Care for Albertans*, November 1991.

[34] Alberta Health, *Health Goals for Alberta : Progress Report*, December 1993.

[35] Available http://www.health.gov.ab.ca/resources/publications/PACH_report_final.pdf.

In its response, *Framework for a Healthy Alberta*, the government recognized that a variety of factors affect health, only some of which are under the control of the individual. The Framework, which involved 11 government departments and agencies, confined its approach to population health to two main goals – reducing chronic diseases and improving healthy behaviours. While it enunciated clear objectives and targets, the government's actions remained for the most part centered on health promotion and disease prevention.[36] Concrete action to address the wider determinants of health failed to materialize.

In 2006, as part of the 'third-way' process to reform health care, the government released *Health Policy Framework*[37] which continued to emphasize autonomy and personal responsibility for health.

Rather than the provincial government, it is key personnel in local government and non-governmental organizations (NGOs) who have expressed greater concern about the effects of the social and economic environment on population health. For example, the Alberta Healthy Living Network (AHLN), formed in 2002, is an informal network of 100 multi-sector local, regional and provincial organizations together with government departments that span health, education, researchers, social services, agriculture, transportation, Aboriginal and multicultural concerns. Its mission is to lead the collaborative efforts needed to promote health and prevent chronic disease in Alberta. The AHLN identified health disparity as one of seven priority strategies in 2004 and formed the Health Disparities Working Group.[38]

Another non-government organization, the Alberta Social and Health Equities Network (ASHEN) was created in 2005 as a coalition of agencies, advocates, policy makers, researchers and community members living with poverty and/or concerned about health disparities across Alberta.[39] The same year, Families First Edmonton (FFE) was launched[40]; FFE is a collaborative partnership including several provincial government organizations, local government organizations and NGOs

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(36) Available http://www.health.gov.ab.ca/key/Framework.pdf.

(37) Available http://www.health.gov.ab.ca/healthrenewal/GettingBetterHealthcare.pdf

(38) A. Dedrick, *Social Determinants of Health – Environmental Scan*, 2005. Available http://www.foodsecurityalberta.ca/content.asp?contentid=108&catid=34&rootid=.

(39) ASHEN Charter – See http://www.foodsecurityalberta.ca/content.asp?contentid=108&catid=34&rootid=.

(40) See http://www.familiesfirstedmonton.ualberta.ca/index.html

which strive collectively to improve the access of families with low-income to services in the Edmonton area. Ultimately, the goal is to determine whether delivering health, family support and recreation services in a coordinated way can improve the health of low-income families.

Municipally, Edmonton appears to be making a mark in population health. The Edmonton Social Planning Council's publication of *Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework* (2005)[41] clearly indicated its recognition that the most pronounced influences on health originate outside the health care system and that a shift was necessary from an 'illness-based' to a 'wellness-based' health system that addresses the determinants of health and thwarts illness and chronic disease. More recently, the Council released *Tracking the Trends: Social Health in Edmonton* which documented the social and economic trends that influence the quality of life and well-being of Edmonton's residents.

2.3 MONITORING AND EVALUATION

Among the health-related information and publications by Alberta Health & Wellness are annual surveys on the province's population health and the health care system. The surveys measure a range of data on issues related to the health status of Albertans, their use of health services and demographic data, including household income. The analyses made available to the public fail, however, to provide data on the relationship of health status to income or, indeed, to social context.[42] Reports also cover an array of lifestyle and behavioural determinants of health – ranging from nutrition, physical activity and injury to immunization – though with scant reference to how lifestyles and behaviours often reflect individual life circumstances.

With information drawn from various Canadian databases, three of Alberta's nine Regional Health Authorities (Chinook Regional Health Authority, Calgary Health Region and David Thompson Regional Health Authority) opted to address the determinants of health in their annual health reports. Particularly notable is the Chinook Regional Health Authority's *Determinant's of Health Survey* (2003) which has gone so far as to analyze statistically the effect of some local

(41) Available http://www.edmspc.com/Uploads/sdoh%20discussion%20paper.pdf.

(42) Available http://www.health.gov.ab.ca/resources/publications/Survey2004.pdf

determinants on population health.[43]

The Alberta Heritage Foundation for Medical Research (AHFMR) is the leading funding agency for health research in the province. Every six years an International Board of Review does an assessment and submits a report to AHFMR and the provincial government. In its most recent report, the International Board advised AHFMR to put greater emphasis on the funding of population health research, making it comparable to that of biomedical research and to apply the fruits of the complete research spectrum to benefit the health of Albertans.[44]

(43) See http://www.chr.ab.ca/bins/doc.asp?rdc_id=5455 .

(44) See http://www.ahfmr.ab.ca/publications/reports/IBR2004/pdf/IBR_report_final.pdf

CHAPTER 3: BRITISH COLUMBIA[45]

3.1 MAIN FINDINGS

- Population health policy in British Columbia has been guided by targets, particularly the 1997 provincial health goals, which are interpreted and implemented by regional health authorities. Only one of these regional health authorities, however, the Interior Health Authority, appears to be taking an explicit population health approach.

- At the provincial level, ActNow BC – a whole-of-government health promotion initiative – has established collaborative, intersectoral partnerships to confront common illness risk factors and reduce chronic disease by promoting healthy schools, workplaces and communities.

- Despite capacity constraints and data limitations, increasing emphasis is being placed on the need for evidence to inform policy and program decisions; this change is evident in the recent introduction of British Columbia's Health and Wellness Surveys that monitor lifestyle targets and public health issues to support program planning and evaluation, and the work of the Data and Evidence Expert Group to determine the state of knowledge on population health.

3.2 DEVELOPMENT AND IMPLEMENTATION

Population health policy in British Columbia has been imbedded in the provincial health goals and expressed in the regional devolution of health service delivery. In 1991, the British Columbia Royal Commission on Health Care and Costs advised the government to establish specific provincial health goals; it also recommended a method to gauge and document progress.(46) To ensure that the goals would have public resonance, the Provincial Health Officer, who was charged with their development, consulted with provincial government departments, community organizations and the public through processes characterized as comprehensive and resource-intensive.(47)

The goals, which were approved in 1997, established a vision for a healthy population and a framework for action. Taking a fundamental population health approach, the goals went beyond the provision of health services to address a number of the other determinants of health:

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45 The information presented in this chapter is based on a paper commissioned by the Subcommittee on Population Health and prepared by Laura Corbett entitled, *Population Health Policy in British Columbia*, 2007.

(46) British Columbia Ministry of Health and Ministry Responsible for Seniors, *Policy and Practice: A Report on the Use of British Columbia's Health Goals by B.C. Government Ministries*, BC Provincial Health Officer, January 2001. http://www.health.gov.bc.ca/library/publications/year/2001/ppfinal.pdf

(47) Williamson, D. L., Milligan, C. D., Kwan, B., Frankish, C. J. Ratner, P. A., "Implementation of Provincial/Territorial Health Goals in Canada", *Health Policy*, 63, 2001, 173-191.

1. Living and Working Conditions: Positive and supportive working conditions in all British Columbia's communities.
2. Individual Capacities, Skills and Choices: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive, to meet life's challenges and to make choices that enhance health.
3. Physical Environment: A diverse and sustainable physical environment with clean, healthy and safe air, water and land.
4. Health Services: An effective and efficient health service system that provides equitable access to appropriate services.
5. Aboriginal Health: Improved health for Aboriginal peoples.
6. Disease and Injury Prevention: Reduction of preventable illness, injuries, disabilities and premature deaths.[48]

These goals were complemented with 44 specific objectives and 150 examples of indicators to measuring progress toward their achievement. A workbook to assist health regions and community organizations in their efforts to develop locally relevant targets and strategies that reflected the provincial vision and goals was also prepared.[49] In terms of accountability, the Provincial Health Officer assumed the lead in promoting and documenting efforts to achieve the goals.

The provincial health goals were not intended to be used only by regional health authorities, the Provincial Health Officer and/or the Ministry of Health. They were conceived as belonging and applicable to all levels of government and to the corporate, business, and non-profit sectors, and to the community at large. Following a review in 2000, however, the Provincial Health Officer found that despite better understanding of health and its determinants by most ministries, the goals had neither been fully adopted nor applied as an explicit template for planning across government.[50]

Over the same period when the health goals were being developed and introduced, the provincial health care system underwent significant restructuring through the partial devolution of responsibility for health delivery to Regional Health Authorities. It was expected that RHAs would be better able than the provincial or federal governments to generate subsidiary goals, indicators,

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[48] British Columbia Ministry of Health, *Framework for Health Goals and a Healthy Population in BC*, 1997. http://www.health.gov.bc.ca/pho/hlthgoals.html

[49] Williamson, D. L. et. al (2003), *op. cit.*

[50] British Columbia Ministry of Health and Ministry Responsible for Seniors (2001), *op. cit.*

strategies and programs more attuned to local characteristics and resources.[51] An audit performed two years after the launch of the provincial health goals, however, found that their implementation was still substantially attenuated at the regional level.[52]

Currently, there are five RHAs in British Columbia Among them, the Interior Health Authority has taken a lead in addressing the determinants of health. Its report *Beyond Health Services and Lifestyle: A Social Determinants Approach to Health*[53] seeks to prompt discussion of population health by enabling stakeholders to understand better how socio-economic conditions influence health as well as genetics, lifestyles and the provision of health services. The hope is that heightened awareness, reinforced by the political will, will serve as a catalyst for the collaborative, intersectoral work needed to reduce health disparities. The Interior Health Authority acknowledges that effectively tackling these disparities requires both social and economic policy responses that are beyond its responsibilities. The challenge for the health authority is to move beyond illness care services and the promotion of healthy lifestyles into collaborative work with other stakeholders on the broader, social determinants of health. In other words, the health authority has accepted the particular responsibility and opportunity to act as a catalyst for change.

One of the leading examples of intersectoral action at the provincial level is ActNow BC, a whole-of-government health promotion initiative introduced in 2006, based in the Ministry of Health. ActNow BC seeks to improve the health of British Columbians through steps to reduce chronic disease and confront common illness risk factors including physical inactivity, poor nutrition, obesity, tobacco use, and unhealthy choices made during pregnancy. ActNow BC's targets for 2010 are to:

- Increase by 20 percent the percentage of the B.C. population that is physically active;
- Increase by 20 percent the percentage of B.C. adults who eat at least five servings of fruits and vegetables daily;
- Reduce by 20 per cent the percentage of B.C. adults who are overweight or obese;
- Reduce tobacco use by 10 percent; and

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(51) Williamson, D. L., Milligan et. al. (2003), *op. cit*.

(52) Kendall, P., *Report on the Use of Provincial Health Goals in Regional Health Service Plans*, Ministry of Health and Ministry Responsible for Seniors, 1999.

(53) Dovell, R. (2006). *Beyond Health Services and Lifestyle: A Social Determinants Approach to Health*. Kelowna: Interior Health, http://www.interiorhealth.ca/NR/rdonlyres/BD005CE4-E0DF-441A-8DD2-4AC315A359B2/0/PopHealthSDOHReportOctober2006.pdf

- Increase by 50 percent the number of women who receive counseling about the dangers of alcohol and tobacco use during pregnancy.[54]

ActNow BC involves all 19 provincial departments and is led by the Minister of State for ActNow BC. Each department is required to view its mandate, goals, programs, activities, and outcomes through a health promotion lens and match them with ActNow BC-related goals. The Minister of State is responsible for social marketing and raising awareness, providing advice and support to ministries, monitoring and evaluation, and reporting to Cabinet on progress. Support is provided by the ActNow BC Assistant Deputy Minister's Committee which brings together representatives from each provincial ministry to monthly meetings, the agendas of which include information sharing and development of strategy. These meetings assist Assistant Deputy Ministers to see their ministry's mandate and business through a health promotion lens, a perspective that strengthens "buy-in" within their ministries and among their executives.[55]

Moreover, ActNow BC is intersectoral; its partnerships reach beyond the provincial government. More than 70 partners from the federal and municipal governments, non-government sector, communities, schools and the private sector are involved, ensuring that responsibility for improving the health of British Columbians extends to all sectors of society.

3.3 MONITORING AND EVALUATION

A number of initiatives are underway in British Columbia to improve the evidence and information base available to policy makers taking a population health approach. For example, the B.C. Health and Wellness Survey (BC-HWS) was initiated in 2006 to provide better information on the health-related lifestyle patterns of British Columbians. The data from the BC-HWS is intended to: allow local communities to monitor the ActNow BC lifestyle targets and initiatives to reach those targets; assess key public health issues, and; inform the development of public policy to improve the health of British Columbians. The survey is modeled after Ontario's Rapid Risk Factor Surveillance System, a randomized telephone survey conducted continuously through the year to monitor health

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(54) British Columbia Ministry of Health, *Backgrounder: About ActNow BC*, 23 March 2006. http://www2.news.gov.bc.ca/news_releases_2005-2009/2006HEALTH0017-000253-Attachment1.htm

(55) Gordon Hogg, Minister of State for ActNow BC, *Submission to the Senate Subcommittee on Population Health*, 12 December, 2007.

behaviour risk factors and the general health of the population. BC-HWS was developed in response to an expressed need by medical health officers, epidemiologists, health planners and health administrators for health data at a more local level than had previously been available in BC.[56]

In order to apply data at a local level, the Population Health Surveillance Unit of the Vancouver Island Health Authority devised a health geographical information system (HGIS) that serves both as a platform for information integration and as an analytical tool; it supports detailed data analysis from a population health perspective.[57] With the assistance of the HGIS and the use of a wide range of data sources, a population health lens can be applied to health services and program planning. Information gleaned from the HGIS supports decisions by the Vancouver Island Health Authority related to the location of services, the composition and numbers of case management teams and the spectrum of services required.

A study identified notable capacity shortcomings of British Columbia's research capacity to translate evidence on health protection, health prevention, and action on the determinants of health into policies and programs; it did find at least one individual in all five regional health authorities with some relevant capacity for research.[58] Over the last two years, the BC Population Health Network has brought together leaders in population health from all the health authorities to network, share best practices and build capacity.[59]

Finally, the Provincial Health Services Authority and the Knowledge Management and Technology Branch within the Ministry of Health have convened a Data and Evidence Expert Group to determine what is known in relation to population health, what is unknown and where the evidence remains lacking. Their findings will form the basis of the Ministry's research agenda.[60]

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(56) British Columbia Provincial Health Services Authority, *British Columbia Health and Wellness Survey Descriptive Report,* January 2007.

(57) Barnard, D. K. & Hu, W., "The Population Health Approach: Health GIS as a Bridge from Theory to Practice", *International Journal of Health Geographics,* 4, 23, 2007.

(58) Ron Dovell, *Discussion Paper: Capacity for Upstream Evidence in B.C.*, BC Population & Public Health Evidence Network, December 2006, http://www.phabc.org/modules.php?name=Contentpub&pa=showpage&pid=34

(59) Lex Baas, B.C. Interior Health Authority, Evidence to the Subcommittee, 12 December 2007.

(60) Ron Dovell (2006), *op. cit.*

CHAPTER 4: MANITOBA[61]

4.1 MAIN FINDINGS

- Since the early 1990s, the department of health has supported a population health approach that aims to reduce health disparities. Although population health terminology is present in the policy and planning documents of Manitoba's regional health authorities, their role in addressing the broad determinants of health seems ambiguous.

- Manitoba's Healthy Child program is a noteworthy example of an interdepartmental initiative led by a high-level Cabinet Committee that takes an intersectoral approach to improving the well-being of Manitoba's children and youth.

- In terms of population health efforts outside the health sector, the development of a community economic development policy framework and lens has attempted to institutionalize community development strategies in programs and policies across provincial departments; it has faced challenges in implementation.

- Manitoba benefits from a history of longitudinal administrative data collection, strong collaborative research, and solid knowledge translation activities which together provide a good basis for monitoring, evaluation and the generation of evidence to inform healthy public policies, programs and practices.

4.2 DEVELOPMENT AND IMPLEMENTATION

In 1992, Manitoba Health published *Quality Health for Manitobans: The Action Plan,* which set out the goals and philosophy of a strategy that would come to define new health policy, planning and delivery in Manitoba throughout the 1990s. The series of goals for health reform included improving the general health status of all Manitobans and reducing disparities in health status.(62)

Provincial responsibilities for population health were outlined in 1997 in *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*. These included: 1) determining provincial priorities; 2) developing a provincial health strategy; 3) assessing provincial

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61 The information presented in this chapter is based on a paper commissioned by the Subcommittee on Population Health and prepared by Laura Corbett entitled, *Population Health Policy in Manitoba*, 2007.

(62) Kay Willson and Jennifer Howard, *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*. Winnipeg: Prairie Woman's Health Centre of Excellence, 2000.

health status and health needs; 4) coordinating health strategy across the province; and 5) leading and participating in research initiatives and communicating findings.[63]

The *Regional Health Authority Act* of 1997 set out the responsibilities of regional health authorities (RHAs) for public and population health. Each RHA is charged with assessing regional health status and health needs, determining regional priorities, and managing the organization and delivery of programs and services.[64] In addition, they bear responsibility for monitoring the impact on health of their actions, initiating practice-based research and participating in provincial research.[65]

A recent survey of three of Manitoba's RHAs revealed how difficult it is to apply a population health lens at the regional level. Few respondents defined population health as that which requires action on the determinants of health; almost no mention was made of the need to diminish social and economic disparities in health as crucially important from a population health perspective.[66]

A model of intersectoral action is demonstrated by Manitoba's Healthy Child initiative, which offers a continuum of programs and services for children, youth and families, starting at pregnancy and continuing until adolescence. These include: Parent-Child Centred Approach; Fetal Alcohol Syndrome Strategy; Healthy Baby; Families First; Triple P - Positive Parenting Program; Healthy Schools; and Healthy Adolescent Development Strategy. Started in 2000, Healthy Child Manitoba brings together provincial departments, other levels of government and community groups to develop child-centred public policy that integrates financial and community-based family supports.[67]

Healthy Child Manitoba is guided by the Healthy Child Committee of Cabinet, which meets bi-monthly to ensure interdepartmental cooperation and coordination of programs and services. Chaired by the Minister responsible for Healthy Living and supported by the Healthy Child Deputy Ministers' Committee, the Cabinet Committee had the following membership in 2006-2007: Minister

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(63) Manitoba Health, *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans,* 1997, http://www.gov.mb.ca/health/rha/planning.pdf

(64) Benita Cohen, "Population Health as a Framework for Public Health Practice: a Canadian Perspective," in *American Journal of Public Health,* Vol.96, No.9, 2006, 1574-1576.

(65) Manitoba Health (1997), *op. cit.*

(66) Benita Cohen (2006), *op. cit*.

(67) Healthy Child Manitoba, *About Healthy Child Manitoba*, http://www.gov.mb.ca/healthychild/about/index.html

of Health; Minister of Aboriginal and Northern Affairs; Minister of Justice; Minister of Culture Heritage and Tourism; Minister of Labour and Immigration and Minister responsible for the Status of Women; Minister of Education, Citizenship and Youth; and Minister of Family Services and Housing. As one of a small number of Cabinet committees, the simple existence of the committee identifies healthy child and adolescent development as a top-level priority for government. Currently, the Healthy Child Committee of Manitoba's Cabinet is the only standing Cabinet committee in Canada that is dedicated to children and youth.[68]

Another example of intersectoral action can be found in the government's adoption in 2000 of a community economic development (CED) Policy Framework and Lens for policy and program development.[69] The province sees CED as a community-driven process combining social, economic and environmental goals to build healthy and economically viable communities.[70] The framework provides a guide for departments to support community economic initiatives that are comprehensive and multifaceted, often addressing multiple determinants of health. The lens serves as a tool for government personnel to review policies and programs.

To facilitate interdepartmental relationships, the government created a central agency – the Community and Economic Development Committee (CEDC) of Cabinet Secretariat – to advance CED policy. The Secretariat coordinates major development and economic projects that require interdepartmental collaboration through the Cabinet Committee. It also leads the CED Working Group, an interdepartmental team that meets regularly to raise awareness of CED across government and encourage the use of the CED Policy Framework and Lens.

The creation of this high-level Cabinet committee does not seem to have been as successful as has been Healthy Child Manitoba. Because the CEDC was assigned a wide range of responsibilities, CED policy has rarely been a primary concern. Furthermore, the CEDC was only armed with the power of persuasion to influence the activities of line departments and to encourage the

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(68) Healthy Child Manitoba, *Annual Report 2006-07*, http://www.gov.mb.ca/healthychild/about/annual_report_2006_07.pdf

(69) Racher and Robert Annis, "Health Promotion in Manitoba: Partnering for Action," in Michel O'Neill et al., *Health Promotion in Canada: Critical Perspectives*, 2nd edition, Toronto: Canadian Scholars Press, 2007.

(70) Eugene Kostyra, "Made in Manitoba: Community Economic Development Provincial Policy Framework and Lens," in *Horizons*, Vol. 8, No.2, 2006, http://www.recherchepolitique.gc.ca/doclib/v8n2_e.pdf

application of the CED Framework and Lens. Departments have not been held accountable for their contributions to CED and, as a result, its implementation has been variable, department by department.[71]

4.3 MONITORING AND EVALUATION

Manitoba is recognized as a remarkably information-rich given that the Manitoba Population Health Data Repository offers 30 years well-served by its wealth of health information, but also by the availability of this information in a format that allows health information to be linked with individual-level data from other relevant departments such as housing, income assistance and education to support detailed analysis of the determinants of health and of population health status.[72] In fact, a review of research published between 1994 and 2002 using longitudinal administrative data showed that the proportion of publications addressing socio-economic factors in Manitoba (22%) far exceeded that in British Columbia (6%) and Ontario (3%).[73] A corollary advantage of linking data sets across sectors is that it constitutes another means of fostering interdepartmental collaboration.[74]

At the University of Manitoba, the Centre for Health Policy and Evaluation draws on the Population Health Research Data Repository to determine the health of Manitobans not only by analysis of their use of health services but through examination of social and economic factors affecting different geographic and demographic groups. Research from the Centre has shown that residents in areas with higher measures of social deprivation use health services more frequently and tend to have the poorest health.[75] Not only does the lack of access to health care contribute to this gradient but so too do social and economic factors such as unemployment, income and education.

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(71) Byron Sheldrick and Kevin Warkentin, *The Manitoba Community Economic Development Lens: Local Participation and State Restructuring*, Canadian Centre for Policy Alternatives-Manitoba, April 2007; and Shauna MacKinnon, "The Social Economy in Manitoba: Designing Public Policy for Social Inclusion," in *Horizons*, Vol.8, No.2, 2006, http://www.recherchepolitique.gc.ca/doclib/v8n2_e.pdf

(72) Marni Brownell, *Inequalities in Child Health: Assessing the Roles of Family, Community, Education and Health Care.* CPHI Regional Workshop, 2003.

(73) Leslie Roos, Verena Menec, and R.J. Currie, "Policy analysis in an information-rich environment," in *Social Science & Medicine, 58(11),* 2231-2241, 2004.

(74) Noraloo Roos, University of Manitoba, *Evidence*, February 13, 2008.

(75) Norman Frohlich, et al. *A Report on the Health Status, Socio-Economic Risk and Health Care Use of the Manitoba Population 1992-93 and Overview of the 1990-91 to 1992-1993 Findings,* Manitoba Centre for Health Policy and Evaluation, 1994.

Predictably, the most deprived segment of the population places the greatest demand on the health care system. In response, Manitoba has attempted to reallocate resources within health care to meet the social needs of the population in greatest difficulty, particularly children in poverty.[76] *The Need to Know Team* at the Manitoba Centre for Health Policy has been supplementing these efforts with knowledge translation initiatives to deliver "accurate and timely information to health care decision makers, analysts and providers, so they can provide services that are effective and efficient in maintaining and improving the health of Manitobans."[77]

An additional strength of Manitoba's population health research work comes from the formal partnership established between Manitoba First Nations and researchers in the Department of Community Health Sciences at the University of Manitoba.[78] This two-decade partnership has produced new and innovative approaches to developing organizations, training initiatives and projects that strengthen First Nations principles of governance. For example, efforts by the Assembly of Manitoba Chiefs and the Northern Health Research Unit generated the Manitoba First Nations Centre for Aboriginal Health Research. The Centre initiates, coordinates and supports research designed to assist First Nations and Aboriginal communities and organizations in their efforts to promote healing, wellness and the improvement of health services in those communities.

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(76) John Frank, and Fraser Mustard, *The Determinants of Health from a Historical Perspective*, Founders Network, 1998.

(77) Canadian Institutes of Health Research, "Dr. Patricia Martens – The Need to Know Team and Manitoba Centre for Health Policy," http://www.cihr-irsc.gc.ca/e/29970.html

(78) John O'Neil, Brenda Elias, Jennie Wastesicoot, "Building a Health Research Relationship Between First Nations and the University in Manitoba," in *Canadian Journal of Public Health, Vol.96, suppl 1,* S9-S12, 2005.

CHAPTER 5: NEW BRUNSWICK

5.1 MAIN FINDINGS

- In 2001, a Select Committee on Health Care of the New Brunswick Legislative Assembly recommended a whole-of-government approach to population health. Its framework for wellness provided broad strategic direction for government to improve population health.

- The Committee recommended development of an action plan to implement the strategy by a high-level interdepartmental coordinating mechanism, such as a committee of Deputy Ministers.

- In 2006, the New Brunswick government released details of a provincial wellness strategy that does not reflect the whole-of-government approach to population health envisioned by the Select Committee. It refers only to contributions by the health sector through health promotion and disease prevention.

- A Deputy Ministers' Wellness Strategy Committee has been established as part of the New Brunswick Wellness Strategy. Among other things, this Committee is mandated to promote and coordinate government activities related to wellness and to facilitate the on-going development of healthy public policy. This could be an important step toward the development of a broader approach to population health.

5.2 DEVELOPMENT AND IMPLEMENTATION

A broad perspective on health and related population health strategies has been advocated and debated continually over the last two decades in New Brunswick. In 1989, a Commission of Selected Health Care Programs acknowledged the limits on the contributions of the health care delivery system to health and the need to examine alternatives approaches to creating healthy populations. It affirmed the responsibility of government to set health goals, objectives and targets in economic and social policy areas. It also noted the need of individuals for help in making healthful choices in their lives through better understanding of the causes of good and bad health just as they need help in making informed choices among treatment and care alternatives. It also stressed that in addition to the health and education ministries, others such as Environment, Income Assistance, Labour, Transportation, Agriculture, Fisheries, Housing and Justice should initiate and be actively involved in a coordinated health promotion and education program targeting low income groups, school children, parents, pre- and post-natal care and baby care, the elderly and disabled persons.[79]

(79) Commission on Selected Health Care Programs, *Report*, Government of New Brunswick, May 1989.

In response, in 1990 the provincial government released *Health 2000* which endorsed the World Health Organization's broad concept of health as defined under its framework of "Achieving Health for All". *Health 2000* also identified five health goals constituting a framework for planning, prioritizing and evaluating programs:

1. To increase the number of years residents of New Brunswick live free of major disease, disability and handicap.
2. To put more emphasis on health promotion and disease prevention.
3. To achieve and maintain healthy, strong and supportive individuals, families and communities.
4. To support the creation of safe environments for all New Brunswickers.
5. To maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.(80)

Health 2000 also encouraged government departments, health care providers, community groups and individuals to transfer the goals into objectives, targets and action strategies. A parallel initiative entitled *Public Health Service: Vision, Mission, Goals and Objectives*, presented in 1993, established goals by health priority area as a means to track and monitor the health status of the population of New Brunswick.(81)

In 1999, a Health Services Review commissioned by the provincial government again recommended the adoption of a wellness model that emphasized health promotion and disease prevention. Perhaps more interestingly, it recommended that government harness all areas of policy in support of good health in a coordinated way through a Deputy Ministers Committee, mandated to monitor on a continuing basis the impact that new and existing policies have on the determinants of health.(82)

In 2000, a Select Committee on Health Care of the Legislative Assembly submitted an initial report on the provincial government's health and wellness-related policies. It included an inventory of government policies, programs and initiatives impacting on the determinants of health; this was developed with input from the Deputy Ministers of all government departments. The policies

(80) Government of New Brunswick, *Toward a Comprehensive Health Strategy – Health 2000: Vision, Principles and Goals*, 1990.

(81) Government of New Brunswick, *Public Health Service: Vision, Mission, Goals and Objectives*, 1993.

(82) Health Services Review Committee, *Report of the Committee*, Government of New Brunswick, February 1999.

and programs of fifteen departments and agencies were identified and classified in relation to their impact on eight health determinants (income and social status, social support networks, education, employment and working conditions, physical environments, personal health and coping skills, healthy child development, health services). Acknowledging that many government programs contribute to population health, the Committee stressed that, to date, there had been no coordinated broad, high-level direction to ensure that all government departments work to enhance population health.[83]

A year later, the Select Committee on Health Care released its second report, *A Wellness Strategy for New Brunswick*, in which it recommended an innovative whole-of-government approach to population health. The proposed strategy focused on healthy lifestyles, children and youth, seniors, communities and the workplace. Key elements to ensure effective implementation of the strategy included: leadership by government, collaboration and partnerships, evidence-based research, monitoring and reporting, citizen participation, and long term commitment. The report recommended that all government departments undertake health impact assessment when developing or reviewing policies and programs and that population health be incorporated into the government's corporate performance measurement system. To achieve intersectoral action, the the Committee recommended establishment of a high-profile focal point/secretariat for population health within government with responsibility to: 1) work with other departments and stakeholders; 2) be a source of expertise on population health; 3) release an annual report on wellness; and 4) facilitate and support a community approach to population health. Finally, it recommended establishment of a high-level interdepartmental coordinating mechanism, such as a Deputy Minister-level committee, to create an action plan to implement the strategy.[84]

In 2002, the Premier's Health Quality Council, established in 2000 with a two-year mandate, released its report on health care renewal. It stated: "The health of the New Brunswick population is not determined by investment in the health system alone. It is socially determined by income, working conditions, environment, early childhood development, education and social support, as well as lifestyle choices and health care services. Sustainable change in the health of New

(83) Select Committee on Health Care, *Wellness Strategy Progress Report*, Legislative Assembly of New Brunswick, First Report, Second Session, 54th Legislative Assembly, 15 June 2000, http://www.gnb.ca/legis/business/committees/reports/healthfirstrep-e/healthfirstrep-e.asp.

(84) Select Committee on Health Care, *A Wellness Strategy for New Brunswick*, Legislative Assembly of New Brunswick, Second Report, Third Session, 54th Legislative Assembly, April 2001, http://www.gnb.ca/legis/business/committees/reports-e.asp.

Brunswickers must be an outcome of all these factors." Accordingly, it supported the recommendations of the Select Committee on Health Care, stating that its blueprint for health care renewal should be predicated on the implementation of the comprehensive and thoughtful recommendations of that Committee.(85)

In 2004, the New Brunswick government published *Healthy Futures: Securing New Brunswick's Health Care System – The Provincial Health Plan 2004-2008*. Interestingly, this document also identified "improving population health" as the government's first strategic priority and announced plans to implement a wellness strategy. Although in *Healthy Futures* the government endorsed the general direction called for in the report of the Select Committee on Health Care, it did not, however, commit itself to adopt the whole-of-government approach to population health recommended by the Committee. In fact, *Healthy Futures* referred to the health promotion and disease prevention contributions of the health sector only.(86) Some experts believe, however, that these health promotion and illness prevention activities nonetheless can be regarded as first steps in the development of a broader approach to population health.(87)

Details of the initiatives to constitute the wellness strategy announced in *Healthy Futures* were released in 2006 in a document entitled *New Brunswick Wellness Strategy*. This focuses on increasing physical activity, promoting good nutrition and healthy eating, preventing and reducing tobacco use, and fostering mental health and resiliency, with an emphasis on partnership and collaboration. The Strategy also announced a multi-media social marketing campaign to increase awareness of the benefits of a healthy and active lifestyle and to help encourage people to assume greater responsibility for their own health.(88) The "Get Wellness Soon" marketing campaign was launched in September 2007.(89)

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(85) Premier's Health Quality Council, *HEALTH Renewal*, Government of New Brunswick, January 2002, http://www.gnb.ca/0089/documents/e-phqc.pdf.

(86) Ministry of Health and Wellness, *Healthy Futures: Securing New Brunswick's Health Care System – The Provincial Health Plan 2004-2008*, Government of New Brunswick, 2004. http://www.gnb.ca/0051/promos/healthplan/index-e.asp.

(87) Monique Allain and Marlien MacKay, "New Brunswick: Government Policy and Action," in *Health Promotion in Canada – Critical Perspectives*, Second Edition, 2007, pp. 189-190.

(88) Government of New Brunswick, *New Brunswick Wellness Strategy – A Provincial Health Plan Initiative*, January 2006, http://www.cahperd.ca/eng/advocacy/cross_canada/documents/wellnessstrategy2006.pdf.

(89) Department of Wellness, Culture and Sport, "New Brunswickers Encouraged to Get Wellness Soon," *News Release*, Government of New Brunswick, 5 September 2007. http://www.gnb.ca/cnb/news/wcs/2007e1104wc.htm.

Notably, the New Brunswick government has been working with other Atlantic governments to develop an Atlantic Wellness Strategy; all Atlantic Premiers are calling for the development of a national wellness strategy through the cooperation of all provinces and territories.[90]

5.3 MONITORING AND EVALUATION

As a component of the New Brunswick Wellness Strategy, the provincial government is investing in a longitudinal surveillance/evaluation and research initiative to monitor and measure progress systematically over time. A Deputy Ministers' Wellness Strategy Committee will monitor implementation of the strategy and report on progress every four years. This Committee is also mandated to promote and coordinate government wellness activities and to facilitate the development of healthy public policy on an ongoing basis.[91] This could be an important step toward the development of a broader approach to population health.

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[90] Government of Newfoundland and Labrador, "Premiers Discuss Action on Issues of Mutual Concern," *News Release*, 22 November 2002, http://www.releases.gov.nl.ca/releases/2002/exec/1122n07.htm.

[91] New Brunswick Wellness Strategy (2006), *op. cit.*

CHAPTER 6: NEWFOUNDLAND AND LABRADOR

6.1 MAIN FINDINGS

- Newfoundland and Labrador's *Strategic Social Plan* laid out in 1998 a vision for social development over the long-term by integrating social and economic development and matching social investment with community and regionally-based development strategies. Province-wide consultations by an external advisory committee contributed to the development of the plan. Its implementation was led by the Social Policy Committee of Cabinet and carried out on a partnership basis between community groups, regional boards, individuals and governments.

- Newfoundland and Labrador is the second Canadian province to address poverty reduction with a comprehensive and integrated strategy. Under the direction of a Ministerial Committee, the province's ten-year plan seeks to improve access to services for those with low incomes, strengthen the social safety net, raise employment incomes, strengthen childhood development, and improve the overall education of the population.

- The 2006 *Provincial Wellness Plan for Newfoundland and Labrador* is the single largest health promotion initiative in the provincial history. Its healthy living focus addresses healthy eating, physical activity, tobacco control and injury prevention in the first phase, and mental health, environmental health, child and youth development and health protection in a second phase. Developed through consultations with a Wellness Advisory Council that brings together broad representation from non-government agencies and government departments, the *Plan* is being implemented by the Department of Health and Community Services.

- In relation to monitoring and evaluation, Newfoundland and Labrador began the first provincial social audit in Canada, creating the infrastructure to assess implementation of the *Strategic Social Plan*. A comprehensive, publicly accessible socio-economic data system called *Community Accounts* was developed; operated by the Department of Finance, a detailed study has examined the extent to which changes in government operating processes were successful five years after the launch of the *Strategic Social Plan*.

6.2 DEVELOPMENT AND IMPLEMENTATION

Newfoundland and Labrador has undertaken a number of policy initiatives over the last ten years to address various determinants of health in strategic and coordinated ways.

A. Strategic Social Plan

The social and economic turmoil resulting from closure of the cod fishery in the early 1990s highlighted the need for a major shift in existing public policy. Following its release of a strategic economic plan in 1992, the government moved to develop a comprehensive social plan as an

overall framework to guide long-term actions and to identify strategic directions, processes, and outcomes.

In 1998, the government approved its five-year *Strategic Social Plan*[92] as the umbrella policy for a long-term approach to social development in Newfoundland and Labrador. The vision was of healthier and more educated people, living in vibrant self-reliant communities. In the plan's new approach, however, was explicit recognition of the link between social and economic development and the fact that neither can be addressed in isolation from the other. The plan signalled a shift in the focus of social development policies from individuals to community-level approaches to integrate social and economic development at local and regional levels; policies would be focused on the underlying causes of individual problems rather than their treatment and the consideration of people's needs in the context of their communities and the socio-economic environment. Strengthening communities and regions would help them to become more self-sustaining and thereby support individual and community well-being, and provide people with opportunities. As an added benefit, the hope was that, "(r)eorienting social programs and services from remedial approaches to strategies which address the root causes of problems will also result in programming that is more efficient and more cost effective."[93]

Implementation of the Plan was by partnerships involving community groups, regional boards, individuals and governments. It encouraged government departments to work together, across government and in communities, and created six Regional Steering Committees to allow for government and community organizations to identify collectively and address issues related to the social and/or economic development of the region concerned. The Social Policy Committee of Cabinet led implementation of the plan; its mandate was to work toward:

- Integrating social and economic policy and planning;
- Conducting the business of government in ways that support coordination and integration and that emphasize accountability for results;
- Providing for meaningful public input in the design and delivery of public services through regionalized/decentralized structures;
- Strengthening capacity within regions to support community action around social development goals and ensuring coordination of efforts to achieve the Plan's outcomes; and
- Accomplishing the policy and program shift from crisis and reactive approaches to prevention and early intervention.

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(92) Government of Newfoundland and Labrador, *People, Partners and Prosperity: A Strategic Social Plan for Newfoundland and Labrador*, 1998, http://www.exec.gov.nl.ca/rural/pdf/ssp.pdf.

(93) *Ibid*.

Five years after its launch, progress toward achieving the outcomes identified in the Strategic Social Plan was evaluated by a social audit. The results are discussed in the Monitoring and Evaluation section below.

B. Healthier Together: Strategic Health Plan for Newfoundland and Labrador

Growing out of the broad social policy directions in the *Strategic Social Plan* and perceiving a need for change in the provincial health and community services system, the government held regional health forums as part of province-wide consultations in the fall of 2001. Based on the input received, a framework for reform laid out three goals to improve:

- The health status of the population of Newfoundland and Labrador;
- The capacity of communities to support health and well-being; and
- The quality, accessibility, and sustainability of health and community services.

Healthier Together: A Strategic Health Plan for Newfoundland and Labrador[(94)] identified specific objectives and strategies associated with each goal, including development of a wellness strategy to increase healthy behaviours, strengthening community partnerships focusing on health and well-being, and improving long-term care and mental health services. Specific five-year planning targets were also set for each objective.

C. Building a Healthier Future: A Draft Provincial Health Charter

Following on a commitment made in the Throne Speech in March 2002, the government launched public consultations on a Provincial Health Charter.[(95)] This charter was to have two purposes: to ensure the people of the province know what to expect from the health and community services system; and to identify the responsibilities people have for their own health and well-being.

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(94) Government of Newfoundland and Labrador, *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*, Department of Health and Community Services, 2002, http://www.health.gov.nl.ca/health/strategichealthplan/pdf/HealthyTogetherdocument.pdf.

(95) Government of Newfoundland and Labrador, "Public consultations on Provincial Health Charter," *News Release*, 26 February 2003, http://www.releases.gov.nl.ca/releases/2003/health/0226n04.htm.

The draft Charter proposed a vision of health as a shared responsibility among individuals, families and communities.[96] Among the 14 points which the document suggested residents of the province could expect of the health and community services system, a number addressed other determinants of health, including:

- a clean and safe environment that promotes health and well-being;
- public policies sensitive to possible impacts on the health of the population;
- a partnership approach that empowers individuals, families and communities to take charge of their own health and well-being; and
- population-based approaches to health, such as immunization, that protect people from major health risks.

But further development of the health charter was not continued after the provincial election and change of government in November 2003.

D. Poverty Reduction Strategy

After Québec, Newfoundland and Labrador was the second province in Canada to establish a comprehensive and integrated strategy to address poverty reduction . In its 2005 Speech from the Throne, the government committed to transforming Newfoundland and Labrador over a ten-year period from a province with the most poverty to a province with the least poverty through a comprehensive poverty reduction strategy. Tackling poverty – improving the well-being and quality of life of those living in poverty – is essential to ensuring a healthy, strong and prosperous future for Newfoundland and Labrador.[97]

The government called for partners to come forward to help identify the best way to reduce poverty.[98] Hundreds of people participated in government hearings, and in June 2006, the government released *Reducing Poverty: An Action Plan for Newfoundland and Labrador*[99] This sets

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[96] Government of Newfoundland and Labrador, *Building a Healthier Future: Development of a Health Charter for Newfoundland and Labrador*, Public Discussion Paper, 26 February 2003, http://www.health.gov.nl.ca/health/publications/pdfiles/HealthCharter2003.pdf.

[97] Government of Newfoundland and Labrador, *Reducing Poverty: An Action Plan for Newfoundland and Labrador*, Department of Human Resources, Labour and Employment, June 2006. http://www.hrle.gov.nl.ca/hrle/poverty/poverty-reduction-strategy.pdf.

[98] Government of Newfoundland and Labrador, *Reducing Poverty in Newfoundland and Labrador: Working Towards a Solution*, Department of Human Resources, Labour and Employment, June 2005, http://www.gov.nl.ca/publicat/povertydiscussion-final.pdf.

[99] Government of Newfoundland and Labrador, "Reducing Poverty: An Action Plan for Newfoundland and Labrador," *op. cit.*

out a vision where "poverty has been eliminated … where all individuals are valued, can develop to their full potential and have access to the supports they need to participate fully in the social and economic benefits of Newfoundland and Labrador."[100] Based on the key directions identified to prevent, reduce and alleviate poverty, the action plan sets out five medium-term goals for the first four years: 1) improved access and coordination of services for those with low incomes; 2) a stronger social safety net; 3) improved earned incomes; 4) increased emphasis on early childhood development; and 5) a better educated population. Each of these goals is supported by medium-term objectives; progress is to be measured at the end of the four-year period. The initial actions to move towards those goals take a multi-pronged approach, including:

- Raising welfare and disability benefits and indexing them to the cost of living;
- Raising the minimum wage;
- Building more affordable housing;
- Removing penalties on the earnings of welfare recipients;
- Expanding prescription drug coverage for the working poor;
- Targeting appropriate employment supports for youth, people with disabilities and aboriginal communities;
- Enhancing supports to vulnerable groups within the justice system;
- Emphasizing early childhood development;
- Reducing the number of school dropouts; and
- Promoting greater access to post-secondary and adult education.[101]

The action plan recognizes that a high level of government commitment is necessary to tackle poverty. To that end, a Ministerial Committee was established with the following membership: the Minister for Human Resources, Labour and Employment, and the Minister Responsible for the Newfoundland and Labrador Housing Corporation, the Labour Relations Agency, Workplace Health, Safety and Compensation Commission and Labrador Affairs (Lead); the Minister Responsible for Aboriginal Affairs; the Minister of Education and the Minister Responsible for the Status of Women; the Minister of Finance; the Minister of Health and Community Services; the Minister of Innovation, Trade and Rural Development and the Minister Responsible for the Rural Secretariat; and the Minister of Justice.

This Committee is supported by a Deputy Ministers' Committee and an Interdepartmental Working Group. Already established processes, such as regular evaluation and

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[100] *Ibid.*

[101] Campaign 2000, *Raising the Falling Fortunes of Young Families with Children*, 2007, http://www.fallingfortunes.ca/portal/images/stories/raisingfallingforutunes.pdf.

monitoring of programs and the reporting of outcomes in departmental annual reports, serve as the initial tools to assess the action plan's progress; others will be added as necessary. In addition:

- The Minister of Human Resources, Labour and Employment will give a statement of progress each year to the House of Assembly.
- Every two years a report will be published outlining progress and reporting on indicators, and recommending approaches to address gaps.
- Departmental annual reports and other accountability mechanisms will document the success of departmental initiatives, including efforts at coordination and integration.

E. Provincial Wellness Plan

In 2003, a Provincial Wellness Advisory Council prepared and submitted recommendations to the Minister of Health and Community Services for a Provincial Wellness Strategy. Based on those recommendations and building on existing initiatives and resources, in 2006 the government launched *Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador*,[(102)] a framework designed to contribute to improvement of the health and well-being of the people. With a $2.4 million budget, it represents the largest single cash infusion in health promotion in the history of the province.[(103)]

This Plan situates itself within a number of strategies directly related to healthy living and wellness, such as the Integrated Pan-Canadian Healthy Living Strategy,[(104)] being played out in the province, in the Atlantic region, and across Canada. The messages in the Plan focus on empowering individuals, groups and communities to take action for their health and wellness by eating well, being physically active, being smoke-free, and managing stress in a positive way. Through this approach, it seeks to "help balance the health agenda and shift the focus from the treatment of illness to the promotion of healthy living and wellness."[(105)] Phase I of the Plan (2006-2008) addresses healthy eating, physical activity, tobacco control and injury prevention. A second phase will consider mental health promotion, environmental health, child and youth development and health protection.

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(102) Government of Newfoundland and Labrador, *Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador*, Phase I, 2006-2008, http://www.health.gov.nl.ca/health/publications/2006/wellness-document.pdf.

(103) Eleanor Swanson, "Newfoundland and Labrador: Government Policy and Action" in Michel O'Neill, Ann Pederson, Sophie Dupéré and Irving Rootman, *Health Promotion in Canada: Critical Perspectives*, 2nd ed., Canadian Scholars Press Inc., Toronto, 2007.

(104) Public Health Agency of Canada, *Healthy Living Strategy*, http://www.phac-aspc.gc.ca/hl-vs-strat/index.html.

(105) Government of Newfoundland and Labrador, "Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador," *op. cit.*

Although the focus of the Plan is on personal behaviours, it acknowledges that there are a number of other initiatives both within and outside the health sector that impact wellness.[106] One of the tools used to incorporate the influences of these other determinants is the *Circle of Health: Health Promotion Framework*.[107] The Circle of Health brings together the main elements required to ensure a comprehensive approach to addressing wellness, incorporating population health, determinants of health and the five health promotion strategies identified in the Ottawa Charter of Health Promotion. The Circle of Health has been selected as a tool to guide the planning, delivery and evaluation of programs, actions and initiatives to address the wellness priorities of Newfoundland and Labrador.

6.3 MONITORING AND EVALUATION

While each of the initiatives mentioned above has its own monitoring and reporting mechanisms, the tools and processes created for the evaluation of the *Strategic Social Plan* are of particular interest because of the multi-pronged approach taken to gather appropriate data and that evaluating change on a number of levels. More precisely, with announcement of the Plan in 1998, the government committed itself to carry out a four-phase social audit to measure social progress in the province five years later; Newfoundland and Labrador is the only province in Canada to undertake a social audit.[108]

- Phase one of the audit was Community Accounts, which provides an on-line social and economic profile of communities and provincial jurisdictions, including employment levels and the health and education of residents (see below).
- Phase two was the compilation of *From the Ground Up*,[109] a report presenting benchmark data across a range of social and economic indicators to serve as a comparative reference point both across jurisdictions and over time.
- *Learning Study: Has Government Started Doing Business as Envisioned by the Strategic Social Plan?*[110] was a report analyzing changes in the way government conducts its business while implementing the *Strategic Social Plan*.
- The final phase of the Social Audit was intended to assess whether resources were being allocated with the long-term social development of the province in mind. But following assumption of

(106) *Ibid*.

(107) *Ibid*.

(108) Government of Newfoundland and Labrador, "Report Acknowledges Shift in Government Thinking," *News Release*, 13 February 2004, http://www.releases.gov.nl.ca/releases/2004/exec/0213n03.htm.

(109) Government of Newfoundland and Labrador, *From the Ground Up*, 2 April 2003, http://www.exec.gov.nl.ca/rural//TOCftgu.asp.

(110) Jane Helleur & Associates Inc., *Learning Study: Has Government Started Doing Business as Envisioned by the Strategic Social Plan?*, 15 December 2003, http://www.exec.gov.nl.ca/rural/pdf/learningstudy-dec2003.pdf.

responsibility for the *Strategic Social Plan* Office by the Rural Secretariat established in February 2004, it is unclear if this final phase was ever completed.

The Community Accounts and Learning Study phases of the social audit are presented below in greater detail.

A. Community Accounts

Community Accounts is an innovative information system that provides in a single on-line source community, regional, and provincial data from a variety of sources. It is the first Internet-based data retrieval and exchange system in Canada that provides unrestricted, free access to view and analyze data down to the community level.

Because the *Strategic Social Plan* addressed issues cutting across sectors, it required an information and evaluation system that embraces an integrated, evidence-based approach to policy and program development through collaboration within and across government departments and between the economic and social sectors. Key social, economic, and health data and indicators needed to understand community health and well-being are often not readily available, too costly to obtain, or too time consuming to retrieve manually or otherwise and compile for policy makers and local citizens. Community Accounts provides a single, accessible and comprehensive resource of that information.

The system allows users to generate custom tables and illustrative graphics on key social and economic indicators organized by geography and data topic within ten distinct accounts: Household Spending, Income, Social, Health, Labour Market, Production, Demographics, Education, Resource/Wealth and Environment. An additional account, termed Well-Being, allows users to compile indicators from each of the above domains to develop a better understanding of the factors that determine the status and progress of their communities and regions.[(111)] Information can be retrieved relating to 400 communities, 80 census consolidated subdivisions (local areas), 20 economic development zones, and the province as a whole. It can also be retrieved at the level of Rural Secretariat Regions, Health Authorities, School Districts, and Human Resources and Social Development Canada regions.

Based on a model designed by Dr. Doug May of Memorial University in collaboration with the Newfoundland and Labrador Statistics Agency, Community Accounts is sustained by the

(111) Community Accounts, *About Us*, http://www.communityaccounts.ca/communityaccounts/onlinedata/about_us.asp.

Economics and Statistics Branch of the Department of Finance in collaboration with other government departments and with private organizations and individuals.

B. Learning Study

It was understood that implementing the goals of the *Strategic Social Plan* required fundamental changes in the way government operated, creating expectations for partnerships with community agencies and decentralizing both the provision of services and choices around delivery. Five years after the launch of the *Strategic Social Plan*, the Learning Study found that:

- Progress in changing operational processes was evolving more slowly than envisioned, especially for government departments, but less so for Regional Strategic Social Plan Steering Committees.
- Allocated resources were insufficient to meet the complex needs of communities and regions. This suggested the necessity of an increased focus on the coordination of investments among government departments, and between the provincial, federal and municipal governments.
- Government departments must work more collaboratively to facilitate the making of joint investments based on integrated business planning, both at the provincial and regional levels.
- The province had been highly adept at leveraging federal initiatives with targeted funds for the development of programs and services consistent with the *Strategic Social Plan* goals. In fact, many of successes identified through the Learning Study were the result of federal funding. Other opportunities to strengthen further the focus on interdepartmental initiatives should be sought.
- Stronger accountability is required to ensure government departments are conducting business consistent with the *Strategic Social Plan*'s vision, values and goals. Clear expectations for departments must be continually communicated and actively monitored. In addition, recognition systems must be introduced that provide an incentive for achievements and the adoption of best practices.
- While the Regional Steering Committees had undertaken projects to achieve "early wins", more significant efforts are required to address, consistent with regional priorities, systemic social and economic development issues by using solid evidence as a basis for planning. Government departments have to ensure that they are actively connected with, and supportive of this work.
- Community-based agencies, key partners envisioned by the *Strategic Social Plan*, highly endorsed its vision, values and goals. However, they desired much more inclusion during implementation and required greater funding to deliver community-based programs that are responsive to the community individual client needs.

CHAPTER 7: NOVA SCOTIA

7.1 MAIN FINDINGS

- No comprehensive population health strategy has been implemented in Nova Scotia, but steps are being taken through a strengthened public health function, intersectoral collaboration and development of a broad-based data collection system.

- Government structures responsible for public and population health have evolved steadily since 2002, most recently with creation of the Department of Health Promotion and Protection (DHPP) in 2006.

- A collaborative intersectoral approach to policy development and program planning is DHPP's "way to work" on issues that require cooperation among individuals, organizations, sectors and government departments.

- An external review in 2006 suggested the need to expand provincial public health legislation to address broader public health functions such as population health assessment, health surveillance, health promotion, and the prevention of disease and injury.

- The impact of a population health approach was evaluated by Community Health. They found that this approach was successful in facilitating community input to and ownership of health-related responsibilities but the absence of a provincial population health framework and tension between a local focus on population health versus a focus on acute care at the regional level impeded implementation of population health policies.

- Nova Scotia Community Counts is a division of the Nova Scotia Department of Finance, established to develop a database on Nova Scotian communities. This database, an adaptation of Newfoundland and Labrador's Community Accounts, provides statistics on a wide range of health determinants – including income, social support networks, working conditions, and physical environments. The database can be used to track population health indicators and monitor policies and programs which impact population health.

7.2 DEVELOPMENT AND IMPLEMENTATION

The Nova Scotia's structures relating to public and population health have evolved steadily in recent years. Following the 1994 *Blueprint for Health System Reform*, the Department of Health devolved a substantial role for policy development to Regional Health Boards and their subsequent replacements in 2002, District Health Authorities (DHAs). The nine DHAs were given responsibility to govern, plan, manage, monitor, evaluate, and deliver health services for acute and tertiary care, mental health, and addictions in their specified regions.

DHAs are also responsible for providing planning support to Community Health Boards (CHBs) in each region. Nova Scotia's 37 CHBs act as the eyes, ears and voice for community health; they consult with residents and organizations to construct a community profile that identifies deficiencies and strengths with respect to factors that affect health, including income and social status, social support networks, education, employment, physical environments, etc.[112] This profile is used subsequently to determine the priority issues affecting health in the community concerned, and to develop annually a Community Health Plan with primary health care and health promotion as its foundation. In turn, the DHAs must consider the community health plans when developing their annual health services business plans.

In 2002 creation of Nova Scotia Health Promotion (NSHP) as a separate ministry brought together the Sport and Recreation Commission with portions of the Population Health branch of the Department of Health to focus on health promotion and the prevention of chronic disease and injury. Later, in 2006, following a review of public health[113], the provincial government created the Department of Health Promotion and Protection (DHPP), building on NSHP to include all public health staff as well as the Office of the Chief Medical Officer of Health − the first department of its kind in Canada.[114] DHPP's expanded focus on population health, reducing disparity, healthy public policy, evidence-informed decision making and community capacity-building addresses common risk factors for the chronic diseases that take the greatest toll on Nova Scotians and burden the provincial health care system.[115] Those risk factors are often in areas beyond DHPP's direct scope of action, however; therefore intersectoral collaboration is key to dealing with them. To facilitate communication, cooperation, collaboration and action among individuals, organizations, sectors and government departments on common issues and strategies, DHPP has developed what is called its "way to work." Some examples of DHPP's current collaborative intersectoral policy development and program planning efforts include:

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(112) Government of Nova Scotia, Department of Health, *Users' Guide to the Health Authorities Act*, revised June 2002, p. 25, http://www.gov.ns.ca/health/downloads/ActUsers_guide.pdf.

(113) Government of Nova Scotia, Health Promotion and Protection, *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians*, *op. cit*.

(114) Government of Nova Scotia, Department of Health Promotion and Protection, *2007-2008 Business Plan*, 22 March 2007, http://www.gov.ns.ca/hpp/repPub/HPPBusinessPlan07-08.pdf.

(115) Rick Manuel, "Nova Scotia: Government Policy and Action," in Michel O'Neill, Ann Pederson, Sophie Dupéré, and Irving Rootman (eds.), *Health Promotion in Canada: Critical Perspectives*, Second Edition, Toronto: Canadian Scholars Press, 2007; and Nova Scotia Health Protection and Promotion home page, http://www.gov.ns.ca/hpp/.

- Community Development Policy and Lens: The Department has participated in development of a Community Development Policy (CDP), which is applied in several of DHPP's Responsibility Centres.
- Nova Scotia Green Plan: The Department works closely with partners such as the Department of Environment and Labour and NGOs in connection with trail development.
- Strategy for Positive Aging: The Department was a key partner with the Seniors Secretariat in the development of a Strategy for Positive Aging. In areas such as the oral health of seniors, falls prevention, chronic disease prevention and physical activity, the Department is continuing collaborative work to reduce the risk factors for chronic disease and injury among seniors.
- Joint Environmental Health Services: In order to fulfil their respective mandates for environmental protection, the Departments of Agriculture, Environment and Labour, HPP, and Fisheries and Aquaculture have worked collaboratively to develop a framework for joint decision-making and strengthen environmental health protection.

One DHPP publication, *Healthy People, Healthy Communities: Using the Population Health Approach in Nova Scotia*, illustrates some of the key lessons learned from organizations in Nova Scotia that have applied a population health approach to their work:

- Considering different perspectives on a problem can enrich its solution. Therefore the population health approach is most successful if it involves many people and organizations. Complex actions to affect the root causes of illness and the conditions that create health are more likely to succeed when partners from many sectors work together.
- It is important to allow enough time to build effective partnerships. Implementation of a population health approach requires the creation of opportunities for people to meet, plan, and collaboratively support activities on an ongoing basis.
- Because moving actions "upstream" (from local community to a region, for example) requires resource reallocation, it is important to involve policy-makers in planning population health strategies. Changing the way resources are allocated is easier if those who make decisions about resources are involved early in the planning process.
- Language/terminology must not stand in the way of building successful partnerships across sectors. Sometimes what people in the health sector refer to as the population health approach is referred to by other terms (community economic development, for example) by people in different sectors, important potential partners, who are equally concerned with the relationship between income and health status and the well-being of communities.
- The expertise of community members is an essential ingredient in planning and implementing population health strategies. Strategies vary from providing programs and services, to influencing the creation of public policy to foster healthy physical and social environments.
- Evaluation of actions affecting population health is important to help build the body of evidence about the strategies that influence the determinants of health.[116]

[116] Government of Nova Scotia, Department of Health Promotion and Protection, *Healthy People, Healthy Communities: Using the Population Health Approach in Nova Scotia*, no date. http://www.gov.ns.ca/hpp/publichealth/content/pubs/Population%20Health%20Approach.pdf.

Nova Scotia has endorsed the Health Goals for Canada[117] and the DHPP has signalled its commitment to upholding them in its policies and programs. To date it has not, however, indicated if targets will be established and, of so, how progress toward them will be monitored.

The public health review in 2006 also noted the need to expand the limited focus of the 2004 *Health Protection Act* to address the remaining public health functions (population health assessment, health surveillance, health promotion, and disease and injury prevention), and associated approaches and accountabilities. Its recommendation was, however, that the legislative update be sequenced later in the overall implementation of system renewal in order to provide time for experience with the various actions recommended in the report to inform the development of comprehensive public health legislation.[118] The provincial government has agreed that the overall public health renewal and restructuring process currently underway will take some time to unfold.[119]

In October 2007, the government announced a series of consultations seeking community input on how best to tackle poverty throughout Nova Scotia. These consultations constitute one component of the government's development of an anti- poverty strategy for Nova Scotia. This initiative will be co-led by the departments of Community Services and Environment and of Labour.[120]

7.3 MONITORING AND EVALUATION

Following regionalization and the creation of DHAs and CHBs, a study was conducted to study the extent to which a population health approach actually influenced health policy development at the regional level between 1997 and 2001. CHBs were expected to apply the determinants of health in formulating their annual plans and recommendations to DHAs. The study found, however, little evidence of guidance or consistency in the development of recommendations as well as confusion among both CHBS and the DHAs as to how the CHB recommendations were to be integrated into the DHA business plans. Furthermore, the disconnect between the CHB goals, which

(117) Public Health Agency of Canada, *Health Goals for Canada*. http://www.phac-aspc.gc.ca/hgc-osc/home.html.

(118) Government of Nova Scotia, Health Promotion and Protection, *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians*, 2006, http://www.gov.ns.ca/hpp/publichealth/content/pubs/07148_therenewalofphinnsreport_apr06_en.pdf

(119) Government of Nova Scotia, Department of Health Promotion and Protection, *2007-2008 Business Plan*, 22 March 2007, p. 5, http://www.gov.ns.ca/hpp/repPub/HPPBusinessPlan07-08.pdf.

(120) Government of Nova Scotia, Department of Community Services, "Government to Hold Poverty Reduction Consultations," *News Release*, 10 October 2007, http://www.gov.ns.ca/news/details.asp?id=20071010003.

highlighted health promotion and population health, and the DHAs' focus on primary, acute care and hospital-based services, both led to and highlighted the absence of support for population health approaches in the plans of the DHAs. The study recommended creation of a province-wide framework for population health as well as provincial legislation making it clear that community health plans must be incorporated into regional planning in order to address the issues affecting population health. Nevertheless, the CHB community health planning process is regarded as a positive mechanism to facilitate community input and create a sense of community ownership of what happens locally to affect positively the social determinants of health.[121]

As a component of public health sector renewal, DHPP is planning in 2007-2008 to begin a multi-year, phased development of a strong science-based decision and program support unit with expertise in population health assessment, communicable and chronic disease and injury surveillance, program and policy evaluation, epidemiology, and research. It is expected that this unit will provide an evidentiary basis for demonstrably cost-effective policies and programs that are appropriately targeted and efficiently delivered.[122]

Publicly initiated in January 2005, Nova Scotia Community Counts is a division of the Nova Scotia Department of Finance, established to develop the infrastructure to provide statistical information about Nova Scotian communities. It is an adaptation of the Newfoundland and Labrador government's Community Accounts, a program launched in 2002 to support that province's Strategic Social Plan.[123]

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(121) Christopher Dawson, Thomas Rathwell, Cari Paterson, et al., *Determining the Impact of the Population Health Approach by Community Health Boards in Nova Scotia*, Dalhousie University School of Health Services Administration.

(122) Government of Nova Scotia, Department of Health Promotion and Protection, *2007-2008 Business Plan*, 22 March 2007, p. 5, http://www.gov.ns.ca/hpp/repPub/HPPBusinessPlan07-08.pdf.

(123) http://www.gov.ns.ca/finance/communitycounts/aboutus.asp.

Community Counts is designed to support the planning and evaluation of policy and program interventions. In relation to health, Community Counts can provide information on a range of health determinants, such as income, social support networks, working conditions and physical environments. The Community Counts database has links with other components of the health care system and with related sectors and aspects of provincial and community development.[124] It can be used to track population health indicators and monitor policies and programs that impact population health.

[124] http://www.gov.ns.ca/finance/communitycounts/documents/NS%20Community%20Counts%20 brochure.pdf.

CHAPTER 8: ONTARIO[125]

8.1 MAIN FINDINGS

- High-level leadership laid the groundwork for the application of population health approaches in the late 1980s and early 1990s, but a change in government and fiscal retrenchment resulted in little action on them.

- The creation of Local Health Integration Networks in 2006 has allowed some regions to apply a population health lens to the planning and delivery of health services.

- A series of early childhood development and childcare initiatives, notably the Ontario Early Years Centres, are rooted in the understanding of early childhood development as an important determinant of health.

- Although the fundamental principles of population health are well-known among government players, provincial health care organizations and many providers of health care, translating this understanding into successful policy, program and/or practice changes continues to be a challenge in Ontario.

8.2 DEVELOPMENT AND IMPLEMENTATION

Population health emerged as a policy interest in Ontario through the late 1980s and early 1990s together with a growing understanding of the determinants of health and the need to invest in flexible and coordinated ways in the broad range of factors affecting health that cut across sectors and jurisdictions. Unfortunately this was coincident with financial restraint and increasing efforts to control escalating health care costs.

The Premier's Council on Health Strategy (PCHS) was created in 1987 with the mandate of selecting health goals for Ontario, informing the development of healthy public policies, and the identifying policies to shift the focus away from health care to health promotion and disease prevention.[126] Chaired by the Premier, joined by seven other Cabinet ministers as well as academic

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[125] The information presented in this chapter is based on a paper commissioned by the Subcommittee and prepared by Bev Nickoloff, *Ontario's Experience in Adopting and Implementing a Population Health Paradigm,* September 2007.

[126] Ann Pederson and Louise Signal, "The Health Promotion Movement in Ontario: Mobilizing to Broaden the Definition of Health," in Ann Pederson, Michel O'Neill and Irving Rootman, *Health Promotion in Canada: Provincial, National and International Perspectives*, Toronto: W.B. Saunders Canada, 1994.

physicians and representatives of health interest groups, and the business, labour and consumer sectors, the PCHS developed a *Vision of Health* and a series of provincial *Health Goals* to advance acceptance of the population health approach. The health goals included: 1) Shift the emphasis to health promotion and disease prevention; 2) Foster strong and supportive families and communities; 3) Ensure a safe, high quality physical environment; 4) Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death; and 5) Provide accessible, affordable and appropriate health services for all. Three broad areas, healthy child development; labour market adjustment; and environmental policy, were identified as requiring policy intervention to improve health.(127)

Despite the fact that all three political parties endorsed the PCHS's *Vision of Health* and *Health Goals* in the Legislature in 1991, translation of these objectives into concrete policy changes or significant shifts in resource allocation patterns did not follow.

Following a change in government in 1990, PCHS was given an expanded mandate, a new structure, and a new name – Premier's Council on Health and Well-being and Social Justice (PCHWSJ). The new PCHWSJ focused on providing the government and the public with research and advice on how to build a healthy, just society. It launched a broad public education campaign to "popularize" information on the determinants of health and to mobilize individuals and communities to take greater control over those conditions that affect their health and well-being. In 1994, PCHWSJ recommended a Health for All Ontarians policy, placing the determinants of health at the top of the government's political agenda. Key to this approach were recommendations to shift resources from cure and treatment to the prevention of illness, as well as the incorporation of a health impact assessment in all Cabinet submissions.(128)

A key initiative undertaken by the PCHWSJ was to identify policy priorities for a particular population group: children and youth. This focused on leading indicators of healthy development, the environments involved, and key determinants of health related to four transition

(127) Premier's Council on Health Strategy, Healthy Public Policy Committee, *Nurturing Health: A Framework on the Determinants of Health*, March 1991.

(128) Premier's Council on Health, Well-being and Social Justice, *Health for All Ontarians: A Provincial Dialogue on the Determinants of Health*, 1995.

phases in child and youth development. These were used to establish priorities and identify strategies to raise a generation of healthy children.

Following the election of another new government in 1995, the PCHWSJ was disbanded and no government ministry was formally assigned the leadership role to continue work on population health.

Building on the work on early childhood development done by the Premier's Councils, in 1998 the government commissioned a report from Dr. Fraser Mustard and the Honourable Margaret McCain inviting recommendations on how the province could best support and most positively impact young children. The resultant *The Early Years Study* led to establishment of 103 Ontario Early Years Centres (OEYCs) that offer: early learning and literacy programs for parents and children; programs to help parents and caregivers in all aspects of early child development; programs on pregnancy and parenting; links to other early years programs in the community; and outreach activities to encourage parents to get involved with their local Centre.[129] Other programs developed in the following years to improve child's health include the Healthy Babies, Healthy Children program which screens all new mothers to ensure they get the supports they need to support the healthy growth and development of their children[130] and the Best Start Plan intended to expand the number of licensed child care spaces, increase access to subsidies, attract and retain qualified child care workers and develop other early learning and child care supports.[131]

In 2005, the Ministry of Health Promotion was created to foster a culture of health and well-being leading to reduction of the burden on the provincial health care system. The Ministry's programs and policies integrate prevention of chronic disease, health promotion, and sport and recreation programs to promote improved long-term health outcomes[132] in collaboration with communities and through partnerships across all levels of government and with the private sector to influence policy development, program design and service delivery.

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[129] Government of Ontario, *What is an Ontario Early Years Centre?* http://www.ontarioearlyyears.ca/oeyc/en/Questions/Whatis.htm

[130] Pegeen Walsh, Ontario Ministry of Health Promotion, *Evidence*, 6 February 2008.

[131] Ontario Ministry of Children and Youth Services, "McGuinty Government Expands Best Start Plan for Children," *News Release*, http://ogov.newswire.ca/ontario/GPOE/2005/07/28/c5315.html?lmatch=&lang=_e.html

[132] Ontario Ministry of Health Promotion, *Results-Based Plan Briefing Book, 2007-08*, http://www.mhp.gov.on.ca/english/resultsplan/RbP_BriefingBook_2007-08.pdf

The *Inter-Ministerial Committee on Healthy Living* is an example of the intersectoral approach of the Ontario government. Led by the Minister of Health Promotion, the Committee is made up of the Ministers of Agriculture, Food and Rural Affairs; Children and Youth Services; Community and Social Services; Education; Environment; Health and Long-Term Care; Labour; and Municipal Affairs and Housing. It is mandated to: 1) Provide a forum to address complex issues that impact health and well-being and identify strategies for resolution; 2) Identify opportunities and approaches to increase health promotion in a range of settings (e.g., recreation centres, child care centres, schools, workplaces); and 3) Identify opportunities to leverage resources through the development of partnerships with the private sector. Experts believe that creation of this Committee constitutes a positive breakthrough and provides a long-overdue mechanism to coordinate policies affecting population and individual health.

The Ministry of Health Promotion has also been involved in a cross-government research initiative to examine persistent disparities in the health of segments of the population. The Equity in Health and Human Services Strategic Research Initiative is led by the Ministry of Health and Long-Term Care which recognizes that the levers to reduce health disparities are found primarily in other sectors: housing, education, child and youth services, labour market attachment, immigration and settlement, and corrections. The initiative seeks to lay the foundation of a sustainable, horizontal approach to developing and implementing health and human services policy, and the identification of tools to guide ministries in their investment in health and human service programming.[133]

In 2006 the government created fourteen Local Health Integration Networks (LHINs), organizations to plan, integrate and fund regional health services including hospitals, community care access centres, home care, long-term care and mental health.[134] LHINs are to work from a population health perspective and use Population Health Profiles produced by the Ministry of Health and Long-Term Care which present health indicators, health services market-share and utilization, and socio-demographic determinants of health. At least one LHIN, Toronto Central, has used a population health

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[133] Pegeen Walsh, Ontario Ministry of Health Promotion, *Evidence*, 6 February 2008, and Brief submitted to Subcommittee.

[134] Ontario Ministry of Health and Long-Term Care, *Incorporating a Population Health Approach in Health Planning and Priority Setting*, Population Health Policy and Planning and Women's Health Branch, June 2006, http://www.blogs.opc.on.ca/wp-content/uploads/2007/07/populationhealthinontariofinal17jul2006.pdf

lens in planning how to integrate its services.[135] The Champlain Region LHIN is taking a population health approach to chronic disease prevention, but has found it a challenge to reallocate resources from health services to address the broader determinants of health.[136]

In September 2007, the provincial government implemented a Health-Based Allocation Model to allocate funding to the LHINs. This model will base each LHIN's share of funding on direct measures of health status and such population-based factors as age, gender, socio-economic status, rural geography and patient flows.

8.3 MONITORING AND EVALUATION

While the LHINs can take a population health perspective in their planning and partnerships, access to reliable, timely data has been identified as a challenge for those LHINs which wants to track a range of socio-economic indicators s to conduct its planning on a population health basis.[137] Not only are the data sparce, so also are the data analysis and interpretation capacity required to support regional and sub-regional planning.[138]

At least two non-governmental organizations are notable for their contribution to information on population health in Ontario. The Institute for Work and Health has played an important role in advancing understanding of the effects of work as a determinant of health, including the causes of work-related disability, optimal approaches to return-to-work, and the adequacy and equity of income security benefits in Canada. The current priority of the Ontario Prevention Clearinghouse is to demonstrate the importance and cost-effectiveness of prevention and health promotion strategies, with specific emphasis on early childhood development, chronic disease prevention, and social inclusion. In 2007, it released *Primer to Action*, a resource to help practitioners concerned about the social determinants of health identify beneficial actions.[139]

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(135) Laura Pisko-Bezruchko, Toronto Central Local Health Integration Network, *Evidence*, 6 February 2008.

(136) Dr. Andrew Pipe, University of Ottawa Health Institute, *Evidence*, 6 February, 2008.

(137) Laura Pisko-Bezruchko, Toronto Central Local Health Integration Network, *Evidence*, 6 February 2008.

(138) Ontario Ministry of Health and Long-Term Care, *Incorporating a Population Health Approach in Health Planning and Priority Setting*, Population Health Policy and Planning and Women's Health Branch, June 2006, http://www.blogs.opc.on.ca/wp-content/uploads/2007/07/populationhealthinontariofinal17jul2006.pdf

(139) Ontario Chronic Disease Prevention Alliance, Ontario Prevention Clearinghouse and the Canadian Cancer Society, *Primer to Action : Social Determinants of Health*, March 2007. http://www.ocdpa.on.ca/rpt_PrimertoAction.htm

CHAPTER 9: PRINCE EDWARD ISLAND

9.1 MAIN FINDINGS

- Prince Edward Island adopted a population health perspective in 1993 and enshrined its population health policy in the *Health and Community Services Act* which identified the mechanisms through which population health policy would be implemented – regional governance and block funding.

- With this legislation, Prince Edward Island became one of the first jurisdictions in Canada to shift resources with the goal of addressing the determinants of health.

- The integration and coordination of a broad array of health, social and community services under regional authorities was an attempt to increase efficiency, emphasize the range of factors that determine health, and bring the planning and delivery of services closer to communities in order to meet local needs.

- Intersectoral collaboration and reallocation proved to be a long term process and a multi-staged policy objective. Partnerships, integration and informal resource shifts are created and are accomplished only slowly.

- Barriers to the implementation of population health policy proved to be both structural and systemic, involving public perception, union agreements, turf protection in the health care field, reduced level of funding and repeated organisational changes.

9.2 DEVELOPMENT AND IMPLEMENTATION

The development and implementation of population health policy in Prince Edward Island was initiated in 1991 when the provincial government established a task force to consider the future of health, social and community services. At that time, the health care system and many social and community services were managed province-wide by government departments, agencies and boards; there were widespread concerns about rising costs and greater service utilization, the effectiveness of services in meeting peoples' needs, and a lack of community involvement in decision making.

In *Health Reform: A Vision for Change*, a Task Force concluded in 1992 that healthy public policy was lacking in Prince Edward Island and that there was little coordination of health policy development with other sectors of government such as education, youth and environment. It recommended a new vision based on a population health approach emphasizing wellness promotion,

need-based planning, community-based services, and local involvement in the planning and delivery of an integrated broad set of health and social services. It also recommended establishment of a provincial health policy council to develop health goals and policies, and to encourage healthy public policy among all government sectors.[140]

The government responded positively and a Health Transition Team was established to plan for implementation of the Task Force's recommendations. In *Partnerships for Better Health*, released in 1993, the Team clearly acknowledged the need to address the broad range of health determinants through a population health approach. It also highlighted the need for health promotion and recognized that primary health care should be based partly on the integration of health, social and economic development. It recommended regionalization of health and social services, development of a resource centre for health promotion, development and implementation of community needs assessment by the new regional authorities, and establishment of a pilot community health centre project.[141]

In the same year the legislature passed the *Health and Community Services Act*, decentralizing significantly the organizational structure supporting the delivery of health, social and community services in the province. It created five regional authorities, with the responsibility of assessing their population's health needs, setting priorities, allocating budgets, employing service providers, and managing and delivering a wide range of health and social services including: hospital services, home care, mental health, public health, addiction services, child welfare, income security, public housing, job creation and employment enhancement, seniors' social services, community development, probation and correctional services, and various other health and social services (prescription drugs, physician services and education were not included). Each regional authority was given funding for all services combined in the form of a block budget.[142] Block funding was intended give regional decision makers the flexibility to address the broad determinants of health through

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[140] Task Force on Health, *Health Reform: A Vision for Change*, PEI Cabinet Committee on Government Reform, Government of Prince Edward Island, March 1992.

[141] Health Transition Team, *Partnerships for Better Health*, Government of Prince Edward Island, June 1993.

[142] Prince Edward Island, *Health and Community Services Act*, Assented to 1993 and repealed in 2005.

program management and resource allocations that responded to local needs. No other Canadian jurisdiction has devolved authority for such a broad array of combined health and social services.[143]

The Act also created two new central agencies, the Health Policy Council to set broad health goals and provide advice to the Minister, and the Health and Community Services Agency to define the core services that the regions would be required to provide, set regional budgets and human resource policies, and provide the regional authorities with program development support.

The Health Policy Council released its draft health goals in 1994 for broad distribution and discussion:

1. A new understanding of health – based on health determinants, with a greater focus placed on health promotion and disease prevention.
2. Healthy individuals, families and communities – to build strong and supportive families and communities.
3. A healthy environment – to preserve and promote healthy and safe physical environments.
4. Quality in health and community services – to provide appropriate, accessible and sustainable health services and ensure that resources are managed fairly and wisely.
5. Healthy public policy – public policy in social, economic, cultural and physical environments has a powerful influence on health. Health impact assessments must be undertaken by other sectors of public policy.[144]

For its part, the Health and Community Services Agency released its strategic plan in 1995. It included four goals:

1. To strengthen families, individuals and communities, with a focus on early childhood development, communicable disease control and at risk population groups.
2. To provide an integrated range of health services – client-based, accessible and affordable with an emphasis on the broad determinants of health.
3. To develop human resources within the health care system and to utilize all providers in the most appropriate ways.
4. To build efficiencies and effectiveness in health care delivery.[145]

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(143) Jonathan Lomas, John Woods and Gerry Veenstra, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the Issues," *Canadian Medical Association Journal*, Vol. 156, Issue 3, February 1997, pp. 371-7, http://www.cmaj.ca/content/vol156/issue3/.

(144) Health Policy Council, *Draft Health Goals for Prince Edward Islanders*, Government of Prince Edward Island, Discussion paper, December 1994.

(145) Health and Community Services Agency, *Health and Community Services System – Provincial Plan*, Government of Prince Edward Island, June 1995.

In 1997, to make regional decision makers directly accountable to the Minister the Health Policy Council was eliminated and the Health and Community Services Agency was amalgamated with the Department of Health and Social Services. The regional authorities were also relieved of responsibility for probation and correctional services. Yet, acute care, home, long term and continuing care, public housing, social services, addiction, child welfare, employment enhancement and income security remained in the single regional global budget envelope.

In 2001, the government released its *Strategic Plan for the Prince Edward Island Health and Social Services System*. Although the broad set of health determinants were recognized, the Strategic Plan focused heavily on the demand and supply of health care, individual responsibility for health, and public confidence in the health care system. It proposed six new health goals:

1. Improve the health status of the population.
2. Increase personal responsibility for health.
3. Improve sustainability of the system.
4. Improve public confidence in the system.
5. Improve workplace wellness and staff morale.
6. Maintain other results at current levels.

The Strategic Plan identified various health status indicators by which to measure and report regularly on progress in relation to each goal.[146] The first report was released in January 2003, a second in December 2004, and the most recent report in October 2006.[147]

The Strategic Plan also enumerated a set of wellness initiatives, announced the creation of a provincial child development strategy, and directed increased partnerships with other departments and agencies, with communities, NGOs, health professionals and the private sector to address the determinants of health. Its wellness initiatives focused on disease prevention, the promotion of healthy lifestyles, wellness for seniors, healthy public policy, public and employee wellness recognition, and support for low income families. The Strategic Plan did acknowledge that additional strategies would be needed to reduce health disparities.

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[146] Department of Health and Social Services, *Pathways to Wellness and Sustainability – Strategic Plan for the Prince Edward Island Health and Social Services System, 2001-2005*, Prince Edward Island Government, December 2001, http://princeedwardisland.com/publications/getpublication.php3?number=711.

[147] Department of Health, *Prince Edward Island Health Indicators*, Prince Edward Island Government, October 2006, http://www.gov.pe.ca/publications/getpublication.php3?number=1355.

In 2002, the provincial government removed responsibility for hospital care and addiction services from the regional authorities, transferring it to the newly formed Provincial Health Services Authority. Then, in 2005, a major reorganization of the health and social services system was announced, ending the regional approach to implementing population health policies and programs in Prince Edward Island. The regional authorities were brought together with the Provincial Health Services Authority as one system under the Department of Health. Community Hospital Boards were established to oversee, manage and plan for community hospitals. A separate Department of Social Services and Seniors was created to focus on children, social services and the special needs of seniors. The government estimated that these changes would result in cost savings of $9 million each year through reduced overlap, duplication and administration.[148] This reorganization implemented alternative mechanisms for program delivery and resource allocation that, to some extent, impacted negatively the province's focus on population health.

Currently, the Department of Health works with stakeholders to promote health and prevent illness through several collaborative, intersectoral approaches to some health determinants. These include the Strategy for Healthy Living (launched in 2003), the Cancer Control Strategy (since 2004) and the Healthy Child Development (with the Department of Social Services and Seniors).[149]

9.3 MONITORING AND EVALUATION

While the *Health and Community Services Act* did not include a provision for monitoring and evaluation, three research projects monitored the reforms and assessed their impact. A joint funding agreement between the federal (Health Canada) and provincial (Department of Health and Social Services) governments led to the establishment of a small group in the latter department known as the System Evaluation Project (SEP). Between 1997 and 1999, SEP developed protocols and guidelines to assist in the evaluation of the cross-sectoral reallocation of resources resulting from the 1993 reform; it also produced a summary document.[150][151] Another research project was jointly

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[148] Government of Prince Edward Island, *Provincial Budget – Backgrounder: Health and Social Services*, April 2005, http://www.gov.pe.ca/budget/2005/backgrounders/health/index.php.

[149] Ministry of Health, *Annual Report for the Year Ending March 31, 2006*, Government of Prince Edward Island, 2006.

[150] The System Evaluation Project produced eight reports: *A Guide to System Evaluation: Assessing the Health and Social Services System in PEI* (1997); *A Conceptual Framework for Cross-Sectoral Reallocation of Resources for*

funded by the Canadian Health Services Research Foundation, the McMaster Institute of Environment and Health and the provincial Department of Health and Social Services.[152] More recently, a third group of Canadian researchers reported their findings on the Prince Edward Island experience with population health policy over the 1993-2001 period.[153] The evidence is summarized below:

- The objectives of the reform were clear: to move away from an emphasis on health care toward a focus on the non-medical determinants of health. Within health care, there was also a desire to move away from institutional toward community-based care.

- Although a population health approach figured prominently in the objectives, the reform documents identified several other equally important objectives including more primary health care, improved effectiveness and efficiency through service coordination and integration, need-based planning, increased personal responsibility for health, and increased community involvement in decision making.

- Policy makers in different government sectors involved in the reform saw the importance of the objectives differently. Whereas the Health Policy Council gave priority to addressing the determinants of health, the Health and Community Services Agency focused on fostering community development, improving integration and coordination, and reducing duplication of services. The department of Health and Social Services, influenced by the government's fiscal concerns, emphasized the need for improvements in both the effectiveness and efficiency of health service delivery.

- At the regional level, the pursuit of so many goals simultaneously affected resource reallocation in two ways. Their sheer number divided the attention of decision-makers among multiple, often competing, objectives, all seemingly of equal importance. Moreover, that some goals (such as improving administrative efficiency) were easier to achieve than others (such as reallocation), probably explained why regional managers moved more slowly on the latter.

- Regionalization required the adjustment and renegotiation of labour agreements, and allowing for the transition of employees from government departments and central or provincial agencies to the regions. This required considerable time.

Health (1998); *Data Collection Instruments for Evaluating Health and Social Service Systems* (1998); *Decision Support Tools for Cross-Sectoral Investments in Population Health in the Context of Health System Change* (1998); *Facilitating Staff Involvement in the Shift to Cross-Sectoral Reallocation* (1998); *Preparing for Media Communications about Cross-Sectoral Reallocation* (1998); *Scan and Plan: Meeting and Managing Potential Challenges to Cross-Sectoral Reallocation* (1998); and *Summary of Results* (1999).

(151) In 1999, the provincial government decided that it was time for action rather than further study. Accordingly, SEP was reorganized and its staff members were assigned other evaluation responsibilities.

(152) John D. Eyles, Greg L. Stoddart, John N. Lavis, Tina Pranger, Laurie Molyneaux-Smith and Colin McMullan, *Making Resource Shifts Supportive of the Broad Determinants of Health: The PEI Experience*, Canadian Health Services Research Foundation, January 2001, http://www.chsrf.ca/final_research/ogc/pdf/eyles_report.pdf.

(153) Greg L. Stoddart, John D. Eyles, John N. Lavis and Paul C. Chaulk, "Reallocating Resources across Public Sectors to Improve Population Health," Chapter 12 in *Healthier Societies – From Analysis to Action*, 2006, pp. 327-47.

- The shifting of resources necessary to develop and implement population health policy is a long term process that can only be facilitated through a long standing commitment to it. The period of the reform, from 1993 to 2001, may not have provided time sufficient for the necessary adjustments and reallocation to take place, nor for them to have any significant impact on health.

- In principle, block funding provided the flexibility to shift resources between the various sectors affecting health and afforded wide scope for reallocation at the regional level. In practice, however, reallocation was limited by three factors. First, the envelopes were allocated to regional authorities based largely on the historical flow of funds, not according to assessment of the respective needs of the regional populations. Second, block funding continued to be reported in governmental budget documents on a line-by-line (i.e., by program) basis, thereby creating rigidities from the outset. And third, cuts to federal transfer payments led to fiscal retrenchment by the provincial government immediately following implementation of the reform; this reduced the discretionary room available to the regions after providing core services and weakened their effectiveness in reallocating resources.

- Regional governance facilitated cross-sectoral reallocation to some extent; it helped ensure intra-regional partnership, integration, coordination and enhanced accountability at the community level. It did, however, diminish inter-regional cooperation.

- Although the reform generated an organizational culture supportive of population health, the regional authorities perceived that the general public needed more time and education to understand fully the shifting of resources particularly away from acute care. The public's reaction to the possibility of reallocating resources away from health care suggested a deeply rooted belief in the importance of health care relative to the impact of social and economic determinants. Education of the public to correct that misperception is essential to support reform.

- The interests of physicians, hospital workers and other service providers also played a role in determining the reform's pace of change. Although some providers, such as those in community care or social service sectors, saw themselves or their sectors as "winners", most workers in the largest sector – institutional care – were concerned about the risk of job losses and/or changes to their working conditions. From the outset, their opposition was strong and vocal.

- For these reasons, reallocation was affected by political concerns, public opinion, changing budget levels, turf protection in the health care field and union agreements and was very difficult to achieve. Regional managers found it extremely difficult to implement major changes to move resources "to upstream prevention from downstream rescue." Such reallocation as did occur involved, in part, staff, space, equipment and information rather than financial resources.

- Evaluation of efforts to shift resources, to assess their impact and the satisfaction of patients and clients could have helped win acceptance and approval of the concept.

- Prince Edward Island has been a pioneer among the provinces and territories in establishing mechanisms to achieve resource shifts supportive of population health.

CHAPTER 10: QUÉBEC

10.1 MAIN FINDINGS

- Québec adopted a public policy approach based on population health in 1992. This approach was innovative at the time, since it called for the involvement of all sectors of government and society in an intersectoral approach designed to improve health and reduce health disparities.

- This policy was renewed and strengthened in 2001 with passage of the *Public Health Act*, one purpose of which was to put in place a government-wide policy based on population health. Section 54 of the Act, which is internationally recognized for its innovative character, assigns to the minister of health and social services the power to initiative and issue advice proactively to other ministers for the purpose of promoting and supporting policies that foster the health of the population.

- Section 54 also obliges government departments and agencies to analyze the health impacts of the proposed laws and regulations. To that end, the department of health and social services has prepared a guide which describes the steps to follow in conducting health impact assessments.

- The *Public Health Act* and the provincial public health program that is its result empower the health sector to influence policy development. The main challenge is to persuade departments whose programs impact on the non-medical determinants of health to participate in the development of healthy public policies.

- Québec's population health policy also emphasizes the need to reduce income inequalities. In 2002, the National Assembly passed the *Act to combat poverty and social exclusion*, which is intended to reduce poverty progressively over a period of ten years. As for the reduction of health disparities, here too intersectoral action is essential.

10.2 DEVELOPMENT AND IMPLEMENTATION

Development of Québec's population health policy was undertaken in the wake of the international "Health for All" movement launched in the early 1980s under the auspices of the World Health Organization. In 1984, the Conseil des affaires sociales et de la famille [Council on social affairs and the family] submitted to the government *Objectif santé,* the report of its Comité d'étude sur la promotion de la santé [Working committee on health promotion]. This report profiled the status of health in Québec, examined the principal determinants of health, formulated health and well-being objectives, and proposed actions based on the population health approach.(154) Similarly, in a report

(154) Comité d'étude sur la promotion de la santé, *Objectif santé*, Conseil des affaires sociales et de la famille, Gouvernement du Québec, 1984.

tabled in 1988, the later Commission d'enquête sur la santé et les services sociaux [Commission of inquiry on health and social services] proposed the adoption of six major orientations, including a government-wide policy based on population health that was presented as an "[translation] indispensable corollary to an evidence-based approach."[155]

In response, the Québec department of health and social services (MSSS) adopted in 1992 its *Policy on Health and Well-being*. Resolutely oriented toward the population health approach, this policy assigned high priority to the non-medical determinants of health and clearly featured concern about health disparities and income inequalities in Québec. Regarded at the time as innovative, this was the first policy statement to call for the involvement of all sectors of government and the community in an intersectoral approach to a common goal. The *Policy on Health and Well-being* was founded on three principles: (1) health and well-being are influenced by ongoing interaction between the individual and the environment; (2) the maintenance and improvement of health and well-being depend on the balanced sharing of responsibilities among individuals, families, communities, public authorities, and society as a whole; (3) the population's health and well-being is a fundamental societal investment. The strategies proposed were designed to: (1) encourage reinforcement of each individual's potential; (2) provide support in social settings and develop safe environments; (3) improve living conditions; (4) act for and with groups at risk; (5) coordinate the policies and strategies of all departments toward these ends; and (6) reorient the health care system toward the most effective and least costly solutions.[156]

In 1997, the MSSS published *Québec Priorities in Public Health 1997-2002*. This policy paper was intended to define better the health sector's contribution to the objectives proposed under the *Policy on Health and Well-being*. In addition to an increased commitment to reducing health disparities and income inequalities,[157] seven priorities were adopted: (1) development and social adjustment of children and youth; (2) diseases preventable by immunization; (3) HIV-AIDS and sexually transmitted diseases; (4) breast cancer screening; (5) smoking; (6) unintentional and intentional injury; and (7) alcoholism and drug addiction.

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(155) Commission d'enquête sur la santé et les services sociaux, *Rapport final*, Gouvernement du Québec, 1988.

(156) Ministère de la Santé et des Services sociaux, *The Policy on Health and Well-being*, Government of Québec, 1992, http://www4.banq.qc.ca/pgq/2007/3256156.pdf.

(157) Ministère de la Santé et des Services sociaux, *Des priorités nationales de santé publique, 1997-2002*, Gouvernement du Québec, 1997, http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1996/96_203.pdf.

An evaluation conducted at the end of the decade (1992-2002) covered by the *Policy on Health and Well-being* revealed that the health sector and the entire community had been encouraged to adopt a more comprehensive vision of health and its determinants and to focus on certain common objectives related to health and well-being. It also showed that the policy had successfully mobilized and structured community action, essential in the population health approach. Other positive effects of the *Policy on Health and Well-being* were the development of indicators of health and well-being and increased financial support for population health research. The participation by governmental sectors other than health and social services, however, were notably lacking and MSSS was criticized for its lack of leadership in securing the support of other government departments and agencies; the government as a whole was faulted for the absence of a formal commitment to require and facilitate the support of all its departments and to advocate intersectoral action. Finally, the evaluation recommended renewal of the policy with emphasis being put specifically on active participation of sectors whose programs have important impacts on the non-medical determinants of health.(158)

In 2001, the National Assembly passed the *Public Health Act*, one of the objectives of which is to establish a government-wide policy based on the health of the population.(159) Section 3 in particular refers explicitly to a population health approach, which calls for "means of exerting a positive influence on major health determinants, in particular through intersectoral coordination." Furthermore Section 54, also internationally recognized for its innovative character, provides major leverage to develop government-wide policy based on population health through obliging all departments to analyse the health impacts of their proposed laws and regulations. It also assigns to the minister of health and social services the power to issue proactive advice to other ministers with the goal of promoting health and supporting the adoption of policies that foster the health of the population.(160) In addition, Sections 53, 55 and 56 assign public provincial, regional and local health authorities responsibility for the determinants of health by encouraging intersectoral collaboration.(161)

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(158) Ministère de la Santé et des Services sociaux, *La Politique de la santé et du bien-être: une évaluation de sa mise en œuvre et de ses retombées sur l'action du système socio-sanitaire québécois de 1992 à 2002*, Gouvernement du Québec, 2004, http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/4b1768b3f849519c852568fd0061480d/c955d244287edd8c85256ed20069e1b5?OpenDocument.

(159) Government of Québec, *Public Health Act*, .R.S.Q., ch. S-2.2, 2001, http://www.canlii.org/eliisa/highlight.do?language=en&searchTitle=Québec&path=/qc/laws/sta/s-2.2/20070813/whole.html.

(160) "The Minister is by virtue of his or her office the advisor of the government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population. In the Minister's capacity

In response to the *Public Health Act*, the MSSS launched in 2002 the *Québec Public Health Program 2003-2012*. This program proposed five strategies: (1) strengthen the potential of individuals; (2) support community development; (3) participate in intersectoral actions that support health and well-being; (4) support vulnerable groups; and (5) encourage use of effective clinical preventive practices.(162) Experts say that the program is too new to assess the effects of its implementation, but that it has good potential given the legislative instruments advanced to encourage interdepartmental collaboration in the development of public policies to enhance the health of the population.(163)

10.3 MONITORING AND EVALUATION

While the adoption of Section 54 was an important step toward the development of policies favourable to health, its implementation presents major challenges which are addressed by a guide to the assessment of the potential effects on health and well-being of the various proposed laws and regulations,(164) prepared by MSSS, for government departments and agencies. An intergovernmental process has also been established to facilitate conducting these assessments. It has three objectives: (1) to permit government departments and agencies to assess the health impacts of proposed laws and regulations while they are being formulated; (2) to facilitate the adoption of

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as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have a significant impact on the health of the population."

(161) Louise St-Pierre and Lucie Richard, "Le sous-système de santé publique québécois et la promotion de la santé entre 1994 et 2006: progrès certains, ambiguïtés persistantes," chapter 10, *Promotion de la santé au Canada et au Québec, perspectives et critiques* (Les Presses de l'Université Laval, 2006), pp. 183-204.

(162) Ministère de la Santé et des Services sociaux, *Québec Public Health Program 2003-2012*, Government of Québec, 2003, http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/ed7acbc94b12630f852566de004c8587/f83fd818c4afad8085256e3800553476?OpenDocument.

(163) Nicole F. Bernier, "Québec's Approach to Population Health: An Overview of Policy Content and Organization," *Journal of Public Health Policy*, 27, 1 (2006), pp. 22-37.

(164) This guide includes two documents: (1) Ministère de la Santé et des Services sociaux, *Guide pour le dépistage – Processus d'évaluation des impacts sur la santé*, Gouvernement du Québec; (2) Ministère de la Santé et des Services sociaux, *Guide pour le cadrage et l'évaluation préliminaire – Processus d'évaluation des impacts sur la santé*, Gouvernement du Québec, http://msssa4.msss.gouv.qc.ca/fr/organisa/LoisRegl.nsf/77b66363fd8d8cad85256714005bc2fa/7c1ca76a4f0ac99085256b5d004dd0e9?OpenDocument.

measures to mitigate the negative effects of laws and regulations on health; and (3) to provide information when decisions are being made by government authorities.[165]

The *Public Health Act* also establishes different ways to monitor changes in the health status of the population and disseminate the resulting information, including in provincial reports. The first such report, released in 2005, notes: "The principal intersectoral means that are likely to influence the common determinants must target the following goals: to reduce poverty and inequalities, to preserve the physical environment, to foster the development of supportive communities, to support the adoption of healthy lifestyles and to support child and youth development."[166] It does not specify, however, how the intersectoral approach is to be mobilized and structured.

To support implementation of Section 54, the government also set up a research program to study public policies favourable to health and well-being. This program, under the aegis of the Groupe d'étude sur les politiques publiques et la santé [Task force on public policies and health], is the result of a partnership between the MSSS, the Institut national de santé publique du Québec, the Fonds de recherche en santé du Québec and the Fonds québécois de la recherche sur la société et la culture.[167]

Finally, in 2007 the MSSS published *La santé, autrement dit…*, addressed both to government departments and agencies and to community organizations, a tool intended to raise awareness of the determinants of health and to focus action on enhancing the health of the population. It offers a succinct profile of government programs and initiatives as they relate to eight major determinants of health: lifestyle, education, housing, transportation, urban planning, physical

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(165) For more information on this subject, see the following two documents: (1) Jean Turgeon, *L'adoption de politiques favorables à la santé pour le Québec*, Paper presented at the École nationale de santé publique, Rennes, France, 17 March 2005, http://www.gepps.enap.ca/fr/index.aspx?sortcode=1.15.19.22; and (2) Groupe d'étude sur les politiques publiques et la santé, *Santé, bien-être et formulation de politiques publiques au Québec : Huit études de cas – Résumés*, May 2007, http://www.gepps.enap.ca/gepps/docs/r%C3%A9sum%C3%A9s%20%C3%A9tudes%20de%20cas/vfresumes%20etudes%20de%20cas%20(8)_gepps_30mai2007.pdf.

(166) National Public Health Director, *Producing Health – National Report on the Health Status of the Population of Québec*, Government of Québec, 2005, http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-228-02A.pdf.

(167) Groupe d'étude sur les politiques publiques et la santé, http://www.gepps.enap.ca/fr/nouvelles.aspx?sortcode=1.15.22.

environment, social environment, and income.[168] It provides a good summary of the Québec government's effort to implement a government-wide population health based approach.

10.4 INTERSECTORAL ACTION PLAN TO COMBAT POVERTY

Under the 1992 *Policy on Health and Well-being*, the MSSS committed itself to partnering with other departments and agencies concerned by poverty and the social dependence it causes in order to formulate a government action plan to reduce poverty, with priority given to families with young children. Between 1993 and 2002, the MSSS, set up a number of committees charged with development of departmental policies to reduce income disparities and health inequalities.

In response to the recommendations of these committees, the government tabled in 2002 its *National Strategy to Combat Poverty and Social Exclusion*, drawn up around five major themes: (1) promoting personal empowerment; (2) strengthening the social and economic safety net; (3) promoting job access and employment; (4) mobilizing society as a whole; and (5) ensuring consistency and coordination of action at all levels.[169]

In the same year, the National Assembly passed the *Act to combat poverty and social exclusion*,[170] built around the intention to make Québec progressively (over a ten-year period) one among the industrialized nations with the least number of persons living in poverty. Its adoption makes Québec the second jurisdiction in the world (after France) to enact legislation to combat proverty through consistent and coherent interventions. Section 12 of the Act provides for the adoption of an action plan specifying how the government plans to achieve its goal. The *Government Action Plan to Combat Poverty and Social Exclusion* was released in 2004.[171] It contains measures to improve the

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(168) Ministère de la Santé et des Services sociaux, *La santé, autrement dit… Pour espérer vivre plus longtemps et en meilleure santé*, Gouvernement du Québec, 2007, http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/fb143c75e0c27b69852566aa0064b01c/1a165acb041a1e7a852572db004c26f3?OpenDocument.

(169) Ministère de l'Emploi et de la Solidarité sociale, *National Strategy to Combat Poverty and Social Exclusion – Policy Statement*, Government of Québec, 2002, http://www.mess.gouv.qc.ca/publications/index_en.asp?categorie=portail|cr|saca|sr.

(170) Government of Québec, *An Act to combat poverty and social exclusion*, R.S.Q., ch. L-7, 2002, http://www.canlii.org/eliisa/highlight.do?language=en&searchTitle=Québec&path=/qc/laws/sta/l-7/20070813/whole.html.

(171) Ministère de l'Emploi, de la Solidarité sociale et de la Famille, *Reconciling Freedom and Social Justice: A Challenge for the Future – Government Action Plan to Combat Poverty and Social Exclusion*, Government of Québec, April 2004, http://www.mess.gouv.qc.ca/publications/index_en.asp?categorie=portail|cr|saca|sr.

income of low-income persons and families, invest in social housing, initiatives to promote food security and other important measures for recipients of Employment Assistance. Finally, it also contains measures to adapt actions to the realities facing Aboriginal peoples.

One of the Act's requirements is for an annual report by the minister of employment and social solidarity on activities implemented under the Government Action Plan. While the 2006 report, prepared by no fewer than eight government departments and two government agencies,[172] presents no poverty indicators by which progress made since the passage of the Act might be assessed, it does underscore the importance of the intersectoral approach and of a commitment of society as a whole to achieving the goal.[173]

[172] Ministère de l'Emploi et de la Solidarité sociale, Ministère de l'Éducation, du Loisir et du Sport, Ministère de la Santé et des Services sociaux, Ministère de l'Immigration et des Communautés culturelles, Ministère de la Famille, des Aînés et de la Condition féminine, Ministère du Développement économique, de l'Innovation et de l'Exportation, Ministère du Travail, Ministère des Affaires municipales et des Régions, Société d'habitation du Québec and Secrétariat à la jeunesse.

[173] Government of Québec, *Year Two Report – Government Action Plan to Combat Poverty and Social Exclusion 2004-2009*, 2006, http://www.mess.gouv.qc.ca/publications/index_en.asp?categorie=portail|cr|saca|sr.

CHAPTER 11: SASKATCHEWAN[174]

11.1 MAIN FINDINGS

- Strong collaborative research and policy partnerships such as the Saskatchewan Population Health Promotion Partnership and Saskatchewan Population Health and Evaluation Research Unit have played a significant role in the evolution of population health approaches in Saskatchewan.

- The 2004 provincial Population Health Promotion Strategy requires regional health authorities to apply a population health promotion approach to four priority areas: mental well-being; accessible nutritious food; decreased substance use/abuse; and active communities.

- Key vehicles for intersectoral collaboration among provincial departments are the Human Services Integration Forum and, at a regional level, Regional Intersectoral Committees.

11.2 DEVELOPMENT AND IMPLEMENTATION

The development of population health policy in Saskatchewan has been shaped by a number of key initiatives dating back to when the health care sector was restructured in the early 1990s. The restructuring resulted in the creation of 30 district health boards (merged in 2002 into Regional Health Authorities (RHAs)) that were given the responsibility to plan, manage, integrate and deliver a range of health services in their districts, including: assessment of the health needs of the population served, assessment and case management of individuals, illness prevention, home-based services and hospital care. A needs-based formula was introduced to fund them.

Following extensive community consultations, the Saskatchewan Provincial Health Council released *Population Health Goals for Saskatchewan* in 1994. This recognized the broad range of factors that determine or influence health and provided a framework to improve the health status of people and communities in Saskatchewan. The goals were: 1) Reassess what determines health; 2) Social justice and equity; 3) Supportive families and communities; 4) A healthy physical environment; 5) Health promotion; and 6) Shared responsibility.[175]

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[174] The information presented in this chapter is based on a paper commissioned by the Subcommittee and prepared by Bev Nickoloff and entitled, *Saskatchewan's Experience in Adopting and Implementing a Population Health Paradigm*, November 2007.

[175] Saskatchewan Provincial Health Council, *Population Health Goals for Saskatchewan*, October 1994. A follow-up document, *Your Health, My Health, Our Health: Our Individual and Collective Responsibilities – A Discussion Paper on the Determinants of Health*, was released in 1996.

To strengthen population health approaches in Saskatchewan, an intersectoral alliance called the Saskatchewan Population Health Promotion Partnership was launched in 1996.[176] The partnership coordinated the development of a conceptual framework to guide the work of RHAs in the promotion of population health (discussed below), led demonstration projects on a population health prevention approach to prevent type 2 diabetes, and organized health promotion summer schools, training events, and research on evaluation.[177]

In 1999, the government issued *Population Health Promotion Framework for Saskatchewan Regional Health Authorities* with definitions, principles and strategies for population health promotion to help RHAs understand their role in promoting population health and to provide insights on how to work effectively with other sectors.[178]

Healthier Places to Live, Work and Play: A Population Health Promotion Strategy for Saskatchewan was released[179] in 2004, to provide a framework for the promotion of population health at the local, regional and provincial levels; it also defined four long-term priorities for the promotion of population health: mental well-being; accessible nutritious food; decreased substance use/abuse; and active communities. The Strategy highlighted the need of those working in the health sector to work with other sectors, government departments and external stakeholders to make and sustain change leading to improvements in the health of individuals and communities. In addition to outlining the vision, framework and priority issues for the promotion of population health in the province, the Strategy was intended to support other key government initiatives such as primary health care reform, and its Integrated Pan-Canadian Healthy Living Strategy.

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(176) Initial partners included: Health Canada; Saskatchewan Health's Population Health and District Management Services Branches; the Prairie Region Health Promotion Research Centre; the provincial health districts, through representatives of the Health Promotion Contacts Group; the Saskatchewan Association of Health Organizations; the Saskatchewan Public Health Association; the Human Services Integration Forum; the Métis Family and Community Justice Services; the Federation of Saskatchewan Indian Nations; and the Saskatchewan Indian Federated College.

(177) Lewis Williams, "Health Promotion in Saskatchewan: Three Developing Approaches," in in Michel O'Neill et al., *Health Promotion in Canada: Critical Perspectives*, 2nd edition, Toronto: Canadian Scholars Press, 2007; and Natalie Kishchuk, "Case Studies of the Regional Mobilization of Population Health," Prepared for the Regional Offices, Population and Public Health Branch, Health Canada, 2001, http://www.phac-aspc.gc.ca/ph-sp/phdd/case_studies/index.html

(178) Saskatchewan Health, *A Population Health Promotion Framework for Saskatchewan Regional Health Authorities*, 1999, http://www.health.gov.sk.ca/health-promotion-framework

(179) Saskatchewan Health, Healthier Places to Live, Work and Play: A Population Health Promotion Strategy for Saskatchewan, 2004, http://www.health.gov.sk.ca/phb-promotion-strategy

The government has partnered with RHAs to apply population health promotion initiatives. Saskatchewan's RHAs have each developed its own regional population health promotion strategies based on the provincial strategy but reflecting each region's needs, priorities, resources, and capacity; these are updated annually. For example, RHA activities contributing to the accessible nutritious food and active communities priorities of the Strategy include:

- Building capacity to support access to nutritious, affordable food, including food costing, good food boxes, community kitchens, leadership development, and food charters;
- Implementing health region and school food/nutrition policies including the collection of baseline data in September 2006 to monitor progress;
- Establishing partnerships to support the work of the sport and recreation sectors;
- Addressing barriers to physical activity through infrastructure changes, active transportation, facility access, and cost-reduction initiatives; and
- Working to increase breastfeeding rates including development of policies and the creation of an indicator to monitor progress.

Although some funding is provided according to needs-based population formulas, historical utilization expenditures continue to dominate the allocation of resources to RHAs rather than an understanding of the population health needs in a given region. Integration of physician services and social and educational services is still more rhetorical than real. The province does have, however, a network of Regional Intersectoral Committees (RICs) that promote integrated human service policy development and planning, in a manner consistent with a population health approach.

The ten RICs are each staffed by a coordinator who helps the committee carry out its mandate and helps to build community capacity. Each committee is made up of representatives of the provincial and federal government departments, health districts, school divisions, Regional Colleges, the Saskatchewan Institute of Applied Science and Technology, housing authorities, police, tribal councils, Métis organizations, and community organizations.[180] Their activities include:

- Working to support community-based planning systems for human services.
- Establishing data collection/information sharing strategies including the development of community profiles in some regions.
- Encouraging the formation of interagency groups or action teams to address issues affecting vulnerable children, youth and families and, in particular, early childhood and youth at risk.
- Supporting existing community interagency groups with planning advice, project funding, and communication support.

[180] Saskatchewan Ministry of Education, "Regional Intersectoral Committees," http://www.sasked.gov.sk.ca/hsif/rics.shtml

- Coordinating local reviews of a variety of projects supported by, for example, Prevention and Support Grants, Community Initiatives Fund, federal Population Health, National Crime Prevention funding, etc.
- Supporting the implementation of an integrated case management approach for cases with complex needs.
- Facilitating community involvement in consultation processes such as Early Years, National Children's Agenda and the Role of Schools.

The RICs are supported provincially by the Associate and Assistant Deputy Ministers' Forum on Human Services which was formed in the fall of 1994 in response to the need for coordination by senior government and growing demand for holistic,integrated human services. The Forum was restructured in 1999 and renamed the Human Services Integration Forum (HSIF). It is led by a Steering Committee made up of the following departments:[181] Education; Justice, Health; Corrections and Public Safety; Community Resources and Employment; Culture, Youth and Recreation; First Nations and Métis Relations; and the Executive Council.

The objectives of the Forum are to: establish and maintain mechanisms to promote and facilitate interagency collaboration, integrated planning and service delivery; to identify and address barriers; to provide funding and policy support; to provide educational supports to human service providers; and, to make the most efficient and effective use of resources. Its policy planning and program development priorities have included early childhood development, youth and citizens in vulnerable circumstances.

11.3 MONITORING AND EVALUATION

In 1999, the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) was established as a non-profit research institute by the University of Regina, the University of Saskatchewan, Saskatchewan Health, the Saskatchewan Association of Health Organizations, and the Health Services Utilization and Research Commission. Since its creation, SPHERU has played a key role in promoting research into population health. Research undertaken by SPHERU is currently organized into three theme areas: northern and Aboriginal health; healthy children, and; rural health.[182]

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[181] Saskatchewan Ministry of Education, "Human Services Integration Forum," http://www.sasked.gov.sk.ca/hsif/index.shtml

[182] Saskatchewan Population Health and Evaluation Research Unit, "About Our Work," http://www.spheru.ca/home

The government's provincial strategy requires RHAs to report on their regional population health promotion strategies. In 2006-2007, for example, the Saskatoon Regional Health Authority's Annual Report discussed the health-related behaviours that were influenced by economic and social conditions in its region as well as reporting progress toward the goal of effective health promotion and disease prevention.[183]

[183] Saskatoon Regional Health Authority, *2006-2007 Annual Report to the Minister of Health and the Minister of Healthy Living Services*, 2007, http://www.saskatoonhealthregion.ca/about_us/documents/shr_annual_report_2006_07.pdf

CHAPTER 12: THE TERRITORIES[184]

12.1 MAIN FINDINGS

- The Territorial governments have documented prominantly the role of the determinants of health in the well-being of northern populations.

- The dynamics of the interplay and importance of the determinants of health differ in the North from the rest of Canada because of the different realities that apply, including the North's proportionally larger Aboriginal populations and remoteness.

- The Northwest Territories has made longstanding efforts to implement a population health approach to policy and programs in its Department of Health and Social Services and across the government, but it has met with challenges.

- Given the difficulties of sampling in northern communities – mainly small sample sizes – northern communities find themselves poorly represented in research on population health. Nevertheless, relevant measures have been incorporated into territorial health status reports and appear increasingly in performance reports.

12.2 DEVELOPMENT AND IMPLEMENTATION

In recent decades administrative structure and the responsibilities of northern governments have changed substantially. The transfer of health service delivery to the territories, the creation of Nunavut, and the increased role of First Nations in health and social service delivery have all contributed to a dynamic policy and program environment.

The interplay of the determinants of health is markedly different in the north than in southern Canada. Development of natural resources in Aboriginal communities is often characterized by rapid, dramatic growth followed by economic decline that often generates profound social and cultural change and exacerbates health problems. The remoteness of northern communities creates challenges for the population's access to affordable, nutritious food. Adequate shelter is harder to provide in the harsh climate. An assessment of self-perceived health among northern residents acknowledges the social, societal and cultural forces, including community participation, family support and access to culturally-sensitive health care, that affect a wide range of health determinants.

(184) The information presented in this chapter is based on a paper commissioned by the Subcommittee and prepared by Laura Corbett, *Population Health Policy in the Territories*, October 2007.

i. Northwest Territories

The Northwest Territories has lead in taking a coherent, coordinated approach to improving population health. Following the direction of a Special Committee on Health and Social Services in 1994,[185] health programs and social services were combined in the Department of Health and Social Services where an emphasis was placed on promotion and prevention, and recognizing the contributions of housing, environmental health, income support and education on population health.

Considerable attention was given to integrating the provision of social services and ensuring a continuum of care. In 1997, the *Northwest Territories Health and Social Services Draft Strategic Plan*[186] made the case for integration for functional and client-service reasons. Functionally, the alignment of financial, human resource and information management across operating units added value to the system. From the client's perspective, the advantage of integration was not only the coordination of care but maintenance of its continuity, the requirement of efficient communication among care providers, easy transfer of information, and the availability of resources and efforts sufficient to ensure that the provision of services to those in need. From both perspectives, the provision of services can be improved through integration while costs are contained by economies of scale and capitation-based funding.[187]

The Strategic Plan laid out the department's commitment to population health in terms of the outcomes and health status of the population served. Formal accountability was proposed for outcomes which are influenced by lifestyle and environmental factors, thereby reinforcing the first strategic goal of health and social services integration − that of ensuring that residents of the Northwest Territories live healthy lifestyles in a healthy environment .[188]

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(185) Government of Northwest Territories, *Renewed Partnerships: In Response to Talking and Working Together. The Final Report of the Special Committee on Health and Social Services*, Yellowknife: Legislative Assembly, Government of the Northwest Territories, 1994.

(186) Med-Emerg International, *Northwest Territories Health and Social Services Draft Strategic Plan*, Yellowknife: Northwest Territories Department of Health and Social Services, 1997, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(187) Capitation is described as a funding system wherein a fixed envelope of money is transferred to the integrated unit based on the size, demographics and needs of its rostered population. Surpluses or deficits are retained by the integrated unit. Retention of surpluses provides an incentive to promote health and prevent illness, and thereby save on treatment costs.

(188) Med-Emerg International (1997), *op. cit,* p.17.

The Government of the Northwest Territories responded in 1998 with *Shaping Our Future: A Strategic Plan for Health and Wellness.*[189] This outlined the four health and wellness objectives of the Department of Health and Social Services: 1) Improving health status; 2) Improving social and environmental conditions; 3) Improving the integration and coordination of health and social services, including those provided by private providers, government bodies, non-government agencies and the voluntary sector; and 4) Devising more responsive, responsible and effective methods to deliver and manage services.

Given the range of determinants that affect health status and the particular social and environmental conditions that apply in the North, the Department was clear that the involvement of many agencies and the support of the public were both crucial in addressing determinants of health such as education, culture, housing, employment, economic conditions and the physical environment. It envisioned its role as a catalyst, ensuring that other departments, agencies and governments have the information needed to think broadly when setting policies and priorities and making decisions that impact population health and well being.

As elsewhere in Canada, the Strategic Plan faced challenges in implementation. A report in 2001 found that the health and social services system was flawed and under considerable stress: front-line staff were frustrated by a lack of resources; managers were struggling to meet what often appear to be unrealistic expectations relating to service delivery, reporting, and the measurement of results; and the failure of the various players to cooperate impeded the delivery of truly comprehensive, integrated services.[190] This report also noted that many other studies had already come to the same conclusions and repeatedly made many of the same recommendations, to repair a continuing lack of action or progress.

Acknowledging the need for change, the *NWT Health and Social Services Action Plan 2002-2005* promised a number of reforms, including providing greater support to staff, improved system-wide management and accountability, the establishment of forums for joint planning of

(189) Northwest Territories Health and Social Services, *Shaping Our Future: A Strategic Plan for Health and Wellness,* Yellowknife: Department of Health and Social Services, 1998, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(190) George B. Cuff & Associates, *It's Time to Act: A Report on the Health and Social Services System of the Northwest Territories,* June 2001, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

interdepartmental initiatives, and a more careful alignment of operational strategies with the department's strategic plan.[191]

In 2004, NWT Health and Social Services committed to an Integrated Service Delivery Model that clarified service integration and professional collaboration, organizational integration, and defined a set of core services that would be available within the health and social services system.[192] Those core services included, among others, health protection, promotion and prevention, with a focus on healthy lifestyles and risk behaviours. The model made clear the proposal of an integrated and well-funded system for prevention and promotion, one that would not be overshadowed by treatment services, using a population health approach supporting a primary community care model of delivery. In the 2006-2010 Action Plan, health promotion and protection services included deliverables related to unhealthy behaviours, homelessness and healthy school programs.[193]

ii. Yukon

Its 2003 Health Status Report revealed the clear understanding of the Yukon on the importance of the determinants of health and described how they influence health. It also presented indicators of education, employment and income.[194]

The health promotion approach was reinforced in the *Report to the Yukon Public on the Primary Health Care Planning Forum* which was called to address a number of principal health issues, including alcohol and drug abuse and chronic disease, and included also a focus on reducing health disparities.[195] The Forum recommended further support for an Interdepartmental Collaboration Initiative between the departments of Justice, Education and Health and Social Services to improve working relationships and reduce barriers to information sharing.

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(191) Northwest Territories Health and Social Services, *NWT Health and Social Services Action Plan 2002-2005*, Yellowknife, 2002, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(192) Northwest Territories Health and Social Services, *Integrated Service Delivery Model for the NWT Health and Social Services System*, Yellowknife, 2004, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(193) Northwest Territories Health and Social Services, *NWT Health and Social Services System Action Plan 2006-2010*, Yellowknife, 2006, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(194) Government of Yukon Health and Social Services, *Yukon Health Status Report 2003*, November 2003.

(195) Government of Yukon Health and Social Services, *Report to the Yukon Public on the Primary Health Care Planning Forum*, November 2003, http://www.hss.gov.yk.ca/downloads/phctf_report.pdf

, After a period of during which Yukon's housing programs, health promotion and public health programs, and family and mental health services were eroded, investment in the non-medical determinants of health appears to have been needed urgently.[196] The Yukon has used its share of funds from the federal Northern Strategy Trust to implement the Yukon Charter, which contains a number of initiatives that address determinants of health, including:

- Investing at the community level in educational resources that recognize and are responsive to community needs.
- Producing a strategy to enhance federal initiatives that address healthy, adequate, affordable, and culturally relevant housing and related infrastructure.
- Working jointly to provide to Yukon communities [197]the resources need to adapt to climate change.

iii. Nunavut

Created in 1999 from partition of the Northwest Territories, Nunavut covers one-fifth of the land mass of Canada; its population of 31,113[198] in 2007 is distributed in 25 communities accessible for the most part only by air. The Nunavut Department of Health and Social Services has a 12-member Population Health Division which directs health promotion activities delivered through community health centres located in every community. Health promotion initiatives have included improving access to nutritious foods, prenatal and child development programs, and strategies to address such communicable diseases as tuberculosis and sexually transmitted infections.[199]

In 2005 a Government of Nunavut workshop on the social determinants of health identified as health determinants as acculturation, self-determination, education, quality of early life, productivity, income and its distribution, food security, health services, the social safety net, housing, and the environment[200].

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[196] Canadian Health Coalition, *Northern Health Care: On Thin Ice?* Ottawa: Canadian Health Coalition, 2003, http://www.healthcoalition.ca/north-report.pdf

[197] Government of Yukon Northern Strategy Trust, *Northern Strategy: Yukon Chapter*, Draft, April 26, 2005, http://www.eco.gov.yk.ca/igr/pdf/yukon_chapter_northern_strategy.pdf.

[198] Statistics Canada, "Canada's Population by Age and Sex," *The Daily*, 29 November 2007. ,http://www.statcan.ca/Daily/English/071129/d071129c.htm

[199] Carol Gregson *et al.*, "Health Promotion in Nunavut: Inspired by Design" in Michel O'Neill et al., *Health Promotion in Canada: Critical Perspectives*, 2nd edition, Toronto: Canadian Scholars Press, 2007.

[200] Nunavut Department of Health and Social Services, *Social Determinants of Health in Nunavut - Workshop Report* , Iqaluit: Government of Nunavut, 2005.

12.3 MONITORING AND EVALUATION

National surveys by Statistics Canada typically involve separate data collection for the territories because of the special challenges of surveying in Canada's North. Between Statistics Canada's and the Yukon government's figures[201] discrepancies occur. Often those challenges result in the omission of residents of the Yukon, Northwest Territories and Nunavut from survey sampling entirely. Furthermore, sampling problems and the statistical techniques peculiar to small sample sizes act to deter exploration of datasets which could inform local decision-makers or provide timely information on pertinent health issues. The problems of small to modest sample sizes, the small number of outcomes measured, and the paucity of cases often mean that analyses are impossible at the community level and challenging even regionally.[202] Frequently results of sampling the three territorial populations are combined into a single 'Territories' sample, or worse -- northern residents are simply omitted from the final reports of national studies.[203] Because northern communities are poorly represented in research results, they become suspicious of the research process itself, making the development of evidence-based policies and programs a special challenge.

Another aspect complicating research in the North is the rural and remote nature of northern communities. On those occasions when the health status of rural Canadians is studied, the research tends to emphasize a particular region or province, to consider a single aspect of health, or to employ a single data set.[204] From an evaluative perspective, knowledge of the northern experience is limited not only by a research agenda that tends to be dictated by evidence derived from the south but by an approach to research that fails to appreciate traditional knowledge and community participation. Although the established research paradigm has begun to accommodate community-based research and to incorporate the interests, priorities and skills of Aboriginal communities, the overall level of engagement, dissemination of specialized knowledge, and training of Aboriginal stewards of the determinants of health in the North remain unrealized. Although many published studies have

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(201) CBC News, "Census Numbers Flawed, Yukon Says," 15 March 2007. http://www.cbc.ca/canada/north/story/2007/03/15/yk-census.html

(202) Northwest Territories Health and Social Services. (2003). *NWT Health and Social Services Performance Measurement and Reporting.* Yellowknife: Northwest Territories Health and Social Services, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(203) Social Agenda Working Group, *Social Agenda – A Draft for the People of the NWT,* Yellowknife, 2002, http://www.gov.nt.ca/research/publications/pdfs/Social_Agenda_Book.pdf

(204) Canadian Population Health Initiative, *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants,* Ottawa: Canadian Institute for Health Information, 2006, http://www.phac-aspc.gc.ca/publicat/rural06/pdf/rural_canadians_2006_report_e.pdf

considered the health of Canada's Aboriginal population, not much research has been done to address the full spectrum of the determinants of health.[205]

Despite these challenges, the performance measurements and reporting done by the Northwest Territories and Yukon Departments of Health and Social Services set remarkable examples. The *Northwest Territories Health Status Report* presents not only health status and mortality indicators, but social, economic and environmental influences on health, personal health practices, measures of social well-being and, in the 2005 edition, healthy child development.[206] It also includes an introductory passage referring to the wider literature to create understanding of the relationship between each determinant and health status. It does not attempt, however, to link its own data on health determinants data and population health. The same strengths and limitations apply also to the *Yukon Health Status Report.*[207] In Nunavut, population health reporting seems to be largely confined to documenting its comparable health indicators as part of the commitments made in the September 2000 First Ministers Communiqué on Health which encouraged all Health Ministers to employ comparable indicators to report provincial/territorial health status, health outcomes and quality of service.[208]

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(205) T. Kue Young, "Review of research on aboriginal populations in Canada: relevance to their health needs," British Medical Journal, Vol.327, pp419-422, 2003 http://www.bmj.com/cgi/reprint/327/7412/419

(206) NWT Health Status Reports using a population health framework date back to 1999. As the first health status report after the creation of Nunavut, it serves as the baseline against which future progress has been gauged. The most recent is: Northwest Territories Health and Social Services, *NWT Health Status Report 2005,* Yellowknife, 2005, http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp

(207) Yukon Health and Social Services, *Yukon Health Status Report 2003,* Whitehorse, 2003, http://www.inchr.org/Doc/November05/healthstatus03.pdf

(208) Nunavut Department of Health and Social Services,*Comparable Health Indicators for Nunavut and Canada*, Iqaluit, 2004, http://www.gov.nu.ca/health/PIRCenglishlow.pdf

CHAPTER 13: COMPARATIVE ANALYSIS

The preceding chapters have summarized the extent to which population health policy has been developed, implemented and evaluated in Canadian jurisdictions. This chapter summarizes the lessons learned from reviewing and comparing the federal, provincial and territorial approaches to the improvement of population health and the reduction of health disparities.

13.1 THE CONCEPT OF POPULATION HEALTH

Population health is not a new concept. Its first prominent elaboration in Canada was in the 1974 Lalonde report, a landmark document recognized worldwide. Subsequently the concept has evolved to include an emphasis on reducing health disparities in addition to the focus on improving overall health status. In the past three decades, since the Lalonde report, the federal and all provincial/territorial governments have devoted considerable attention to population health and the F/P/T Advisory Committee on Population Health has been instrumental in advancing this concept.

Yet, there remains a lack of knowledge about and understanding of the determinants of health, population health and health disparities, all of which are usually lumped together with the highly politically-sensitive responsibility for treatment services under the aegis of health departments. Only one in three members of the general public understands that the broader non-medical determinants of health – e.g. income, education, housing, etc. – are linked to health.[209] Canada's politicians and media have not succeeded in engaging the public in appreciating the importance of the non-medical determinants of health or, indeed, of optimizing the health of the population. The profound structural changes needed to secure investment in population health will only occur if and when public awareness of its importance is raised and political will developed. Because politicians are accountable to the public, changes that do not have broad public support are difficult to sustain. For changes that require long timelines before the desired outcomes are achieved, a solid public understanding of the policy process is essential; otherwise it cannot be sustained over multiple terms of political office. As described above, reforms in a number of provinces have been cut short by a change of government.

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[209] Elyzabeth Gyorfy-Dyke, Social Determinants of Health in Canada, Canadian Population Health Initiative, Canadian Institute for Health Information, 8 November 2005. http://secure.cihi.ca/cihiweb/en/downloads/SDOH_Sept_2005.pdf

Within governments, the discourse on population health and health disparities has, for the most part, been confined to health departments and health service researchers. Some 58% of senior Canadian federal and provincial civil servants surveyed from across government departments describe themselves as quite or very familiar with the determinants of population health, but 83% of them reported that they needed more information about the health consequences of the policy alternatives their departments faced. Some 45% of respondents from finance departments do not believe that they should consider the health impact of all major government initiatives, compared to 20% in labour and 6% in health and social services departments.(210) This suggests that, although a strong promoter of the population health approach, the health sector has not convinced other non-health sectors to commit to long term, sustained interdepartmental initiatives to address either population health or health disparities.

13.2 HEALTH GOALS AND TARGETS

Every province articulated health goals between 1989 and 1998; the F/P/T Ministers of Health established health goals for Canada in 2005. Inspired by the WHO "Health for All" movement launched in 1984, health goals appealed to policy-makers, at least in part, because they offered a rational approach to policy-making that was thought to generate effective and efficient outcomes and goal-specific measurable objectives, indicators, targets, strategies and actions.(211)

By the end of the 1990s, however, health goals to guide population health policy development, implementation, or evaluation were no longer being used explicitly in most provinces, having been replaced by business plans in the majority of health departments and regional authorities. In regional health authorities policy makers have given health care system goals continued dominance over all others.(212)

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(210) John N. Lavis *et. al*., « Do Canadian Civil Servants Care about the Health of Populations?" *American Journal of Public Health*, April 2003, pp. 658-663. http://www.ajph.org/cgi/content/abstract/93/4/658

(211) Treena Chomik and James Frankish, "Factors that facilitated and challenged the development of health goals and targets," *Canadian Journal of Public Health*, 1999, S39-S42; Martin McKee and Naomi Fulop, "On target for health," *British Medical Journal*, 2000, 327-328.

(212) Deanna L. Williamson et al., "Implementation of Provincial/Territorial Health Goals in Canada", *Health Policy*, Vol.64, 2003, 173-191.

Despite the development of high level health goals across the country and their endorsement by F/P/T Ministers of Health, to date these goals have not evolved into a national strategy nor have they been transformed into measurable changes in the health of the population. Moreover, national targets to reduce health disparities have not been set.

Clearly, setting health goals can help galvanize the shift of resources toward population health and stimulate the monitoring of progress on health indicators and of improvements in health information systems. But, for political leaders, goals and targets are a double-edged sword – they lead to inceased accountability for quantifiable health improvements, require the re-allocation of scarce resources to actions designed to meet those goals, and end up a risk to re-election if the targets are not met.[213]

13.3 HEALTH IMPACT ASSESSMENT

The most powerful of the determinants of health are not themselves within the purview of the health sector. Policies made in sectors other that health have the greatest potential to improve (or worsen) population health and well-being and to reduce health disparities. They should, therefore, be assessed for their potential impact of health prior to their implementation. Health impact assessment (HIA) is a formal approach used to predict the potential effects of a policy; particular emphasis can be also paid to the impact on health disparities.

In 1997 a submission to the federal Cabinet recommended that HIA be used to assess the health impacts of federal policies and programs. Similarly, the use of HIA has been recommended in a number of provinces. To date, however, only Québec has passed legislation to ensure that the health impacts of proposed laws and regulations are assessed. This legislation empowers the Minister of Health to issue proactive advice to other Ministers with the goal of promoting health and supporting policies that foster the health of the population. The application of HIA more broadly would be one of the first steps towards the development of population health policy; it would also lead to a better understanding of how and how much public policies impact on the health of the population.

(213) Treena Chomik and James Frankish (1999), *op. cit.*

13.4 MONITORING, EVALUATION AND RESEARCH

Population health-related data and research capacity has improved significantly in Canada. Survey data on population health, health determinants and health disparities are available and many health research programs focus on the non-medical determinants of health.

Nationally, the significant health knowledge infrastructure includes the Canadian Population Health Initiative within CIHI, the National Collaborating Centres, as well as federal departments and agencies such as Statistics Canada, Health Canada, the Canadian Institutes of Health Research, and the Public Health Agency of Canada. At the provincial level, the Manitoba Centre for Health Policy has a unique, comprehensive, integrated data repository that not only generates sound information on patterns of care and profiles of illness but also links health to various health determinants, including income, education, employment and social status. In Newfoundland and Labrador, the Community Accounts provide key social, economic and health data and indicators by region. The B.C. Health and Wellness Survey is another promising tool to improve the evidence and information base available to policy makers taking a population health approach. Taken together, these new tools and research organizations equip Canada with an unprecedented opportunity to inform policy- and decision-making by governments and others, measure outcomes, and effect positive changes in population health policy. It is important to ensure that all national surveys and initiatives be coordinated with the work of provincial, territorial and local knowledge infrastructures and university centres.

A number of issues remain, however. For example, consensus is needed on which indicators best monitor trends in health disparity. Data collection must be improved; population health data are not always readily available at the territorial or regional level, or at a neighbourhood level. And while much research is being done on population health and health disparities, more practical evidence-based conclusions are needed on what works and what doesn't in terms of population level policy and program interventions. More needs to be done to increase our understanding of the policies and programs we need to put in place to improve population health and reduce health disparities.[214]

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[214] Glenda Yeates, CPHI at CIHI, *Brief to the Subcommittee*, 13 February 2008.

13.5 ROLE OF THE HEALTH SECTOR

So-called "health imperialism" is a course of high level concern. Health departments may be seen to be dictating to other sectors what they should do, especially if the health sector has not itself taken significant action. It is not enough to acknowledge that the essential role of other sectors in leveraging policy within their domains to address the determinants of health and reduce health disparities; those other sectors have to generate "credit" publicly and with their political masters. The main challenge for health departments is to persuade, encourage and engage the other departments whose programs have an impact on the non-medical determinants of health to participate in the development of population health policy. A formal commitment by the government would greatly facilitate this process of intersectoral action.

13.6 REGIONALIZATION

Although all provinces have gone through a process of regionalizing health care delivery, the focus on and use of the determinants of health by regional health authorities (RHAs) is highly variable. While some RHAs use population health frameworks to guide the planning and delivery of services, these are the exceptions rather than the rule. A survey of health regions across Canada found that even among the exemplary RHAs in this respect, the determinants of health that are addressed vary. Child development and personal health receive the greatest attention, both internally and through intersectoral activities, while culture, gender and employment/working conditions receive the least. Furthermore, there are few institutional incentives to intersectoral coordination with agencies concerned with other determinants such as education, housing, or early childhood development when vertical reporting requirements remain sectorally-driven.[215]

Where regional bodies have attempted to use population health as a framework for planning and decision-making, training, tools and support from higher levels has been required. This was noted in Prince Edward Island, where regionalization weakened inter-regional cooperation. British Columbia is responding to the need for support of population health staff in RHAs through its Population Health Network.

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[215] Frankish, C. J., Moulton, G. E., Quantz, D., Carson, A. J., Casebeer, A. L., Eyles, J. D., Labonte, R. & Evoy, B. E., "Addressing the Non-Medical Determinants of Health: A Survey of Canada's Health Regions," *Canadian Journal of Public Health*, 98(1), 2007, pp. 41-47.

13.7 FUNDING

Although the federal Cabinet formally adopted a whole-of-government population health policy in 1997, significant funding cuts impeded its implementation. Only one out of the 18 departments implicated in the proposed policy, Health Canada, moved to apply a population health lens to its programs and initiatives. Similarly, the implementation of population health policy in Prince Edward Island was significantly curtailed by cuts in federal transfer payments which, in turn, resulted in reductions to the provincial spending devoted to population health. Provincial population health initiatives that were coincident with reductions to federal transfers in the mid-1990s have fallen victim to the unfortunate timing. This, combined with continuing greater-than-inflation rates of growth in health care costs, have seriously compromised and sometimes doomed population health reforms led by the health sector.

Another funding issue related to population health reform involves reallocation of budgets. In Ontario, one Local Health Integration Network that is trying to apply a population health perspective has found funding reallocation to be a high barrier to investments in health's non-medical determinants. Funding mechanisms have not yet been reconfigured to facilitate greater emphasis on and funding for health promotion and disease prevention, much less non-medical determinants, as opposed to the continuing high costs of health care delivery.[216]

13.8 INTERSECTORAL ACTION

Because Canada's provinces and territories have direct responsibility for many of the most significant determinants (education, income security and employment, health services, early childhood development, housing, etc.), it is at that level that the most promising opportunities for interdepartmental approaches are to be found. In provinces such as Québec, Prince Edward Island (during the time of its population health reforms) and the Northwest Territories, in which health and social services are combined in one department, policy coordination relating to the full range of health determinants can be simplified.

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[216] Dr. Andrew Pipe, University of Ottawa Heart Institute, *Proceedings*, 6 February 2008.

Provinces have used a wide range of mechanisms to implement whole-of-government policy priorities. These have been led by Cabinet Committees, interdepartmental (ADM) working groups, and Premier's Councils and leadership from the top in some cases. Current whole-of-government approaches tend to be too narrowly structured around singular health determinants, such as ActNow BC's focus on personal health practices, early childhood development by Healthy Child Manitoba, or poverty with Québec's anti-poverty action plan.

Some regional intersectoral structures located outside health departments also seem to be effective in promoting collaboration and partnerships; examples include regional steering committees in Newfoundland and Labrador and regional intersectoral committees in Saskatchewan.

The example of the F/P/T Advisory Committee on Population Health is noteworthy given its successful brokering of intergovernmental consensus. The Committee was able to achieve provincial, territorial and federal consensus followed by collaboration in the production and support of policy directions on population health. The Committee played a key role by taking a long term, integrated view of the health of the population and forging policy coherence across all affected sectors. But, despite the commitment in principle to address health disparities that has been secured at the F/P/T level, there has yet to be agreement on a list of recommended actions and the designation of an organization to play a leadership role in addressing health disparities throughout Canada. Why the wonderful efforts at the F/P/T level have failed to convert into concrete action must be better understood.

Nor has the federal government succeeded in implementing a comprehensive, whole-of-government approach to population health, despite the fact that Health Canada has developed a template that provides guidance to successful implementation of population health policy in both the health and non-health sectors Nevertheless, there have been successes and much has been learned. For example, the National Family Violence Initiative brought together seven federal departments with provincial/territorial governments, community groups, professional associations, and private sector organizations to develop an intersectoral response for the prevention of family violence.

The extensive efforts by our governments described above, suggest that there is no one single set of policy initiatives nor intersectoral mechanism that is "right" to enhance population health

or reduce health disparities. While Canada has accumulated a lot of experience upon which to build, it remains that the production of policy statements, strategies, goals and objectives has not been matched by comparable action on the ground where people's health is actually affected. Sadly, the great majority of those fine policy statements that have been produced by the federal, provincial and territorial governments since the Lalonde report, 30 years ago, to foster greater emphasis on the non-medical determinants of health, population health, and health disparities remain little more than well-meaning but empty rhetoric. Canadians deserve better!

13.9 WHY DO SERIOUS HEALTH DISPARITIES PERSIST IN CANADA?

Despite all the resources and the numerous government programs and initiatives described in this report, Canada does not necessarily rank very much better by international comparisons. For example, WHO data indicate that Canada ranks 9th among 30 countries in terms of healthy life expectancy at birth for women. Moreover, Unicef statistics show that we rank only 12th among 21 industrialized countries in terms of children well-being. And the recent release of the Euro-Canada Health Consumer Index places Canada 23rd out of 30 in Total Index Score, and 30th out of 30 in Best Value for Money Spent. In other words, this index shows that we spend more money on health care to achieve worse results than the other countries surveyed.

These sobering numbers tell us we are doing something terribly wrong regarding health and the health care delivery system. At first glance, this would appear to be a lack of concentration and investment on population health and an over-investment in a very inefficient health care delivery system. The other major reason would appear to be the lack of adequate community resources that could integrate and evaluate the health resources in relation to other dozen or so major determinants of health.

Hopefully our study can assist governments, the business sector and NGOs to come together and solve this disturbing situation because poor population health and health disparities produce a barrier to prosperity.

APPENDIX 1 - WITNESS LIST

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
39th Parliament 1st Session			
World Health Organization Commission on the Social Determinants of Health	The Honourable Monique Bégin, P.C., Commissioner	22-02-2007	1
Institute of Population Health	Ronald Labonté, Canada Research Chair in Globalization and Health Equity	28-02-2007	1
Provincial Health Services Authority, B.C.	Dr. John Millar, Executive Director, Population Health Surveillance and Disease Control	28-02-2007	1
School of Health Policy and Management - York University	Dennis Raphael, Professor	28-02-2007	1
Public Health Agency of Canada	Jim Ball, Director, Development and Partnerships Division, Strategic Policy Directorate, Strategic Policy, Communications and Corporate Services Branch	21-03-2007	2
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, Associate Scientist	21-03-2007	2
Public Health Agency of Canada	Maura Ricketts, Acting Director General, Office of Public Health Practice, Public Health Practice and Regional Operations Branch	21-03-2007	2
Public Health Agency of Canada	Dr. Sylvie Stachenko, Deputy Chief Public Officer, Health Promotion and Chronic Disease Prevention	21-03-2007	2

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Statistics Canada	Michael Wolfson, Assistant Chief Statistician, Analysis and Development	21-03-2007	2
Institute of Population and Public Health	Dr. John Frank, Scientific Director of the Canadian Institutes of Health Research	28-03-2007	2
Global Health and Social Policy	Dr. Jody Heymann, Canada Research Chair in Global Health and Social Policy	28-03-2007	2
McGill University	Dr. John Lynch, Canada Research Chair in Population Health	28-03-2007	2
Public Health Agency of Canada	Jim Ball, Director, Development and Partnership Division, Strategic Policy Directorate	25-04-2007	3
Indian and Northern Affairs Canada	Marc Brooks, Director General, Community Development Branch, Socio-economic Policy and Regional Operations sector	25-04-2007	3
Centre for Aboriginal Health Research, University of Manitoba	John O'Neil, Professor and Director	25-04-2007	3
Health Canada	Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch	25-04-2007	3
Institute of Aboriginal People's Health (IAPH) for the Canadian Institutes of Health Research (CIHR)	Dr Jeff Reading, Scientific Director	25-04-2007	3
Research Faculty/Saskatchewan Population Health and Evaluation Research Unit	Sylvia Abonyi, Canada Research Chair in Aboriginal Health	02-05-2007	3
National Aboriginal Health Organization (NAHO)	Mark Buell, Manager, Policy and Communication Unit	02-05-2007	3
University of British Columbia - Department of Psychology	Dr. Michael J. Chandler, University of British Columbia	02-05-2007	3

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
	Professor and Distinguished Canadian Institutes for Health Research (CIHR) and Michael Smith Foundation for Health Research (MSFHR) Investigator		
National Aboriginal Health Organization (NAHO)	Carole L. Lafontaine, Acting Chief Executive Officer	02-05-2007	3
Toronto University	Dr. Kue Young, Professor, Department of Public Health Services	02-05-2007	3
Observatory on Ageing and Society (OAS)	Dr. André Davignon, Founder	16-05-2007	4
Nova Scotia Department of Health	Valerie J. White, Executive Director, Seniors Secretariat	16-05-2007	4
Public Health Agency of Canada - Division of Aging and Seniors	Margaret Gillis, Director	16-05-2007	4
Canadian Association on Gerontology	Mark Rosenberg, Professor Queen's University	16-05-2007	4
The CHILD Project	Dr. Hillel Goelman, Director, Senior Scholar, Human Early Learning Partnership (HELP)	30-05-2007	4
Canadian Institutes of Health Research	Dr. Michael Kramer, Scientific Director, Institute of Human Development, Child and Youth Health	30-05-2007	4
Council of Early Child Development	Stuart Shankar, Professor, President	30-05-2007	4
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate	31-05-2007	4

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	Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba		
Métis National Council	David Chartrand, Minister of Health	31-05-2007	4
Métis National Council	Marc LeClair, National Advisor to the Minister of Health	31-05-2007	4
Métis National Council	Rosemarie McPherson, National Spokesperson for Women of the Métis Nation	31-05-2007	4
BC Ministry of Health	Dr. Evan Adams Aboriginal Health Physician Advisor, Office of the Provincial Health Officer	01-06-2007	5
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	01-06-2007	5
Institute of Aboriginal Peoples' Health	Laura Commanda, Assistant Director, Partnerships, Knowledge Translation and International Relations	01-06-2007	5
Pauktuutit Inuit Women of Canada	Jennifer Dickson, Executive Director	01-06-2007	5
Native Women's Association of Canada	Claudette Dumont-Smith, Senior Health Advisor	01-06-2007	5
Indigenous People's Health Research Centre	Willie Ermine, Professor, Writer - Ethicist	01-06-2007	5
Inuit Tapiriit Kanatami	Anna Fowler, Project Coordinator, Department of Health	01-06-2007	5
National Association of Friendship Centres	Alfred J. Guay, Policy Analyst	01-06-2007	5

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Assembly of First Nations	Valerie Gideon, Director of Health and Social Development	01-06-2007	5
University of Alberta	Malcom King, Professor, Department of Medicine	01-06-2007	5
Aboriginal Nurses Association of Canada	Julie Lys, Director, North West Territories Region	01-06-2007	5
Toronto University	Chandrakant P. Shah, Professor emeritus	01-06-2007	5
Congress of Aboriginal Peoples	Erin WolskiHealth Policy Program	01-06-2007	5
39th Parliament 2nd Session			
Ministry of Health and Social Affairs	Irene Nilsson-Carlsson, Deputy Director General, Public Health Division	22-11-2007	1
Swedish National Institute of Public Health	Dr. Gunnar Agren, Director General	22-11-2007	1
Karolinska Institute:	Dr. Piroska Ostlin, Dept. of Public Health Sciences	22-11-2007	1
Swedish National Institute of Public Health	Bernt Lundgren, Public Health Policy Expert	22-11-2007	1
The Quaich Inc.	Patsy Beattie-Huggan, President	28-11-2007	1
McMaster University	John Eyles, Professor, School of Geography and Earth Sciences	28-11-2007	1
PEI Department of Health	Teresa Hennebery, Assistant Deputy Minister, Health Operations	28-11-2007	1
Group d'étude sur les politiques et la santé	France Gagnon, Professor and co-chair	05-12-2007	2
University of Montreal	Nicole Bernier, PhD, Assistant Professor	05-12-2007	2
U.K. Department of Health	Dr. Fiona Adshead, Director	11-12-2007	2

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	General of Health Improvement		
B.C. Interior Health Authority	Lex Baas, Director of Population Health	12-12-2007	2
University of British Columbia	James Frankish, Professor and Director	12-12-2007	2
Ontario Ministry of Health Promotion	Pegeen Walsh, Director, Chronic Disease Prevention	06-02-2008	3
Toronto Cental Local Health Integration Network	Laura Pisko-Bezruchko, Senior Director, Planning	06-02-2008	3
University of Ottawa Heart Institute	Dr. Andrew Pipe, Medical Director, Prevention and Rehabilitation Centre	06-02-2008	3
Canadian Institute for Health Information	Glenda Yeates, President and Chief Executive Officer	13-02-2008	3
Canadian Institute for Health Information	Keith Denny, Acting Manager	13-02-2008	3
University of Manitoba	Noralou Roos, Professor, Faculty of Medicine	13-02-2008	3
Public Health Agency of Canada	Jim Ball, Director General, Strategic Initiatives & Innovations	27-02-2008	3
Finance Canada	Yves Giroux, Acting Director, Social Policy	27-02-2008	3
Treasury Board of Canada	Sally Thornton, Indian Affairs and Health	27-02-2008	3