Evidence Guiding Health Care

ICES Institute for Clinical Evaluative Sciences

What Does it Take to Make a Healthy Province?

A benchmark study of jurisdictions in Canada and around the world with the highest levels of health and the best health behaviours

ICES Investigative Report

November 2009

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About ICES

Ontario's resource for informed health care decision-making

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization that produces knowledge to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES' evidence supports health policy development and guides changes to the organization and delivery of health care services.

Key to our work is our ability to link population-based health information, at the patient-level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 12 million of 30 million Canadians allow us to follow patient populations through diagnosis and treatment, and to evaluate outcomes.

ICES brings together the best and the brightest talent under one roof. Many of our scientists are not only internationally recognized leaders in their fields, but are also practicing clinicians who understand the grassroots of health care delivery, making the knowledge produced at ICES clinically-focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, our faculty and staff compete for peer-reviewed grants from federal funding agencies, such as the Canadian Institutes of Health Research, and project-specific funds are received from provincial and national organizations. These combined sources enable ICES to have a large number of projects underway, covering a broad range of topics. The knowledge that arises from these efforts is always produced independent of our funding bodies, which is critical to our success as Ontario's objective, credible source of *Evidence Guiding Health Care.*

Executive Summary

This report benchmarks Ontario against the leading Canadian and international jurisdictions which have achieved the best overall heath and health behaviours in their populations. We examine how such jurisdictions have achieved their leading status.

Within Canada, there is consensus that British Columbia is the leading province in terms of overall population health and health behaviours (including smoking cessation, engaging in regular physical activity, choosing a healthy diet and maintaining a healthy body weight). Quebec is also a leader due to the fact that, over the past two decades, the province has instigated major and steady efforts aimed at improving population health. This has allowed Quebec to pull ahead of many other provinces in terms of residents' life expectancy. Internationally, Sweden ranks first in terms of having the healthiest population.

What, if anything, can we learn from these provinces and countries? We argue that these jurisdictions are not leaders because good health is somehow a by-product of living within their provincial or national borders. Clearly, these jurisdictions are doing something different, and they are doing it right.

So what does it take to be a leading health jurisdiction?

We reviewed the scientific literature, consulted experts across Canada and abroad, and examined health strategies and programs from leading jurisdictions to determine how and why certain regions lead the way in encouraging and maintaining good health among their citizens. We discovered that there are many different paths towards leadership in population health. But they all start in the same place: faced with an overwhelming sense of imperative, responsible individuals and groups made a concerted and sustained effort to improve the people's overall health and well-being.

After studying the efforts made by leading national and international jurisdictions, we have distilled our explorations, reflections and conversations into five "lessons learned" which are summarized as follows:

1. A guiding health imperative must drive overall health strategies.
2. The best strategies for improving population health and health-related behaviours arise during the tenure of strong political leaders.
3. Government must pay attention to societal attitudes about health and make efforts to understand the prevailing political and social structures.
4. To solve broad-based problems, one must seek solutions which can be applied across governments with the participation of the larger civil society.
5. Leading jurisdictions act promptly. They do not necessarily wait for conclusive scientific evidence and are often the first to implement innovative interventions.

Our ultimate goal is to provide some new and fruitful directions for Ontario as it continues its own efforts to improve the health of its citizens. To that end, we also compared Ontario's health strategies, targets and programs to those of British Columbia and Quebec.

We found that strategies for improving health looked quite similar across all three provinces. For example, all three jurisdictions have been working towards similar targets in the areas of smoking cessation, healthier body weights and increased physical activity in their populations. However, health behaviours among British Columbia residents were better than those observed in Ontario. We also noted that, compared to Ontario, both British Columbia and Quebec are spending much more per capita on health improvement programs; British Columbia is currently investing about three times as much as Ontario and Quebec twice as much.

How can Ontario become a national leader in population health?

We believe that unless Ontario makes an effort to learn from other leading jurisdictions, the province will slip even further behind British Columbia over the next few years. We can also expect to see Quebec's life expectancy rates continue to rise to the point where they will exceed Ontario rates sometime in the next 10 to 20 years.

In this report, we offer seven "recommendations for action" which might help Ontario improve its population health and prevent it from lagging further behind other provinces. These recommendations reflect the five lessons learned in our study of leading national and international jurisdictions. We will also propose methods for measuring progress on these recommendations.

Recommendations for action:

1. Ontario should identify its own specific health imperatives. These should be used as the touchstone for making an extraordinary effort to improve its citizens' health and health behaviours.
2. The Premier should proclaim that a major government goal is for Ontario to become the healthiest province in Canada.
3. Ontario's health behaviour targets should be no less relevant and ambitious when compared to those of leading provinces within Canada. This means that by 2015, we should achieve the following goals:
   - Fewer than 15 percent of Ontarians use tobacco.
   - More than 73 percent of Ontarians are physically active—that is, they take part in more than 30 minutes of moderate physical activity each day.
   - Fewer than 32 percent of Ontarians are either overweight or obese, according to Body Mass Index (BMI) calculations.
4. The Ontario government should have a clear understanding of how Ontarians feel about specific health behaviours and then incorporate that understanding into its population health strategy.
5. Compared to other leading jurisdictions, the Ontario government should allocate more resources towards improving health behaviours related to smoking, physical activity, diet and obesity. This means increasing investments in these areas by more than $165 million per year.
6. Ontario should become a leader in introducing innovative and effective strategies aimed at achieving broad improvements in health behaviours.
7. Ontario should narrow existing disparities in health and health behaviour. Interventions should ensure that people in disadvantaged groups—whose health tends to be poorer—make the first and the greatest gains in these areas.

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Introduction

This report benchmarks Ontario against the leading Canadian and international jurisdictions which have achieved the best overall heath and health behaviours in their populations. We examine how such jurisdictions have achieved their leading status and ask, "What, if anything, can we learn from them?"

We argue that these jurisdictions are not leaders because good health is somehow a by-product of living within their provincial or national borders. Clearly, these provinces and countries are doing something different and they are doing it right.

This report, which contains a number of factual and conceptual elements, is aimed at decision-makers both within and outside governments. These elements include:

- a broader exploration of how leading jurisdictions have achieved and/or maintained their leading status
- a distillation of our findings into five specific "lessons learned," which might provide new and fruitful directions for Ontario as it continues its own efforts to improve the health of its citizens
- an overview of strategies, programs and targets from different jurisdictions, including a comparison between Ontario's current strategy for improving population health and those of the leading Canadian provinces
- recommendations to inform and assist the provincial government in its efforts toward making Ontario the leading Canadian province in optimal health behaviour

While our report was prepared mainly for sharing with Ontario's Ministry of Health and Long-Term Care (MOHLTC), this key group is not the only relevant player when it comes to population health. Many other Ministries also have a vital—although perhaps less direct and obvious—role in the health of citizens. We believe this report should be read by anyone who has a stake in the health and well-being of Ontarians.

A few words about "health"

For the purposes of this report, we define health in terms of two measures: life expectancy (i.e., the number of years a person would be expected to live based on specific mortality statistics); and health expectancy (defined as life expectancy adjusted for health-related quality of life[1]). Life and health expectancy are often related to even broader concepts of quality-of-life, such as having the capacity or resources for everyday living,[2,3] and also to narrower measures such as infant mortality or avoidable mortality.[4,5]

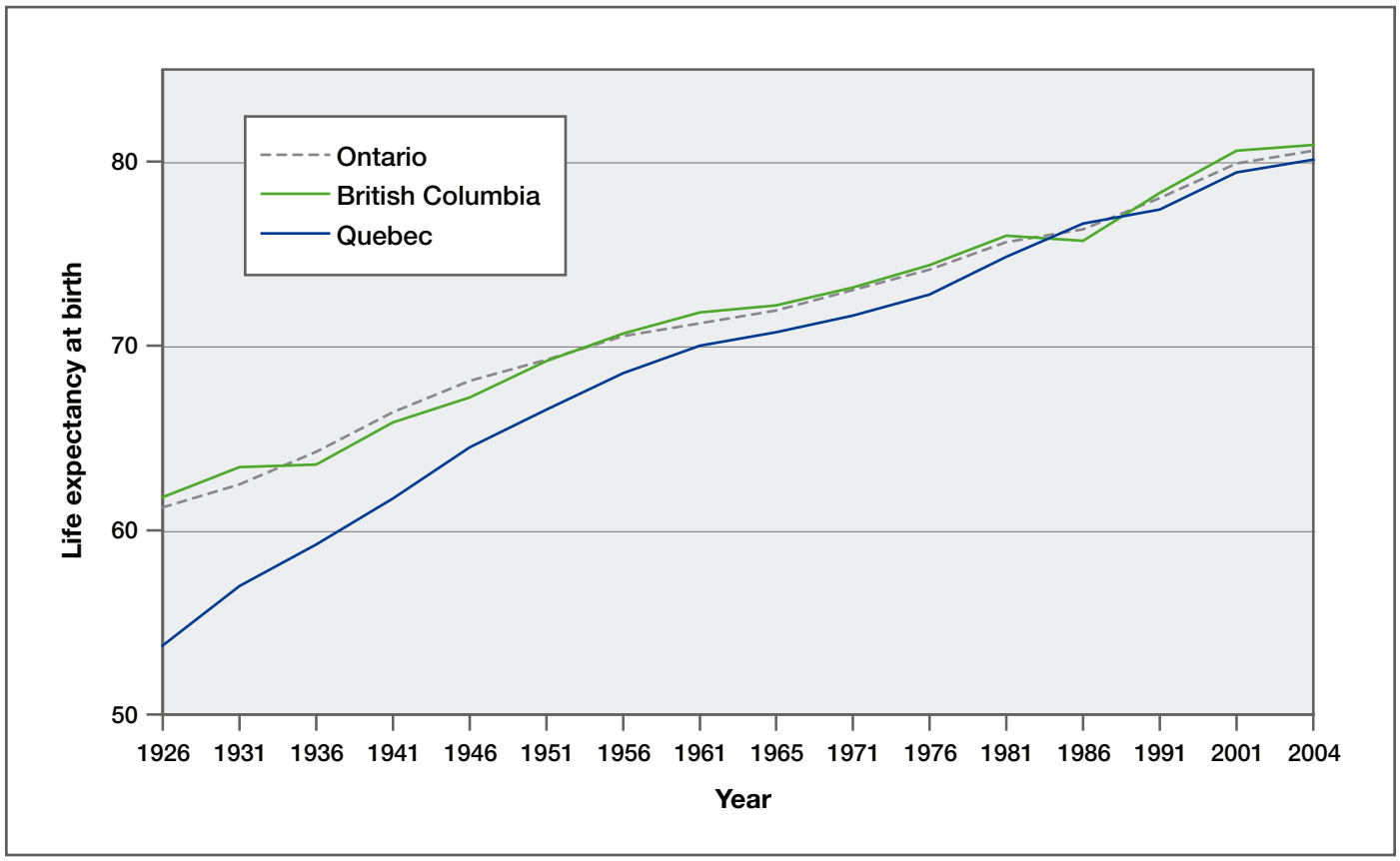
The health of any society is influenced by many different factors or "determinants." This report focuses on health behaviours that Ontarians have already identified as important during consultations to develop strategic priorities regarding health and health care.[6] These include smoking avoidance, regular physical activity, choosing a healthy diet and maintaining healthy body weight.

The focus on health behaviours is reasonable, since it would be difficult, if not impossible, to have the healthiest population in the absence of widespread and positive health behaviours. We have observed that, to achieve such an uptake of positive behaviours, leading jurisdictions pay considerable attention to a wide range of health determinants. This includes determinants which reside in both the physical and social environment and which will be discussed later in our report.

Findings and Exhibits

A comparison of health and health behaviours in Ontario to those in leading national and international jurisdictions

Exhibit 1. Life expectancy rates in British Columbia, Quebec and Ontario, 1926–2004



Data source: Statistics Canada

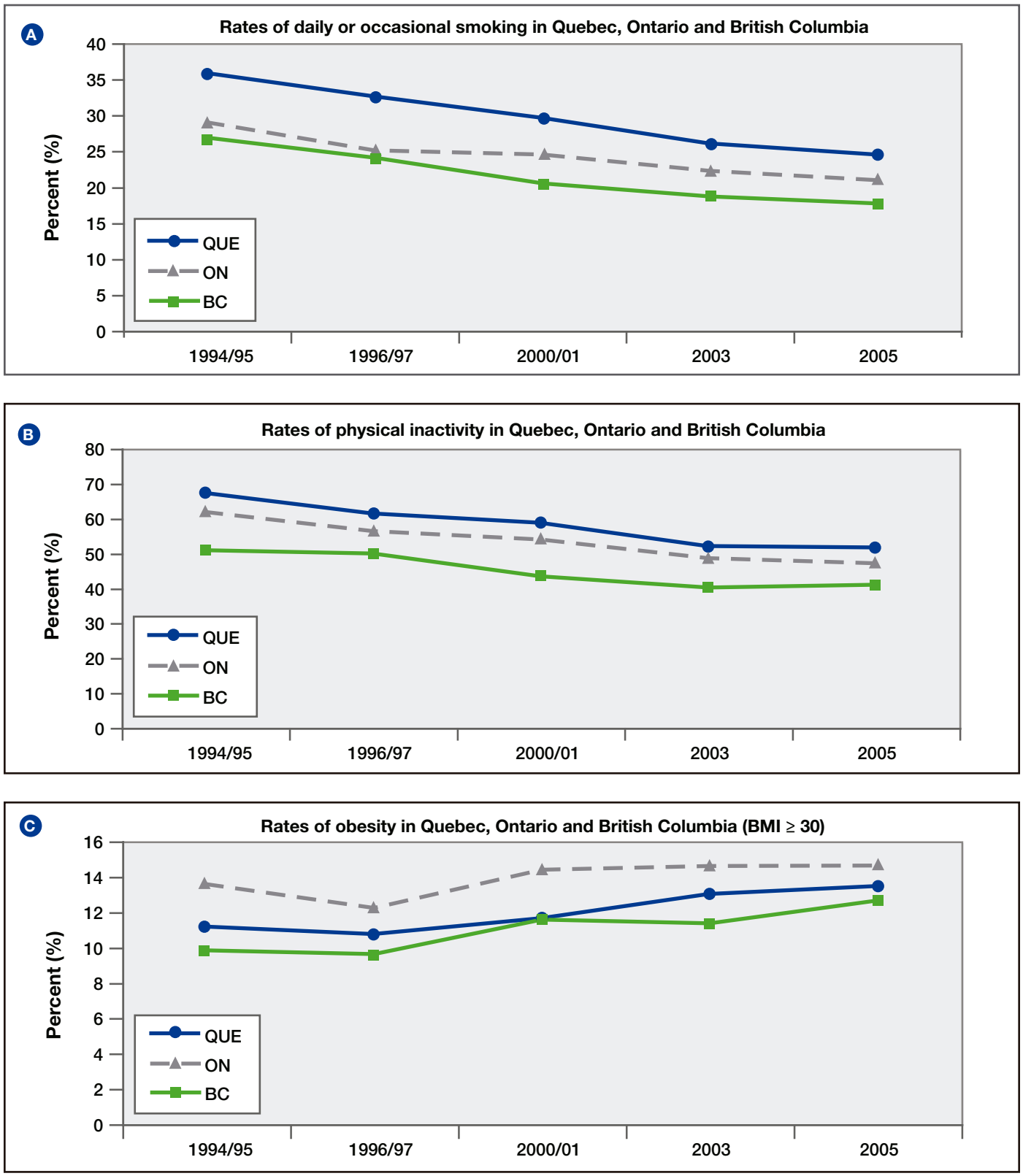
What are the healthiest jurisdictions, both nationally and internationally?

In Canada: There is consensus that within Canada, British Columbia and Quebec lead in terms of their populations' overall health and healthy behaviours.[7]

British Columbia has had the highest life expectancy rates in Canada since the early 1990s, although several other provinces, including Ontario and Alberta, have followed closely behind. When it comes to healthy behaviours, British Columbians smoke much less than other Canadians, are more physically active, and they have healthier body weights.[8]

Quebec is also considered a leader, but not because its population is among the healthiest within Canada. Indeed, for most of the last century, Quebec had the lowest provincial life expectancy rates; in fact, it still lags behind many other provinces in terms of both life expectancy and rates of smoking. Quebec's leading status is due to the fact that, over the past two decades, the province has instigated major and steady improvements, allowing it to pull ahead of many other provinces in terms of life expectancy.[9,10]

Exhibit 2. Health-related behaviours/conditions in British Columbia, Quebec and Ontario, 1994–2005



Data source: Statistics Canada: National Population Health Survey, 1994/95, 1996/97; Canadian Community Health Survey, 2000/01, 2003, 2005

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Around the world: Internationally, Japan has the highest life expectancy, but cultural and societal differences make direct comparisons with Canada and Ontario difficult. Other healthiest jurisdictions which are more similar to Canada include Nordic European countries (Sweden, Norway, Finland and Iceland), Switzerland, France and Australia.[11]

None of these countries leads in all aspects of health and healthy behaviours. However, Sweden's life expectancy rates continue to rise more quickly than those in most other countries.[12] The country also has low rates of death from causes that can be avoided through effective public health and health care.[13] Also, since 1980, Sweden has claimed the lowest infant mortality rate worldwide.[14]

Other countries which have experienced relatively rapid improvements in population health and life expectancy include some southern European countries (Portugal, Spain and Italy) and several eastern European nations (such as Poland).[15,16] In many ways, these countries are similar to Quebec, in that they embody the attributes of jurisdictions which are making rapid gains in terms of population health and health behaviours.

Looking ahead: Will Ontario be among the healthiest jurisdictions?

In the future, those Canadian provinces and developed countries which achieve the greatest progress towards increased life expectancy will be those that have found a way to prevent chronic conditions that are largely responsible for premature death—for example, cancer, heart disease and diabetes.

Based on current trends in health behaviour, morbidity and life expectancy, and taking into account existing policies and programs, Ontario's life expectancy rates will likely improve in the short term (i.e., the next five to 10 years)—at least when compared to many European countries.

However, beyond the short term, it seems likely that:

- **Ontario will start falling behind European leaders.**
- **Quebec will continue to make significant gains in this area compared to other provinces.**
- **Life expectancy rates in Quebec will surpass those in Ontario in the next 10 to 20 years.**
- **British Columbia will continue to have the highest life expectancy rates in the country.**

Many of these gains will be achieved through improved health behaviours. Currently, up to 40 percent of morbidity (illness) and 53 percent of mortality (deaths) in developed countries can be attributed to risk factors associated with the consumption of tobacco, excess alcohol intake, an unhealthy diet and obesity.[17] Studies show that between 80 and 90 percent of type 2 diabetes and heart disease could be prevented if people adopted a healthy diet, were more physically active, maintained a healthy body weight, reduced stress and avoided smoking.[18]

What does it take to make a leading jurisdiction?

We reviewed the scientific literature, consulted experts across Canada and abroad, and examined health strategies and programs from leading jurisdictions to determine how and why certain regions lead the way in promoting and maintaining good health among their populations. Our goal was to provide insight into how Ontario can improve the health of its citizens.

After studying the efforts made by leading national and international jurisdictions, we have distilled our explorations, reflections and conversations into five "lessons learned."

These lessons involve:

- the need for a guiding health imperative which drives overall health strategies
- taking a new look at what constitutes effective leadership
- gaining a better understanding of and shaping societal attitudes toward health
- taking a more broad-based, "whole government," intersectoral* approach to health interventions
- encouraging early, widespread adoption of innovative programs and policies—in some cases, even before evidence for effectiveness exists

We believe the first three lessons—the need for a guiding health imperative, rethinking effective leadership and shaping societal attitudes towards health—are an essential foundation on which to build a dynamic and transformative population health strategy.

The remaining two lessons—taking a "whole government" approach which involves many sectors of society and the early adoption of innovative programs and policies—describe what an outstanding population health strategy looks like.

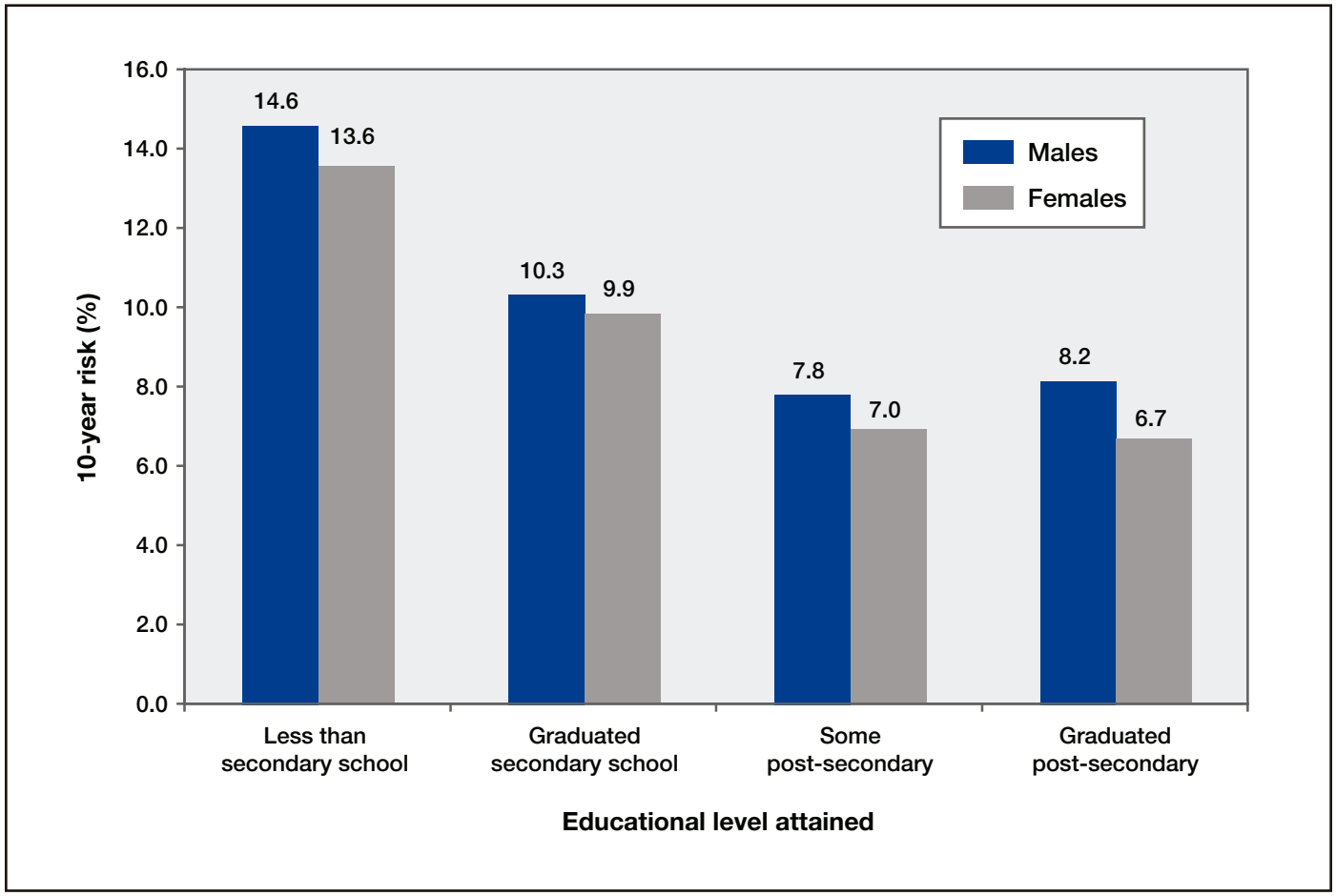
To become a leader, Ontario must make gains in disadvantaged populations.

Beyond understanding and acting on the "lessons learned" in this report, we note that leading jurisdictions all pay special attention to disadvantaged populations. Disadvantaged groups, such as low-income individuals and families, and First Nations populations require such focused attention for a number of reasons:

- People in the lowest socioeconomic position account for the greatest proportion of a jurisdiction's poor health and negative health behaviours.[20-23] This particularly applies when one looks at emerging health risks such as type 2 diabetes *(see Exhibit 3)*. A study by Wilkins et al. showed that life expectancy rates in Canada would increase more if we eliminated the mortality gap between the highest and lowest socioeconomic groups than it would if we were to somehow totally eliminate premature deaths from cardiovascular disease.[24]
- Many authors believe that the Swedes are leaders because they do a better job of addressing and resolving health inequities than any other country in the world. Indeed, Sweden's health imperative *(see Lesson 1)* is social equity.[12,25] Leadership *(see Lesson 2)* plays a key role in this area because the voices of disadvantaged citizens are not heard as easily as the voices of those in more privileged sectors of society. Effective leaders must make a special effort to hear what less advantaged people are saying and to consider how their strategies affect these groups.

* The concept of "intersectoral" action refers to forming relationships between the health sector and other sectors (both public and private) for the purpose of taking action on specific issues to achieve better health outcomes.[19]

Exhibit 3. Predicted new cases of type 2 diabetes (per 100 people) by level of education attained, in Canada, 2005–2015



Data source: Rosella L, Manuel D. A population-based risk algorithm for the development of physician-diagnosed diabetes mellitus (DM). *Am J Epidemiol.* 2006; 163(11 Suppl):S182.

- It is fundamentally unfair to try and change social attitudes *(see Lesson 3)* or to tell poor people they should take more responsibility for their health if governments do not remove societal barriers which might prevent them from doing so. For example, studies show that health promotion interventions in low-income households are insufficient to outweigh the negative effects of poverty on nutrition.[26] The Swedish model for enacting behaviour change focuses on creating social conditions for change rather than focusing on individual responsibility.[27,28] The Swedish example also highlights the fact that broad-based solutions for improving health *(see Lesson 4)* are essential—for example, building safer communities so people are more likely to go for a regular walk after dinner. Interventions at the population level are seen as most effective when they address the broad range of underlying social, economic and environmental conditions.[29]
- Finally, there is a tendency for people in higher socioeconomic groups to be the first beneficiaries of population health interventions. Unless care is taken to ensure rapid implementation of effective programs and policies throughout the population *(see Lesson 5)* or better yet, to begin introducing them in among disadvantaged citizens, health inequalities are likely to increase. Indeed, our review suggests that strategies employed by leading jurisdictions are disproportionately helpful for people experiencing the greatest need.[14] That stated, even in Sweden, obesity is increasing among poor people while it is decreasing among the rich.[12,28]

The Five "Lessons Learned"

While our list of "lessons learned" can be applied across jurisdictions, we observed that healthiest provinces and nations are by no means alike. Each leading jurisdiction has developed an outstanding health strategy based largely on studying effective strategies in other jurisdictions and in the literature. However, each jurisdiction then tailored its own strategy to suit its population and to serve its specific needs. In the end, each chose a variety of paths towards achieving their leading status; not all of these have been considered, nor are they reflected in our review.

Lesson 1: A guiding health imperative must drive overall health strategies.

Our analysis suggests that in leading jurisdictions, an extraordinary level of attention is paid to achieving the best possible health among their citizens. This "health imperative" permeates both the government itself and the surrounding civil society.

For example, in British Columbia, simple cost estimates showed that if the burden of illness caused by chronic diseases was left unchecked, the delivery of health care services would become unsustainable.[30] In the words of Andrew Hazlewood, Assistant Deputy Minister in British Columbia's Ministry of Health, this created a "burning platform"* for the development of the province's current *ActNow* strategy. This strategy, launched in 2005, is an integrated, partnership-based, multisectoral, health promotion and chronic disease prevention strategy. It was designed to improve the health of British Columbians by focusing on the risk factors associated with chronic ill health: physical inactivity, poor nutrition, tobacco use and alcohol use during pregnancy. More recently, in June 2008, BC created the Ministry of Healthy Living and Sport, with the responsibility of health promotion and protection and public health planning. Creating this new Ministry emphasizes the fundamental importance of promoting healthy living to improve population health and emphasizes that the role of government in health is not just the delivery of health services.

In other leading jurisdictions, the guiding health imperative relates to the overall value of having a healthy society. For example, Sweden is characterized by a fundamental belief that all citizens have an equal right to be healthy. In Quebec, health is viewed by some opinion leaders as "part of the collective wealth." In making that statement, Dr. Denis Roy (Directeur de la gestion de l'information et des connaissances, Agence de la santé et des services sociaux de la Montérégie) said that the people's health must be protected and that "it is the *raison d'etre* of the government to do (so)."

Leading jurisdictions create ways to constantly remind themselves about what really contributes to better health among populations and what kinds of decisions are needed to achieve it. They also avoid letting themselves become distracted by "crises" which seem to be a part of daily life for government departments involved in health. The crisis "du jour" (such as long wait times, crowded emergency rooms, economic recession and political scandals) and the attention paid to media reports on these crises can create a sense that deep systemic problems exist. But these problems are not always a true reflection of the health of a community. While leaders should certainly address real problems when they arise, they must also create a sense of balance by promoting and celebrating real achievements.

* When the oil platform Piper Alpha in the North Sea caught fire, a worker was trapped by the fire on the edge of the platform. Rather than choose certain death in the fire, he chose probable death by jumping 100 feet into the freezing sea. The term "burning platform" is now used to describe a situation where people are forced to act because the alternative is somewhat worse (i.e., a crisis already exists and just needs to be highlighted).

Lesson 2: The best strategies for improving population health and health-related behaviours arise during the tenure of strong political leaders.

Outstanding leaders are not necessarily larger-than-life figures. They are people who propel a jurisdiction beyond its expected course. Many are comfortable knowing that, in the minds of most, the success of an initiative will never be traced directly back to them.[31] In fact, credit for such success will reasonably be attributed to others, especially when the outcome is as massive as improving population health and shifting the health behaviour of many thousands or even millions of people.

Effective leaders do not always find the solutions themselves. They may draw upon the collective intelligence of people within the existing government and within the civil society at large—from academics to community leaders, from legal experts to journalists. The best kind of leadership unites different government ministries and departments together around a common purpose and signals how the larger society can best engage and support government strategies.

Effective leaders take ownership over three activities:

- **They articulate a future vision and/or change by setting clear goals and by establishing structures to measure accountability.** One characteristic that distinguishes leaders in successful jurisdictions is their open commitment to clearly articulated goals. Such health goals are not only important in their own right; they can also be used as an accountability tool because they provide a metric against which performance can be measured.
- **They are inclusive.** Effective leaders are able to find a balance between being personally involved in a new health initiative and allowing other senior team members to play a leading role. Many of the healthiest jurisdictions we studied are characterized by coordinating structures, chaired by the leader, at the most senior levels of government. For example, British Columbia has a Minister of State; this person is a cabinet minister who is the government coordinator for the province's *ActNow* health program and who is also responsible for the program's overall implementation.
- **They understand how to properly allocate resources.** Suggesting change which is aimed at improving population health and encouraging healthy behaviours will affect many levels of government and will also impact the broader society. Inevitably, this will require considerable resources, which must be available across many fiscal years. Senior political leaders ultimately have the most influence when it comes to allocating such government resources. But even effective leaders may meet political opposition as governments face the twin imperatives of growing the economy and exercising fiscal restraint.

Our analysis shows that even the healthiest jurisdictions sometimes allocate surprisingly small amounts of resources to activities directly tied to population health strategies. This is despite the fact that population health strategies usually offer good value for money. For instance, leading jurisdictions have learned that strategies to curb and prevent smoking—such as raising taxes on tobacco and ultimately reducing tobacco-related illness—have been revenue-generating. Strong political leaders are often willing to spend money on improving health today in order to save both needless suffering and health care dollars tomorrow.

Examples of effective health policy leadership in Canada and elsewhere

Leaders in health and health policy have typically been provincial premiers and ministers of health. British Columbia has had the most enduring record of leadership in introducing effective health behaviour strategies, including the country's first ban on tobacco advertising which was implemented in that province in 1971.

British Columbia

In 2006, Gordon Campbell, the current Premier of British Columbia, launched a province-wide healthy living program called *ActNow*, described as one of the "five great goals for a golden decade." This broad campaign is directed at all sectors of the population, with tailored messages for each group. It is comprehensive in encouraging positive changes in diet, physical activity and tobacco use, in encouraging healthy weight maintenance, and in promoting women's health during pregnancy.

"We live in an incredible place and there's no reason why we can't be a world leader in physical activity and healthy living."

—Gordon Campbell, Premier of British Columbia (March 19, 2005)

The stated goal of the *ActNow* program is to make British Columbia, which will be hosting the Winter Olympics in 2010, the healthiest jurisdiction to ever host the Olympic games. The program is currently Canada's most ambitious strategy aimed at improving the health of an entire provincial population.

Quebec

In Quebec, much of the current public health infrastructure was instituted when Jean Rochon was the provincial Minister of Health. Before entering provincial politics, Rochon founded the Département de Médecine Sociale et Préventive at Laval University. He also led a special commission involved in restructuring health care in Montreal (La Commission Rochon) between 1985 and 1987.

Quebec has been regarded as a leader, not just within Canada, but around the world, for successfully developing and launching large, comprehensive public health strategies. The "Network of Healthy Towns and Villages" is an example of a health initiative that began 20 years ago as a project in a small Quebec town.* This initiative was so successful that it has been used as a model for "healthy municipal policy" in Europe, South America, Mexico and Africa.[32]

Quebec's emergence as a leading jurisdiction can be largely credited to a dramatic enhancement of public health and social infrastructure that began two decades ago.[9,10] This infrastructure expansion and enrichment was aimed at supporting health-oriented public policy and programs. Quebec is currently the only province with a comprehensive independent public health institute, L'institute National de Santé du Publique Québec—although British Columbia has the British Columbia Centre for Disease Control, an independent institute focused on communicable disease and environmental health.

Finland

In the European Nordic countries, there is a long history of leaders who championed social policies, which (either directly or indirectly) benefited the health of their populations. Thirty years ago, rates of cardiovascular disease in Finland were among the highest in the world. In 1972, the Finnish government initiated the North Karelia project, one of the world's first, largest and most successful community-based programs aimed at reducing heart disease. The result was a 75 percent drop in Finland's rate of heart disease (compared to rates in the rest of Europe).[33] This monumental change came about under the leadership of Dr. Pekka Puska, the project's chief investigator, who was later elected to the Finnish National Parliament and has since held many health leadership positions.

* This Network began in 1987 as a project in a small mining town called Rouyn-Noranda. The impetus was concern about the health effects of environmental pollution related to the local mine. An effort was made to create collaborations between citizens, local industry, labour unions, municipal authorities, community groups and members of local public health groups. The goal was to tackle and solve local health issues at the municipal level.

Strong leaders persevere when faced with opposition.

Why is strong political leadership a virtual necessity when it comes to developing and adopting strategies that can significantly improve population health? The fact is that many people find it boring or off-putting to hear constant messages from their health care providers and others (including politicians and policy makers) about the need to eliminate smoking, curb obesity, eat a healthier diet and engage in regular physical activity. Consistently championing these issues gains politicians few votes—indeed, it involves considerable risks, which only the most savvy and committed leaders are willing to assume.

Effective leaders typically welcome criticism from within the larger civil society, including criticism which is aimed directly at their governments. For example, they are willing to resist challenges to new, health-oriented programs and policies which come from vested interests, such as medical devices/pharmaceutical industries or health professional groups. The fact is that public health policy which benefits the greatest number of people almost always encounters opposition from lobbyists representing small but powerful groups. For example, tobacco companies have been effective in derailing many well-meaning programs aimed at reducing tobacco use and thereby improving public health.

To date, British Columbia remains the only province in Canada that has attempted to sue tobacco companies for damages and costs related to smoking.[34] Leadership from the Office of the Attorney General in British Columbia won considerable public approval and provided support for the introduction of many "smoke-free" programs. But the province's anti-smoking program has met with considerable opposition along the way. A proposal to make restaurants smoke-free provoked the wrath of the food and hospitality industries. Despite this, and after several failed attempts, a number of British Columbia municipalities and local governments implemented smoke-free restaurant policies, providing a model for action that will benefit other jurisdictions.

In 2000, leaders in Quebec, recognizing that addiction to tobacco is a medical and treatable condition, made the decision to publicly fund tobacco cessation drugs and products. So far, Quebec is the only province in Canada to take such a step.

But even the most effective leaders need help, especially if their plans are not fully supported within their own governments and in the larger civil society. They understand the benefits of establishing a strong leadership infrastructure, including the nurturing of secondary leaders, both within and outside government.

Effective leaders set up infrastructures for improving health that remain even after they are gone.

Political leaders are elected officials, and their names and faces typically change on a regular basis—usually every three or four years. The most effective leaders understand this and know how important it is to craft and introduce systems which will outlast their own personal political tenure.

Thus, when the current leadership changes or wanes, the existing infrastructure allows leading jurisdictions to sustain their health strategies through a broad base of advocates and supporting agencies. Such an infrastructure also mobilizes quickly to support new leaders when they emerge.

For example, both British Columbia and Quebec provide adequate, stable and long-term funding to a coalition of non-profit agencies which are collectively accountable for developing health policy and programs.[9] This model has been particularly successful in developing tobacco strategies in many provinces, including Ontario.[35] The responsibilities of independent provincial public health agencies in British Columbia and Quebec include policy development. Coalitions and intersectoral partnerships have contributed greatly to the success of public health programs in these two leading Canadian jurisdictions.[36]

Lesson 3: Pay attention to societal attitudes about health, and make efforts to understand the prevailing political and social structures.

Societal attitudes about health—for example, how people feel about the importance of physical activity and maintaining a healthy body weight—are important because they exert considerable influence on whether and to what degree people engage in healthy behaviours. Such attitudes also affect whether new policies and/or programs are instituted and, if they are, whether they will yield positive results. That is why leading jurisdictions nurture positive attitudes about health and introduce programs that are closely aligned to these values. If the prevailing attitudes seem to be more negative (i.e., people are indifferent or even hostile to concepts of good health), effective leaders respond by developing and introducing programs aimed at countering these negative values and beliefs.

If we study the healthiest jurisdictions, we observe that these environments make it easier for residents to live healthier lives.[3] Of course, each individual is ultimately responsible for making the best choices in terms of healthy behaviours. But we noted that leading jurisdictions do whatever they can to support people so they eventually do make positive choices. This occurs through the combined effect of social influence and providing supportive physical and social environments.

We noted that in leading jurisdictions, a "snowball" effect seems to occur (i.e., the small snowball rolling down a snowy hill, getting larger and larger in the process). As more people take on a healthy lifestyle, more people start wanting, even demanding a social and physical environment that allows them to achieve their potential. As the healthier behaviours become the new norm, people who continue living unhealthy lifestyles experience more pressure to change—and more support—from family, friends and colleagues who have adopted and are benefiting from healthier choices and activities.

Brandon Zagorski:
ICES data analyst, recent Ontario immigrant, and bike enthusiast

Ontario businesses actively seek and recruit the best knowledge workers. The Institute for Clinical Evaluative Sciences (ICES), a population health research institute in Toronto, Ontario, was fortunate to hire Brandon Zagorski, a health care data analyst from Chicago, Illinois.

Brandon says a key attraction for him in making the move to Canada, and to Ontario in particular, was Toronto's active bicycling community and the fact that he would be able to commute to work as well as travel around the city by bike.

Since he started work at ICES a few years ago, Brandon—who volunteered for community bicycle organizations in Chicago—has formed an active BUG (bicycle users group) at his new workplace. He has helped many of his co-workers begin cycling and has also volunteered in local community groups which advocate for a better bicycling infrastructure in Toronto. The overflowing bike racks outside the ICES building are a testament to his personal initiative, and also to how a community that supports healthy living can attract people who then go on to help make their adopted communities even healthier.

It probably does not matter which came first in British Columbia—healthy social attitudes combined with a supportive environment, or an increase in the proportion of residents adopting and modelling healthy behaviours. What does matter is the fact that it has been relatively easy for leaders in British Columbia to introduce programs that support healthy living.

It seems intuitive that provinces and municipalities with the highest smoking rates should be the first to initiate a comprehensive anti-smoking strategy. After all, they have the most to gain from reduced smoking and improved health. But, somewhat perversely, quite the opposite is true in Canada[37] and in most of the world. Indeed, British Columbia, which has had the lowest smoking rates in the country for over 20 years, was the first province to introduce many smoke-free policies. This eventually led to a further decrease in tobacco use in British Columbia and created a social environment for even more comprehensive smoke-free policies.

Leading jurisdictions target their lagging social attitudes towards health.

Fortunately, even jurisdictions characterized by poor health behaviours among a large portion of residents can turn things around both effectively and promptly if the will to do so exists. Arguably, smoking has been part of Quebec culture to a degree not seen in other provinces. Yet tobacco use in Quebec has declined more quickly in recent years than it has in most other Canadian provinces. How can this be?

Rapidly improving jurisdictions share certain key features. For example, the gap between their historic social attitudes and the implementation of health strategies may be relatively small. Some such regions actually develop programs geared specifically to raise public awareness about a particular health issue and/or to encourage people to change unhealthy attitudes.

We observed that, when it came to smoking—a leading cause of preventable morbidity and mortality—even leading jurisdictions experienced many program and policy implementation setbacks. *But this did not stop them.* Their leaders learned from those failures and pushed forward towards incrementally building comprehensive programs. In fact, the initial "failed" implementation often helped shift civil and/or political attitudes. In other cases, policy makers re-tooled proposed programs, ensuring they would be better aligned with the dominant social and political environment. For example, Quebec's action plan for preventing obesity, *Investing for the Future,* is the only provincial strategy that specifically identifies "promoting favourable social standards" as one of its five priority activities.[38]

A 30-year-old Canadian success story in transforming health behaviours

The 1979 *ParticipAction* campaign is the iconic Canadian example of how governments and other stakeholders can develop and deliver a positive message that transforms health behaviours in a national population.

Nearly 30 years ago, the federal government sponsored a 15-second television advertisement which showed a young Canadian male running beside an older Swede with the following narration: "The average 30-year-old Canadian is in the same shape as the average 60-year-old Swede." Although the ad was broadcast only six times, it galvanized Canadian leaders and others. The relatively low levels of physical fitness among Canadians were debated in Parliament, and new physical activity programs soon spread across Canada.

Societal attitudes can help overcome governmental barriers.

It's a fact that the majority of Canadians supported smoke-free policies for years before these policies were actually implemented.[35] Non-governmental leaders (including academics), as well as non-governmental organizations, advocated for smoking-related policy change by engaging with political and government leaders.

In a democracy, the views of elected politicians often reflect those within the surrounding civil society. However, even if the views of the politicians and the people are aligned, changes in policy may not be forthcoming. In such situations, other barriers may exist—for example, within the civil service. Individual civil servants and organizations can and often do find ways to minimize the enthusiasm of elected leaders for a particular program or policy.

Such impediments can stem from underlying structures. These might include individuals or groups within government who are tasked with the multiple roles of policy analysis, decision-making and program implementation, yet who are not given additional resources for program implementation. One approach common to leading jurisdictions is the use of agencies external to government—or at least external to government decision-makers—which provide support for policy and program development and also help with implementing new programs.

Governments must understand and harness the powers of prevailing social structures.

Societal structures such as government institutions, family structures and labour markets all play a role in the health of populations within a particular jurisdiction, whether this is a nation, a province or a municipality. How citizens feel about each of these societal structures often determines why one approach is emphasized more than others.

Many authors argue that Sweden's emphasis on government or "institutional" welfare is the most important reason that country has emerged as a global population health leader.[14,39,40] If these authors are correct, other jurisdictions may face an insurmountable challenge if they choose to take the same approach as the Swedes. It may be impossible for them to succeed without that country's high level of societal support for social welfare programs—for example, if they decided to reduce income equity through taxation reform. Indeed, such political and social attitudes typically lie outside the scope of regional health or health behaviour strategies designed to improve the well-being of populations.

Others argue that Sweden's success does not rest on its government institutions. Instead, they believe that an effective symbiosis between different structures—government "welfare" institutions, family structures and labour markets[41] —is the real key to success. For example, Sweden has developed and implemented well-financed social protection programs, including a highly progressive taxation system and an emphasis on publicly-funded social support structures such as equitable health care, child care and education. But the country also has a high rate of labour force participation and low unemployment, which reflects the efficiency of the labour market in terms of job opportunities, equality in earning and economic security, among other factors.

Many counties in southern Europe (including Portugal, Spain and Italy), which have recently been making strides towards becoming leaders in population health, can best be characterized as "family welfare" states. These countries have lower levels of social expenditure, less income equality and lower rates of employment. But they are characterized by strong, traditional family structures.[41] For example, extended family members are expected to assume responsibility when a relative is in need of financial or social support; care of young children and the elderly is shared across the family. Such strong family structures may contribute to positive health behaviours such as choosing to eat a healthy, locally-grown diet and to take part in regular physical activity.[41]

By contrast, countries such as Canada, Australia and some central European nations are characterized by a mix of "institutional welfare" and "family welfare." Family ties are important in these countries but not as prominent or binding as those which exist in other societies. The mixed emphases on different social structures may be a conducive social setting for good health if there is a high degree of efficiency between these structures.[41] But this does not appear to be the case: we observed only intermediate levels of efficiency between societal structures in these jurisdictions.

Lesson 4: To solve broad-based problems, look for solutions which can be applied across governments with the participation of the larger civil society.

Health behaviours are influenced not only by individual choice but also by the broader social and physical environment in which we live. For example, food choices are influenced by what resources are available in neighbourhoods (i.e., in local grocery stores, restaurants, school and workplace cafeterias). Decisions which affect daily physical activity are influenced by a host of factors (i.e., whether effective local public transportation is available and accessible, whether there are enough accessible public recreation spaces, the relative safety of neighbourhoods). Behaviours are also shaped by what children are taught in school, and by the messages—some subtle, others more obvious—that people receive via the media.

The complex relationship between people and their environment requires a comprehensive and intersectoral or "whole government" approach to tackling health behaviours, both within government itself and in the larger civil society. If a jurisdiction is to become a leader in health and healthy behaviours, policy makers and planners must be engaged across most government sectors and on all levels, from federal to municipal.

Our analysis suggests that the healthiest jurisdictions in Canada have achieved their leadership status through highly coordinated activities that spanned most provincial ministries:

- For example, British Columbia's *ActNow* program involves almost all government ministries in addition to the province's Ministry of Healthy Living and Sport.[8] A special Minister of State coordinates the overall *ActNow* strategy and is accountable to government for achieving the program goals.
- In 2002, Quebec legislators enacted Article 54 to ensure that all public policies across all government ministries were evaluated for their impact on population health, at both regional and provincial levels. All ministries in that province are required to perform these health impact assessments and to report their findings to the Ministry of Health.
- Quebec and Prince Edward Island (PEI) are the only Canadian provinces where health care and social services are integrated within the same government structure. This allows for, and indeed encourages, greater integration between social policy and health policy. By choosing this structure, government leaders in Quebec and PEI have acknowledged that many determinants of health such as income, education and employment are social in nature.[9]
- In Sweden and other leading European jurisdictions, the federal government assumes a dominant role in preserving and promoting population health. As well, there is a considerable amount of coordinated policy development across countries within the European Union.

Success is linked to creating a key role for municipalities.

However, people do not live in nations, provinces or cities—in reality, they live in neighbourhoods within cities and towns, and that is where the greatest opportunities for encouraging healthier behaviours exist. Clearly, municipal governments are important and must be involved in efforts to improve population health and health behaviours. For example:

- Sweden's successful national health policy explicitly includes municipalities in the accountability structure for achieving that country's national public health goals.[42]
- The architects of British Columbia's *ActNow* strategy understood the importance of building it from the bottom up: B.C. municipalities have been and continue to be a key partner in the initiative.

While municipal involvement in provincial and federal health and health behaviour strategies in Canada is not always obvious, we note that many innovative and important health policies originated in dynamic and forward-thinking cities and towns. These policies then spread to other municipalities and eventually expanded to become provincial policies. A good example of this phenomenon is the move towards smoke-free public spaces and healthier foods on restaurant menus:

- Smoke-free public spaces initiatives were spearheaded in the municipalities of Ottawa and Vancouver, and soon similar policies were adopted across Canada.
- More recently, Calgary and New York City led the way by introducing a ban on cooking with and serving meals containing unhealthy trans fats in restaurants.*

* Calgary is no longer enforcing this ban since the Alberta health authorities decided that it was "unfair" to have a different standard for Calgary than the rest of the province.

Success depends on co-operation between government and civil society

For a jurisdiction to be successful in efforts to improve population health and health behaviours, structures which facilitate intersectoral collaborations and/or actions must exist. Successful implementation of programs targeting whole populations depends on an alignment between government and civil society.

Leading European countries take a comprehensive approach to food availability and selection which simultaneously targets industry, social environment and individuals.[28,43-46] For example, in Finland, leaders realized that the high levels of cardiovascular disease and mortality which existed 30 years ago in that country were, in part, the result of a national diet that was extremely high in unhealthy fat. In 1976, the Finnish government launched a Heart Health Strategy which included transforming the country's agricultural industry to decrease the traditional focus on meat and dairy products and to emphasize the growing of whole grains and berries. National research agencies even developed new crops such as cold-weather resistant grains and berries. (Indeed, Finland is currently Europe's leading berry exporter.)

These initiatives are an excellent example of how government, business and industry were able to work together in a complementary and economically viable way to improve the diet of an entire population. This, in turn, yielded significant improvements in population health: between 1976 and 2002, mortality from chronic heart disease dropped by 76 percent in Finnish men aged 35–64 years—a change which is largely attributable to improvements in population health behaviours.

Successful strategies are comprehensive and multifaceted

When it comes to effecting broad societal changes in health behaviours, multi-pronged and comprehensive strategies seem likeliest to succeed. For example, the decrease in tobacco consumption in Canada over the past 15 years has been influenced by a number of different programs and initiatives over time *(see Exhibit 4).* These include: educating the public about the dangers of smoking; enacting legislation that restricts who can buy and sell tobacco; limiting where people can smoke in public; curbing tobacco advertising; increasing taxes; and introducing programs aimed at helping smokers quit.

Strategies aimed at reducing obesity—seen by many as a current high-priority target—and at boosting levels of physical activity within populations will have to be similarly comprehensive.[47,48] For example, a recent study conducted by Toronto researchers looked at neighbourhood characteristics associated with high rates of type 2 diabetes among residents. The researchers found that variables such as population density, service density and dispersion, crime rates, car ownership and opportunities for physical activity were all associated with how often people chose to be physically active in their neighbourhoods—a behaviour linked to reduced diabetes risk.[49]

▸ Lesson 5: Act promptly. Leading jurisdictions do not necessarily wait for conclusive scientific evidence and are often the first to implement innovative interventions.

Over the past two decades there has been a worldwide movement toward "evidence-based" public health and health care. This means that interventions are not usually implemented before conclusive evidence of their effectiveness and safety has been published. But our review suggests that leading jurisdictions often act to protect population health *before* there is indisputable supporting evidence in favour of a specific intervention or outcome.

For instance, in the early 1990s British Columbia launched strategies to reduce tobacco consumption (*see Exhibit 4)*. Such strategies, which seemed intuitively reasonable, included raising tobacco prices, providing smoking cessation help, placing restrictions on tobacco advertisement and legislating smoke-free workspaces. These intervention-based strategies were put in place before systematic evaluations of their effectiveness were available and before nearly all other jurisdictions world-wide took similar steps.[34,50] Currently, British Columbia boasts one of the lowest rates of smoking in the world. In contrast, many lagging jurisdictions (both within Canada and internationally) have still not implemented similar tobacco control interventions, even though the benefit to population health has now been clearly demonstrated.

Exhibit 4. A four-year* interval timeline of provincial and national tobacco policies in Canada, 1970–2005

Timeline	Ontario	British Columbia (BC)	Quebec
1970–1974		**1971** - Tobacco advertising is banned in BC.	
1975–1979	**1976** - The city of Ottawa passes a municipal bylaw restricting smoking in public, the first of its kind in Canada (effective in 1977).		
1980–1984			
1985–1989		**1986** - A bylaw restricting workplace smoking is passed in Vancouver, BC.	**1986** - Quebec passes a bylaw to restrict smoking in workplaces and in some public places (effective in 1987).
	1988 - Canada bans tobacco advertising (the *Tobacco Products Control Act*) and restricts smoking in federally regulated workplaces and public places *(the Non-Smoker's Health Act).*		
1990–1994	**1992** - *The Ontario Tobacco Strategy (OTS)* is established with committed government funding of $60 million/year. **1993** - The Ontario Tobacco Research Unit is established.		
	1994 - Ontario and BC (along with New Brunswick, Nova Scotia and Newfoundland) raise the legal tobacco products purchase age to 19 years.		
	The *Ontario Tobacco Control Act* is passed, increasing restrictions on who can buy and sell tobacco. It also restricts smoking in public spaces and places more emphasis on enforcement and penalties.		
1995–1999		**1996** - Vancouver, BC bans smoking in restaurants.	
	1997 - The *Tobacco Act* (Bill C-17) is passed in Canada, further restricting youth access to tobacco, restricting the promotion of tobacco products, increasing the mandatory health information required on tobacco packages and establishing authority for tobacco product regulation.		
		1997 - BC is the first province to introduce legislation to enable lawsuits against the tobacco industry. **1998** - BC adopts the *Tobacco Testing and Disclosure Regulation.* **1999** – The Capital Regional District in BC becomes the first place in Canada to successfully pass, implement and enforce a 100% smoke-free bylaw which covers smoking in bars and restaurants.	**1998** - The *Quebec Tobacco Act* is enacted.
2000–2004		**2000** - The BC College of Pharmacists votes to ban cigarette sales in pharmacies.	**2000** - Quebec is the first (and to date the only) province to fund smoking cessation drugs and products. **2001** - The *Plan quebecois de lutte contre le tabagisme* is implemented to "denormalize" smoking.
	2000 - New graphic health warnings (including full-colour pictures and text) are required on all cigarette packages sold in Canada, setting a number of world precedents and serving as an international model for cigarette labeling.		
	2003 - Ontario's Workplace Safety and Insurance Board rules in favour of a waitress who developed cancer after long exposure to second-hand smoke at work.	**2002** - BC bans smoking in workplaces, but continues to allow designated smoking areas (DSAs) both inside and outside the workplace.	
2005–2006	**2006** - The *Smoke-Free Ontario Act* comes into effect, strengthening youth access regulations and banning smoking in enclosed workplaces and public places.	**2005** - The Supreme Court allows the BC government to sue the tobacco industry for health-care costs related to smoking; BC launches its *ActNow* campaign for healthy living.	**2006** - Quebec bans smoking in enclosed public places and workplaces and requires the registration of all tobacco retail outlets.

*Except for data in 2005–2006 which correspond to a 12-month interval.
Sources: Cunningham R. Smoke and Mirrors: *The Canadian Tobacco War.* Ottawa: International Development Research Centre; 1996. p. 289–91. Canadian Council for Tobacco Control. *Backgrounder: Chronology of Tobacco Control Milestones.* Accessed on April 10, 2008, at: http://www.cctc.ca/cctc/EN/mediaroom/backgrounders.

As we have already mentioned, a public health challenge similar to the one caused by tobacco use is now being posed by rising levels of obesity, both in Canada and in other western countries. For example, there is evidence that the prevalence of overweight and obesity among Canadian children has nearly quadrupled since the 1980s.[51] But instead of acting, policy makers and academics continue to debate and study the causes, prevention and treatment of obesity, waiting for incontrovertible evidence about the effectiveness of various approaches to the problem. This has no doubt led to some hesitation in implementing broad-based programs targeted at reducing obesity.

This may not be a wise approach. Indeed, some leading jurisdictions have decided not to wait. British Columbia and Quebec have developed and introduced the largest and most comprehensive package of measures ever seen in Canada to increase levels of physical activity and improve eating habits among their resident populations.[8,38] For example, programs are underway to remove high-fat, high-sugar foods from schools in those provinces and to introduce more nutritious food choices. These jurisdictions are also looking at ways to offer young people more opportunities for daily physical activity. In these cases, widespread implementation is based less on scientific evidence and more on a combination of sound scientific judgement and an understanding of specific communities.

Leaders expand quickly from demonstration programs to full implementation

In most jurisdictions, new population health interventions usually start as small "demonstration" or pilot programs. But our analysis suggests that in this area, there are important differences between jurisdictional leaders and laggers.

Leading jurisdictions typically introduce large programs, often skipping smaller demonstration projects altogether. They are also the quickest to adopt and fully implement programs which have been proven effective elsewhere. By contrast, laggers often jump from one demonstration project to another and never commit themselves to widespread implementation of successful programs. What's worse, in many cases they fail to discontinue clearly ineffective programs.

We observed that in leading jurisdictions, there is adequate and sustained investment in population and health behaviour programs. This allows governments and their partners to establish and maintain fully implemented strategies. Currently, British Columbia and Quebec are the only two provinces with well-resourced public health agencies (the Public Health Agency of British Columbia and the Institut National de Santé Publique du Québec (INSPQ), respectively). We noted that these provinces are spending between three and eight times more dollars per capita on programs compared to Ontario.

A summary of "lessons learned"

Based on our research, we suggest jurisdictions review their situations to see if they possess the key "enabling structures" for the early adoption and widespread implementation of programs.

These are:

- **well-resourced and effective scientific and policy structures, both within and outside of government**
- **ongoing assessment of community need**
- **clear goals**
- **close collaboration among partnering agencies**
- **readiness by decision-makers to (re)allocate resources**

Benchmarking Strategies, Programs and Targets

To better understand Ontario's progress towards becoming a jurisdictional leader in population health and healthy behaviours, we conducted a focused review:

- First, we sought to identify all provincial and federal strategies and programs specifically designed to address either population health and/or health behaviour. We also consulted previously published reviews summarizing each province's health behaviour targets.[52-56]
- We compared Ontario's current population health strategies, programs and targets to existing federal ones and also to those of British Columbia and Quebec, both considered the leading provinces in population health and healthy behaviours. *(see Exhibit 5).*
- Finally, we looked at information about what different countries around the world are doing to address specific health problems, such as obesity, which likely require widespread changes in health behaviour.[38]

At the program level, many monitoring and reporting agencies—including the Health Council of Canada[57]—have found it difficult to compare jurisdictions in terms of what they are doing to improve population health and health behaviours. However, we felt it was worth the effort to take a closer look.

We found that most jurisdictions around the world have produced some kind of comprehensive report acknowledging the importance of improving overall health and health behaviour. They have also developed strategies designed to address these issues. Not surprisingly, most jurisdictions we studied express a sense of urgency about the rising rates of overweight and obesity in their populations.

Our analysis suggests that the strategic approaches adopted by different jurisdictions in Canada have elements which are virtually identical. They all emphasize an "integrated," "multisectoral" or "whole government" approach that includes "partnerships" between government and civil society. These approaches also promote the use of "best practices." We noted that such approaches look the same for leading as well as lagging jurisdictions; they do not seem to vary based on the level of allocated resources, even though the allocated resources themselves did vary considerably.

One illustrative example concerns programs which come under the umbrella of "public health." While public health is just one sector which might be involved in a jurisdiction's population health strategy, it is undeniably a key player. Yet we were unable to find any systematic comparisons focused on the activities and success of public health programs across provinces.[58] For example:

- The 2003 Naylor report on the outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto examined Canada's public health infrastructure and capacity at the time; however, the authors of this report had trouble simply determining the amount of money that was currently allocated to public health in Ontario, as well as in other provinces.[59]
- In reports issued in 1997 and 2003, the office of Ontario's Provincial Auditor stated that descriptions of the public health services currently offered by local public health units were lacking.[60,61] Years later, such information is still not generally available.

For the purposes of our own report, we attempted to estimate the total cost of different population health strategies by adding together the spending amounts listed in each jurisdiction's published strategic planning report. We realize that such an estimate may be inaccurate for a variety of reasons. One confounding issue is that most jurisdictions offer a range of programs which are delivered via a number of government sectors and non-governmental organizations. These programs may not be included as part of a jurisdiction's overall strategy.

Exhibit 5. A comparison of health behaviour strategies in British Columbia, Quebec, Ontario and Canada, 2008

	British Columbia (BC)*,**	Quebec‡	Ontario§	Canada¥
Strategies	***ActNow* Strategy**	***Investing for the Future*—A government action plan for the promotion of healthy lifestyle and prevention of weight-related problems (2006–2012)** **National Public Health Program**	***Action Plan for Healthy Eating and Active Living*** **Active 2010**	***Vision for Healthy Living***
Goal(s)	• Make BC one of the healthiest jurisdictions to host the Olympic and Paralympic Games • Encourage British Columbians to reduce tobacco use, eat healthy foods, be more active and make healthy choices during pregnancy • Build community capacity to create healthier, more sustainable communities • Reduce demand on the health care system	• Improve the quality of life for Quebecers by allowing them to live in environments that promote the adoption and maintenance of healthy habits, a physically active lifestyle and a healthy diet	• Champion health promotion in Ontario and create a culture of health and well-being • Provide programs, services and incentives that will enhance health and well-being • Create intersectoral collaborations to promote health and well-being • Make Ontario a leader in health promotion within Canada and internationally	• Improve overall health outcomes • Reduce health disparities
Health Behaviour Objectives Target Date	2010	2012	2007 (a smoke-free Ontario) 2010 *(Active 2010)*	2015
Obesity	• Reduce obesity and overweight among adults by 20%, from 42.3% in 2003 to 33.8% in 2010.	**Between 2006 and 2012:** • Reduce obesity among youth and adults by 2% • Reduce overweight among youth and adults by 5%		• Increase normal body weights by 20%
Physical Activity	• Increase the number of people who are physically active by 20%, from 58.0% in 2003 to 69.6% in 2010.	**Between 2006 and 2012:** • Increase the proportion of Quebecois who are physically active by 5%	• Increase from 48% (in 2003) to 55% (in 2010) the proportion of Ontarians who are physically active	• Increase the proportion of people who are physically active by 20%
Smoking	• Reduce tobacco use by 10%, from 16.0% in 2003 to 14.4% in 2010.	**Between 2006 and 2012:** • Reduce smoking rates: aged 15+ years from 24%* to 16%; 15 years and younger from 23%* to 13% **2002 prevalence rates*	*Between 2003 and 2007* • Achieve a 20% reduction in tobacco consumption	
Diet	• Increase the number of people who eat at least 5 servings of fruits and vegetables daily by 20%, from 40.1% in 2003 to 48.1% in 2010.	• Increase the number of people who eat at least 5 servings of fruits and vegetables daily by 5%		• Increase the number of people who make healthy food choices by 20%
Total $†	**$90 million**	**$31 million** for smoking programs **$96.3 million** for healthy lifestyle programs directed at controlling obesity	**$90 million** (excluding mandatory programs in chronic disease	
Total $ Per Person Each Year	**$21.00**	**$16.80**	**$7.40**	

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	British Columbia (BC)*,**	Quebec‡	Ontario§	Canada¥
Progress	Apart from having already achieved their tobacco reduction goals, BC is seeing few measurable improvements in diet, physical activity and proportion of the population who are overweight. Despite this, BC is maintaining its top ranking in Canada for tobacco consumption, physical activity and body weights.		A 31.8% decline in tobacco consumption between 2003 and 2006	

Data sources:

* Province of British Columbia Annual Strategic Plan Report 2006/07, available at: http://www.bcbudget.gov.bc.ca/Annual_Reports/2006_2007/BCAnnualStrategicPlanReport_06_07.pdf.

**ActNowBC, Measuring Our Success: Progress Report - I. Technical Report. January, 2008, available at: http://www.hls.gov.bc.ca/publications/

‡ Quebec Public Health Program 2003–2012, available at: http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/ed7acbc94b12630f852566de004c8587/f83fd818c4afad8085256e3800553476?OpenDocument;
Gouvernement du Québec (2006) Investir Pour L'Avenir - Plan d'action gouvernementale de promotion des saines habitudes de vie et de prevention des problemes relies au poids, available at: www.msss.gouv.qc.ca.

§ Ontario Ministry of Health Promotion (2006), Ontario's Action Plan for Healthy Eating and Active Living, available at: http://www.mhp.gov.on.ca/english/health/HEAL/actionplan-EN.pdf; Ministry of Health Promotion, Active 2010, available at: http://www.mhp.gov.on.ca/english/sportandrec/active2010.asp; personal communication with Jostin Algroy at the Ministry of Health and Long-Term Care on February 15, 2008.

¥ Minister of Health (2005), The Integrated Pan-Canadian Healthy Living Strategy, available at: http://www.phac-aspc.gc.ca/hl-vs-strat/pdf/hls_e.pdf

† Expenditure estimates come from government documents sent by and from conversations with provincial ministry employees.

The following is a breakdown of figures used to calculate total dollar estimates:

For British Columbia: $665,000 (BC School Fruit and Vegetable Snack program), $30,000 (Early Years Specialization), $40 million (LocalMotion), $1.5 million (Action Schools! BC), $1.3 million (for schools to purchase sports equipment), $950,000 (Healthy Schools Network), $280,000 (Healthy Living for Families booklets), $17 million (Healthy Kids Program), $1.27 million (Quit Smoking Now!), $275,000 (Cooking and Skill Building Project), $91,667 (Aboriginal Youth FIRST Outdoor Leadership Program), $50,000 (Get Outdoors Program), $26,000 (Healthy Ecosystems Healthy People), $2,500 (Work Bike Program).

For Quebec: $56.3 million (Investing for the Future – direct government funding), $40 million (for funding OMG and community programs – $20 million from La Fondation Chagnon and $20 million matched funding from Quebec government).

For Ontario: $90 million includes funding for: Smoke-free Ontario, Healthy Eating Active Living, Community in Action Fund, some programs directed at chronic conditions; this estimate excludes mandatory public health programs.

But regardless of these limitations, we found that currently, on a per capita basis, British Columbia appears to be spending much more on population health and health behaviour strategies than Ontario. To reach British Columbia's current level of spending, Ontario would need to spend about 13 to 14 dollars more per capita per year, for a total of $170 million more per year.

We cannot state for certain that higher levels of spending per capita on health is the main reason that British Columbia seems to be outperforming other provinces in terms of population health and health behaviours. However, such spending could be seen as a tangible outcome of following the five "lessons learned" presented in this report. The province declared a clear health imperative and used this to create a case for more resources. They even created a new, distinct Ministry, the Ministry of Healthy Living and Sport, to clearly communicate the importance and future emphasis on health behaviours and disease prevention in improving population health in the province. Their leaders then took the necessary steps to effectively reallocate resources, including considerable resources directed toward non-governmental agencies. As a result, the province has more money to spend toward implementing innovative and broad-based programs designed to improve population health.

While making fair and accurate comparisons of spending among jurisdictions is challenging, comparing jurisdictions' population health targets is a more straightforward task. Here's what we found:

- All Canadian provinces have established targets for smoking reduction, achieving healthier weights (obesity reduction) and increasing physical activity. Several provinces have also established targets for healthier diets and decreasing the excessive use of alcohol.
- British Columbia, Quebec and Ontario all share similar health behaviour targets in terms of desired percentage reductions in unhealthy behaviour; however, reductions start from different baselines of health behaviour rates, and goals are set according to different time periods.
- Even if all three provinces reach their goals, British Columbia will continue to maintain its leading status in healthy behaviours among its population.

Measuring Progress Towards Achieving Population Health Goals

Across Canada and internationally, we noted a woeful lack in the evaluation of population and health behaviour strategies. We found either poor or non-existent descriptions of services or programs offered in various jurisdictions, and poor or non-existent evaluations of performance including program efficiency, effectiveness, coverage and equity (or other attributes of modern performance evaluations).

Most of the evaluations we did find during the course of our research were similar in nature and usually limited to reports on the prevalence of health behaviours (i.e., the proportion of people who smoke) or similar health outcome measures.

We believe the five "lessons learned" described in this report are key for Ontario and for others seeking to significantly improve population health and health behaviours. We also believe these lessons could be usefully integrated into evaluation efforts. For example, when evaluating a new anti-smoking program or a project aimed at getting healthier foods into school lunch rooms, evaluators might ask: Has there been strong, effective leadership in developing and promoting the new intervention? Did those involved take time to examine current local attitudes towards health in general and towards smoking cessation (or healthy eating) in particular? Does the current intervention fit in with other broad-based solutions being attempted in other sectors? Have steps been taken to ensure there is understanding and to determine whether support exists in the surrounding civil society?

We are not aware of any Canadian jurisdictions—including British Columbia, Quebec and Ontario—which factor these elements into their evaluations, although some performance frameworks do include these perspectives.[60,62-64] To fill this gap, we have developed a list of sample indicators which governments might use in the course of evaluating their own population health initiatives *(see Exhibit 6).*

Recommendations for Action and Indicators of Progress

If Ontario wants to become the ***healthiest province*** in Canada, **better support is required across the board** to encourage healthy behaviours among its population. These include: being physically active, maintaining a healthy body weight and avoiding or quitting smoking. We offer the following **recommendations** for *action*:

1. **Ontario must identify its own specific health imperative.** During public consultations for long-range health system planning, Ontarians identified excellent population health and healthy behaviour as their top priorities. While this is a good start, it does not qualify as an overarching health imperative, which we define as: "the reason for making an extraordinary effort to improve population health." During the preparation of this report, we asked people in leading jurisdictions why health was so important to their government and/or residents. They provided immediate and often detailed answers. This was not the case in Ontario when the same question was asked.

2. **The Premier should proclaim that a major goal of his government is for Ontario to become the healthiest province in Canada.** Leadership and senior government structures must be developed and/or nurtured to develop specific health strategies and to ensure that goals and targets are achieved. There are several structures that may work well in Ontario—for example, the former Premier's Council on Health and Well-Being or a new cabinet position, similar to the one in British Columbia, whose only mandate is to coordinate the strategy and to be accountable for its success.

3. **Ontario's health behaviour goals should be at least as ambitious as those stated by other leading provinces.** This means that by 2015, Ontario should achieve the following targets:
   - Fewer than 15 percent of Ontarians use tobacco.
   - More than 73 percent of Ontarians are physically active (i.e., they report more than 30 minutes of moderate physical activity per day).
   - Fewer than 32 percent of Ontarians are overweight or obese.

4. **The Ontario government should understand how Ontarians feel about health behaviours and incorporate that understanding into the province's health strategy.** For example, if Ontarians say that they are extremely concerned about childhood obesity, then the province should enact the most comprehensive and innovative strategy worldwide to address this problem. If certain attitudes towards curbing childhood obesity are not as favourable among Ontarians as they are among residents in other jurisdictions, efforts should be made to understand why. Companion strategies can then be designed and implemented to educate and create more positive attitudes among specific groups (i.e., parents, teachers, children, school officials).

5. **Compared to other leading jurisdictions, the Ontario government should allocate more resources towards improving health behaviours related to smoking, physical activity, diet and obesity.** This would mean an increased investment of at least $170 million per year. However, a successful strategy requires much more than simply allocating more funding. For Ontario to achieve leading status, resources will need to be more effectively, efficiently and equitably used. Also, the government must realize that many effective policies and programs are relatively inexpensive and should be considered for implementation and/or expansion. For example, a policy to ban food containing high levels of unhealthy trans fats in restaurants would be relatively inexpensive to develop. The main costs of ensuring compliance could be rolled into the existing system of food premises inspections. (Of course, in some cases, substantial costs will have to be borne by civil society to ensure government goals are achieved. For example, restaurants would likely incur some costs in removing foods that contain trans fats from their menus.)

6. **Ontario should be the first province to introduce new innovative and effective strategies to improve health behaviours among its residents.** British Columbia was the first Canadian province to enact a smoke-free policy and is again leading the way with innovative programs to support physical activity and healthier weights. Ontario must find ways to match or surpass British Columbia's lead in these areas.

7. **Ontario should narrow existing health and health behaviour disparities.** Interventions should ensure that people in disadvantaged groups—whose health tends to be poorer—make the first and the greatest gains in these areas. This means that the strategies for improving health must be at least as effective in disadvantaged groups as they are among in the healthiest people. Achieving a successful strategy in disadvantaged groups will likely require additional resources and different or additional programs targeted towards these groups.

Exhibit 6. Recommendations for action and indicators of progress

Lesson Learned	Recommendation	Indicator of Progress
1. A guiding health imperative must drive overall health strategies.	Ontario ***must*** identify its own specific health imperative, (i.e., the reason for making an extraordinary effort to improve population health).	Leaders in government and civil society share a common viewpoint and an understanding of Ontario's health imperative. Ideally, this viewpoint should be known and supported by all Ontarians.
2. The best strategies for improving population health and health-related behaviours arise during the tenure of strong political leaders.	The Premier should proclaim that a major goal of his government is for Ontario to be the healthiest province in Canada.	Most Ontarians identify the Premier as a champion for improving the health of citizens. Most Ontarians know that a major government goal is to be the healthiest province in Canada.
	Ontario's health behaviour targets should be at least as ambitious as those stated by other leading provinces. This means that by 2015, Ontario should have achieved the following targets: Fewer than 15 percent of Ontarians use tobacco; more than 73 percent are physically active (i.e., report more than 30 minutes of moderate physical activity per day); fewer than 32 percent are overweight or obese.	The health behaviour of Ontario residents is on track to reach targets and is improving more quickly than behaviour in other leading provinces.
3. Pay attention to societal attitudes about health and understand the prevailing political and social structures.	The Ontario government should understand Ontarians' attitudes towards health behaviours and incorporate that understanding into its health strategy.	There is a small gap between the government policy and social attitudes. For example, if there is support to ban trans fats in restaurants, then governments should quickly enact policies to accomplish that.
4. To solve broad-based problems, look for solutions which can be applied across governments with the participation of the larger civil society.	Compared to other leading jurisdictions, the Ontario government should allocate more resources towards improving health behaviours related to smoking, physical activity, diet and obesity. This means an increase investment of at least $165 million per year.	The increased investment to improve health behaviour is shared across government ministries, other levels of government and civil society agencies responsible for health (i.e., investments are not limited to the provincial Ministries of Health and Long-Term Care and Health Promotion).
5. Act promptly. Leading jurisdictions do not necessarily wait for conclusive scientific evidence and are often the first to implement innovative interventions.	Ontario should be the first province to introduce new innovative and effective strategies to improve health behaviours.	The Ontario government can claim a number of "firsts"—for example, being the first province to enact new health-related strategies such as banning trans fats in restaurants.

Overarching Equity Themes

- Health and health behaviour improves more quickly in disadvantaged groups compared to those with the best health and health behaviour.
- Ontario must make gains in disadvantaged populations.
- Ontario should narrow health and health behaviour disparities.

Conclusion

Where Do We Go from Here?

From our perspective in 2008, Ontario is continuing to fall behind British Columbia and Quebec when it comes to population health and healthy behaviours. Catching up presents a considerable challenge. These two leading Canadian jurisdictions, along with the international front-runner, Sweden, have decades of experience in developing health behaviour strategies, combined with strong current leadership and a track record of successful collaboration across government sectors and with the larger civil society. Levels of obesity in British Columbia and Quebec are already lower than those in Ontario, and British Columbia also has lower rates of tobacco use and physical inactivity than Ontario.

In general, Ontario will need to allocate more resources to keep its per capita spending on population health on par with those already established by policy makers in British Columbia. The province will need to devote considerably more resources if Ontario is to keep up with with—or even bypass—British Columbia—in terms of improving health behaviours among its citizens.

Even if Ontario has the will and the leadership needed to take advantage of the "lessons learned" in our report, there is only so much that governments can do. It will take years to successfully follow in the footsteps of national and international jurisdictional leaders—that is, to change our neighbourhoods, develop new relationships within civil society and pass legislation to promote intersectoral collaborations.

In terms of intersectoral collaborations, one problem area specifically identified during consultations for this report has been Ontario's ability to work across sectors *(see Lesson 4)*. Even in the case of narrowly-focused health problems—such as the 2000 outbreak of E. coli-related illness in Walkerton, Ontario[65] and the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto,[59]—there was concern about the lack of communication between provincial ministries, local and federal governments, and across/between local, provincial, federal and international public health agencies. Such experiences do not bode well for jurisdictional success in combating less acute—but still urgent—population health problems such as obesity. Such efforts will require even more positive, wide-ranging and sustained collaboration.

On the positive side, however, we heard considerable optimism during consultations for this report about Ontario's capacity to be a leader. We are not far from leading status in terms of overall health. In particular, our smoke-free strategy is viewed internationally as exemplary and has been emulated by many others.

Combining knowledge from the lessons learned in this report with our demonstrated experience in improving health behaviours may allow Ontario to one day join the ranks of national and international leaders in population health.

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