



Health Promotion in Canada

A Case Study

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Table of Contents

Preface.....	v
Part One: The Historical Development of Health Promotion in Canada.....	1
Introduction	1
1. Getting Started: The Lalonde Report and Its Implications	2
Broadening the Health Discourse	2
Establishing New Infrastructures: A Health Promotion Directorate.....	2
Impacts on Policy and Practice at Other Levels.....	3
2. Moving Ahead.....	3
The <i>Ottawa Charter</i> and <i>Achieving Health for All</i>	3
Building a New Socioecological Model of Health	4
a. Federal Government Programs	4
b. Provincial/Territorial Programs.....	5
Providing an Impetus for Infrastructure Development.....	6
a. Provincial/Territorial Health/Health Promotion Councils	6
b. The “Healthy Community” and “Strengthening Community Health” Initiatives	7
c. Framing a New Research Agenda and Infrastructure	8
d. The Voluntary Sector	9
3. External Factors Shaping Health Promotion	9
Restructuring at the Federal and Provincial/Territorial Levels	9
a. Change at the Federal Level.....	9
b. Changes at the Provincial/Territorial Level	10
The New “Population Health” Discourse.....	11
Health Care Reform.....	12
4. Taking Stock: Reflecting on Health Promotion in Canada Today	12
Health Promotion Assessed Through the Charter	12
a. Building Healthy Public Policy	12
- Experience with Intersectoral Action.....	13
- Health Impact Assessment.....	13
- Goals.....	13
b. Create Supportive Environments	13
c. Strengthen Community Action.....	14
d. Develop Personal Skills.....	14
e. Reorient Health Services	15
Health Promotion Assessed Through Health Status and Inequalities	15
a. Health Status	15
b. Health Inequities.....	16
Directions for the Future	17
a. <i>Perspectives on Health Promotion</i>	17
b. The National Forum on Health.....	17

Part Two: Factors Contributing to the Success or Failings	19
A Conceptual Basis for Action.....	19
Strong Enlightened Leadership	20
Translating Concepts into Action.....	21
The Influence of Health Reform.....	21
Partnerships for Sustainability.....	22
Maintaining the Momentum.....	23
The Evidence Conundrum.....	24
Fiscal Restraint and Organizational Change.....	25
The Emergence of Population Health	25
Support for Healthy Public Policy	26
Part Three: Lessons for the 21st Century	29
Appendix A: Milestones in Health Promotion - A National Perspective (Timeline).....	33
References.....	37

Preface

Health Promotion in Canada: A Case Study was commissioned by Health Canada at the suggestion of Dr. Ilona Kickbusch, Director of Health Promotion, Education and Communication for the World Health Organization (WHO). It is intended to serve as a background paper for the Fourth International Conference on Health Promotion being held in Jakarta, Indonesia in July 1997.

This overview attempts to show how and why health promotion has developed as it has in Canada, with particular emphasis on the social and political context. It explores how health promotion thinking emerged, was interpreted and implemented. As well, this review illustrates the balance between policy and practice and outlines the role of health promotion infrastructures.

This case study has been developed at a time of considerable change to the landscape of health promotion in Canada. For some, this raises concerns about capacity for future leadership and continuing contribution to health reform. For others, the brief but rich legacy of experience reviewed here suggests new opportunities for further strong health promotion action in Canada, albeit in the context of new constructs and partnerships. It is hoped that this document will contribute to a critical and timely dialogue on how health promotion values, principles and strategies can continue to inform action as we commit to global Health-for-all for the 21st century in the face of challenge and change.

The initial research and background documentation for this case study was conducted by Dr. Trevor Hancock with the assistance of Dr. Ron Labonté. The document incorporates many of their perspectives and interpretations. The paper also includes input and feedback of other key individuals in the field of health promotion in Canada, namely Ron Draper, Peggy Edwards, Joan Feather, John Millar, Michel O'Neill and Irving Rootman. Several Health Canada officials also provided advice and comments: Ed Aiston, Tariq Bhatti, Carmen Connolly, Nancy Hamilton, Glenn Irwin and Kathy Stewart. The final document was prepared by Brian Bell and Kathryn Joly. Thus, this case study is also in many respects a “story”—a composite of the views and experiences of many people as reflected by the narrator.

Part One: The Historical Development of Health Promotion in Canada

Introduction:

Since 1974, Canada has had an international reputation for its work in the area of health promotion based on the development of important initiatives including community action projects for health promotion, health advocacy and healthy public policy, as well as Canada's role in the birth of the international Healthy Cities/Communities movement. Canada's leadership was acknowledged during the First International Conference on Health Promotion held in Ottawa in 1986, which gave rise to the *Ottawa Charter for Health Promotion*¹. This was followed by a period in the late 1980s and early 1990s when health promotion flourished in Canada. However, more recently the commitment to health promotion by governments has been questioned by some in the face of a wide range of both domestic and global developments.

As a case study, this document begins by asking "What happened?" (Part One), then "Why did it happen?" (Part Two) and finally, "What can we learn from this experience?" (Part Three). In the first part, the evolution of health promotion is traced from the early 1970s to present. The second part discusses a number of key issues that had an impact on health promotion in Canada. The final part explores the lessons learned that will hopefully be of value to Canada and other countries in the future.

It is important to note that there is no singular, national experience of health promotion. This is due in part to the division of powers under the Canadian Constitution that accords primary responsibility for health and social programs to the provincial governments.² The federal government generally relies upon the exercise of "federal spending power" and transfer payments to the provinces to exert policy and program leadership.

During the 1960s and 1970s, the federal government significantly expanded its spending on social programs, in particular by establishing a national program of health insurance in collaboration with the ten Canadian provinces. The effect of this is that Canada does not have a common national health system, but rather ten provincial and two territorial systems. Health promotion exists in thirteen different systems, including the federal health system, and as a result there tends to be considerable diversity in the health promotion experience across Canada.

1. Getting Started: The Lalonde Report and Its Implications

Broadening the Health Discourse

Canada's international leadership in modern health promotion began in 1974, with the publication of *A New Perspective on the Health of Canadians*,³ under the leadership of Marc Lalonde, the Minister of Health and Welfare Canada at the time. This report signified the first time that a major government publicly acknowledged that medicine and the health care system play only a small role in determining health status.⁴ It was also the first document to suggest "health promotion" as a key strategy for improving health. The report proposed that health was determined by the interplay of human biology, health care organization, environment and lifestyle. Although the report was well accepted on the international front, within Canada some felt that the report had limitations.

Establishing New Infrastructures: A Health Promotion Directorate

Three outcomes of *A New Perspective on the Health of Canadians* were:

- the creation of the federal Health Promotion Directorate housed within the Department of National Health and Welfare in 1978
- rapid growth in programs aimed at lifestyle featuring social marketing and health education campaigns.^{5,6}
- a refinement of health promotion practice in communities and grassroots endeavours across the country.

The Health Promotion Directorate was formed through the merger of several independent units working in the areas of alcohol, tobacco, drugs, nutrition and child health issues. The work undertaken fell into the broad categories of:

- social marketing (public education and information)
- supports to community action (funding programs)
- policy and program development
- knowledge development.⁷

Most health promoters in Canada at that time worked primarily from a lifestyle or health behaviour approach that mixed mass media with group education strategies, school health education⁸ and community action. Through its conceptual leadership and funding programs, the Health Promotion Directorate helped to firmly establish the concept of health promotion within Canada, to support its practice nationally and internationally and to advance the development of new practice models. There was a strong commitment to women's and children's health promotion and project funding was available for priority groups such as women, indigenous Canadians and persons with disabilities to develop and operate health promotion activities.⁹

Impacts on Policy and Practice at Other Levels

While the key role in these early days was played by the federal Department of National Health and Welfare, provincial/territorial initiatives were also underway. In most provinces/territories, health education had a long history (in some cases dating back to the 1920s). With the advent of *A New Perspective on the Health of Canadians*, many provinces/territories broadened their perspectives and established areas within their structures for expanded health promotion efforts.

There was also growing activity at the municipal level. By the late 1970s, the Toronto Department of Health, as well as other Canadian public health departments began to develop more socially critical approaches to health promotion that emphasized structural determinants, community development and advocacy strategies.^{10,11}

In 1984, the Toronto Board of Health, the Canadian Public Health Association and Health and Welfare Canada jointly sponsored an international conference, *Beyond Health Care*. This conference strengthened the relationship between Canadian health promoters and the European Office of the World Health Organization, which is credited with much of the international advancement of health promotion.¹² At this conference, two key ideas in health promotion were born: the concept of “healthy public policy” and the idea of a

2. Moving Ahead

The Ottawa Charter and Achieving Health for All

The First International Conference on Health Promotion was held in Ottawa, Canada in 1986, co-hosted by Health and Welfare Canada, the Canadian Public Health Association and the World Health Organization. A key result of this conference was adoption of the *Ottawa Charter for Health Promotion*, a document that has since been translated into more than 50 languages and which has become a guidepost for health promotion around the world. The *Charter* identified five key strategies for health promotion practice and the “new public health” as follows:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.

At the same conference, the federal government released its follow-up to *A New Perspective on the Health of Canadians* entitled, *Achieving Health for All: A Framework for Health Promotion*.¹³ This framework set out a matrix of health promotion challenges, mechanisms and strategies and gave more prominence to the broader determinants of health. *Achieving Health for All: A Framework for Health Promotion* was widely distributed both in Canada and internationally. The document was instrumental in developing health promotion knowledge and establishing a research agenda.¹⁴

The impact of both documents was to position health promotion as a conceptual centrepiece in accelerating federal and provincial/territorial efforts to reform and restructure increasingly costly health care systems. More important, both documents, and particularly the *Charter*, are considered by many to have spearheaded a key shift in health promotion practice wherein living and working conditions, or prerequisites for health, were given additional prominence. The five years following the release of these documents were marked by significant health promotion advancements in many areas including:

- the establishment of large-scale federal strategies targeted to specific health issues or groups
- the strengthening of provincial/territorial health promotion programs
- the establishment of provincial/territorial health councils to guide health care reform
- the creation of national and provincial/territorial “Healthy Communities” and “Strengthening Community Health” projects
- the development of knowledge and research in the area of health promotion.

Building a New Socioecological Model of Health

1. Federal Government Programs

By the mid-1980s, there was growing concern about a health promotion orientation based largely on lifestyle. It was argued that the health of people living in relatively disadvantaged circumstances was also determined by structural conditions, such as poverty, unemployment, social discrimination, powerlessness, poor housing, and pollution, to name just a few. It was the contention that personal lifestyles were not freely determined by individual choice, but rather existed within social and cultural structures that conditioned and constrained behaviour.

In 1987, the budget of the Health Promotion Directorate nearly tripled as new federal initiatives came on stream with national strategies in the areas of drugs, tobacco, impaired driving and AIDS. Efforts were made to develop intersectoral action, qualitative research and evaluation methods. Social marketing campaigns emphasized more positive messages and funding programs allowed for greater autonomy in defining local health issues.^{15,16} Significant support was provided to community-based initiatives through the regional offices of the Health Promotion Directorate, including the strategic funding of selective community initiatives through the Health Promotion Contribution Program and participation in the Canadian Healthy Communities Initiative and the Strengthening Community Health projects.

The integrated approach to health promotion is illustrated by the following examples:

- The Heart Health Initiative is a five-phase, fifteen-year strategy involving Health Canada, ten provincial Departments of Health, the Heart and Stroke Foundation of Canada and more than 300 voluntary, professional and community organizations located across Canada.

- A collaborative process in nutrition spanning several years led to consensus among a broad range of partners on national nutrition policies, programs and messages. The process began with agreement by the experts from the scientific and communications communities on Nutrition Recommendations and Canada's Guidelines for Healthy Eating and included an extensive consultation process with policy-makers, public health professionals, educators, industry and the public. It culminated with the production of a significantly revised *Canada's Food Guide to Healthy Eating*.
- A ParticipAction public/voluntary/private sector initiative building on a combination of community action and social marketing strategies, encouraged Canadians to become more physically active.
- As in many countries, the National AIDS Strategy was a response to and recognition of the growing incidence of HIV and AIDS. It was greatly influenced by mobilizations of local advocacy groups and grew very quickly into a multifaceted, multisectoral approach.
- The Tobacco Demand Reduction Strategy played an important role in marshalling the evidence against tobacco and in supporting collaborative action against the tobacco industry.

In addition, the settings approach was adopted as an important health promotion strategy. This approach brings together all of the elements of health promotion and integrates them in settings that have meaning to people—home, school, workplace, hospital and community. Research, knowledge development and related infrastructures were also actively supported.

2. Provincial/Territorial Programs

By the early 1980s, most provincial and territorial governments had established branches, offices or departments of health promotion. Many of these areas grew significantly in size and budget during the 1980s. However, these activities retained a strong orientation toward communication, social marketing and community action, with some involvement in public policy development.

A profile of developments in the area of health promotion in several provinces/territories follows:

- British Columbia:
 - The Office of Health Promotion was established in 1989.
 - British Columbia hosted the First National Conference on Health Promotion and Disease Prevention in 1989.
 - The development of the “Healthy Communities Network” was supported and grants were provided to undertake healthy community planning.
 - An innovative healthy schools program and health-promoting workplaces program were established.
 - A community guide to enacting healthy public policy was published.

- British Columbia was instrumental in establishing the process that required a health impact assessment of all major policy submissions to Cabinet.
- A health impact assessment tool kit and guidelines for health impact assessment were developed.
- Ontario:
 - The Health Promotion Branch was established in 1987.
 - The principal focus was on cardiovascular health, healthy lifestyles, community mobilization for health and reduction of tobacco use.
 - Ontario supported community mobilization and healthy public policy strategies.
 - In 1992, forty-seven “health promotion specialists” were housed in forty-two health units located across Ontario.
 - The Premier’s Council on Health Strategy (an intersectoral committee chaired by the Premier) was established in 1987.
- Atlantic Provinces:
 - The Atlantic Health Promotion Network was established as a catalyst for cooperation and development.
 - Nova Scotia’s Heart Health program was adopted by the other three Atlantic provinces.
 - Dartmouth became the first locale in the Atlantic provinces to join the “Healthy Communities” project.
- Northwest Territories:
 - Regional Health Boards were established in 1988, followed by the staffing of Regional Health Promotion Officers to act as consultants in health promotion and be responsible for territorial health promotion policy and planning.
 - As direct delivery of health promotion was devolved to the Regional Health Boards through the early 1990s, the territorial health promotion section provided consultation and support.

Providing an Impetus for Infrastructure Development

1. Provincial/Territorial Health/Health Promotion Councils

In the years that immediately followed the arrival of the *Ottawa Charter* and *Achieving Health for All*, most of the provinces/territories established commissions and/or provincial/territorial health councils to recommend health reform strategies. These intersectoral bodies were influenced by health promotion thinking and most incorporated research and policy development on the broader determinants of health (e.g., income redistribution, housing, environmental protection, labour market adjustments and retraining, equity, etc.). In most cases, health promotion practice was viewed as a means of acting on the broader determinants of health, reducing health care expenditures and advancing health care reform.

2. The “Healthy Community” and “Strengthening Community Health” **Initiatives**

The “Healthy Cities/Communities” movement originated in Canada and was implemented in 1986 by WHO Europe, in consultation with Health and Welfare Canada. The federal Department supported the Canadian Healthy Communities project in the early stages (jointly sponsored by the Canadian Institute of Planners, the Federation of Canadian Municipalities and the Canadian Public Health Association). From 1988 to 1991, the Canadian Healthy Communities project published several newsletters and a guidebook, provided consultation and workshops in numerous communities across Canada and organized a national conference.

Simultaneously, several provincial/territorial “Healthy Communities” projects were initiated and provincial healthy community networks were established in both Quebec and British Columbia in the late 1980s and in Ontario in 1991. An overview of several provincial/territorial projects follows:

➤ Quebec:

- A formal association (*Villes et Villages*) was established in 1990 by those municipalities that adopted a “Healthy Community” project. By late 1991, the network grew to more than 600 members representing more than 300 different organizations, including more than 150 municipalities.
- In early 1997, the provincial information centre has full-time staff and 113 municipalities are now members.
- Small local projects have had considerable impact on the development of healthy public policies at other levels of government.

➤ British Columbia:

- Grants were made available to municipalities for project development.
- Participating local governments passed resolutions endorsing the adoption of “Healthy Community” principles.
- In 1991, the majority of the 38 funded projects had established a multisectoral approach to health, involving more than three sectors on their steering committees and more than 45,000 people in their activities.
- By the mid-1990s, some 100 municipalities had become involved despite the fact that funding was reduced and the network became less active.

➤ Ontario:

- Fifteen provincial associations from the health, social, environmental and urban planning sectors actively pursued funding in the late 1980s.
- A provincial network and office were established in 1992.
- By 1997, there were 72 “Healthy Community” projects in the province.

The “Strengthening Community Health Project” (SCHP) was also established in 1988, by the Canadian Public Health Association (CPHA), with funding from the Health Promotion Directorate. Overall, the SCHP played a role as a catalyst in bringing together many different agencies and organizations to create new partnerships for health. The emphasis was on collaborative action, the development of a community agenda for health and strengthening the capacity of community members on health issues.¹⁷

Despite some confusion between the “Healthy Communities” and “Strengthening Community Health” initiatives, as well as the overly optimistic time frames for producing results and the short-term nature of the funding, both projects were seen as innovative approaches to working within communities.

3. Framing a New Research Agenda and Infrastructure

Achieving Health for All acted as a strong catalyst in the creation of a number of new health promotion knowledge development initiatives in Canada. The Health Promotion Directorate carried out two major national health promotion surveys in 1985 and 1990. These surveys have left an important legacy. Today, the National Population Health Survey, which is carried out every two years by Statistics Canada, incorporates some of the work of the Health Promotion Surveys. The Directorate also undertook a series of knowledge development symposia across Canada in conjunction with the National Health Research and Development Program (NHRDP). Literature reviews on eight components of *Achieving Health for All* were conducted through a special competition of NHRDP. A health promotion committee was formed by NHRDP in 1987 and a special competition was held in 1990, related to health promotion research.

In the late 1980s and early 1990s, health promotion gained considerable acceptance within the academic community. The First National Health Promotion Research Conference was held in Toronto in 1990.

Another important development in this process was the creation in the early 1990s of more than twelve Health Promotion Research Centres located across Canada. Six of these Centres are funded jointly by NHRDP and the Social Sciences and Humanities Research Council (SSHRC). All of the Centres deal with health promotion knowledge development and evaluation, although there is a considerable range of interests and priorities amongst the Centres. Most Centres have developed strong working relationships with the practice community and sponsor successful health promotion summer schools. In 1996, thirteen of the Centres formalized their associations with the creation of a Consortium with support from Health Canada.

The 1980s and 1990s also saw numerous universities and colleges initiating certificate, degree and postgraduate courses in health promotion, drawing registration from the disciplines of public health, health science and applied social sciences. In many provinces/territories, employment in health promotion-related positions increased significantly in public health departments, community health centres, hospitals, local governments and social service agencies.¹⁸

favour with policy-makers.

1. Change at the Federal Level

In the early 1990s, the Health Promotion Directorate of Health Canada continued to be active in the four areas of policy and program development and implementation: knowledge development; social marketing, public education and information; and support for community action. A significant portion of the Health Promotion Directorate's funding was allocated to the major strategies, while more than 350 community projects were being supported through the Health Promotion Contribution Program.

In the mid-nineties, several forces combined to influence how federal health promotion programs are delivered. Government-wide efforts to address the deficit have had an impact on resources available for programming, as they have had on programs across the government. Secondly, restructuring of the new Health Promotion and Programs Branch has resulted in a shift in responsibility for the administration of the health promotion programs. Albeit with reduced resources, the Branch continues to have lead responsibility for programs such as child development, HIV/AIDS, substance abuse and family violence. Finally, the population health paradigm has been adopted by the federal government as a way of thinking about and acting on health. This paradigm reinforces the importance of health promotion and builds on its legacy by emphasizing the significance of healthy public policy, intersectoral action and the development of tools and mechanisms to assess health impacts of federal programs and policies across the entire range of its activities.

2. Changes at the Provincial/Territorial Level

While health promotion as a concept has declined in prominence in many of the provinces and territories of Canada, the nature and degree of this decline vary. In some provinces/territories, health promotion has actually grown in importance and influence during this period. This is particularly true at the local level. An overview of the situation in several provinces/territories follows:

➤ Saskatchewan:

- The main focus has been the control of health care expenditures and reform of the health care system, with the creation of Regional Health Boards.
- The Provincial Health Council has been disbanded, but health goals and a health promotion approach to guide the health care reform process are in existence.
- A Population Health Branch has been established and is headed by the Chief Medical Officer of Health. The Branch uses a model that combines population health determinants and health promotion strategies.
- The Branch is engaged in traditional public health activities and is also developing a health component for environmental impact assessments; exploring workplace needs within health care; organizing a health promotion summer school; developing a strategic plan for population health promotion; shifting the focus of provincial wellness grants to health determinants; and preparing a health status report. (Population Health Branch, 1996).

➤ Manitoba:

- The Health Public Policy Programs Division has been consolidated into the Community Core Programs and Operations Branch.
- A child and youth secretariat that combines representation from five different ministries has been created to initiate a coordinated and integrated system of services for children, youth and their families, including services provided through four departments—education and training, family services, health and justice.

- Quebec:
 - A new health and welfare policy was released in 1992 that sets objectives for 19 policies in five areas (i.e., social adaptation, physical health, public health, mental health and social integration).
 - The policy includes six strategies including development of healthy and safe environments, improvement of living conditions and coordination of public policies.
 - Greater recognition is being paid to the importance of socioeconomic factors and the social environment in influencing health.
- Yukon:
 - In the Yukon, health is understood to be the result of the “interweaving of physical, mental, social and spiritual dimensions”, while the health of individuals is very connected to the health of their families and communities.
 - A new Yukon Health Act provides “a model for healthy public policy, as it enshrines the definitions and decision principles essential to health promotion”.
 - Issues of land claims and Aboriginal self-government are an integral element of healthy public policy, as is community development in the areas of alcohol and drug programming, wildlife management, environmental contaminant control and chronic mental illness.¹⁹

The New “Population Health” Discourse

In the early 1990s, a new construct—entitled population health²⁰—began to replace health promotion in many government and health policy circles. As with health promotion, the term itself and many of the ideas are not new but describe trends in health and disease among social groups in contrast with health and disease among individuals. In Canada, the recent rise in prominence of population health is largely attributed to the Canadian Institute for Advanced Research (CIAR), an independent think-tank established in 1982.

Health promotion and population health have much in common. Nevertheless, they operate from somewhat different theoretical bases and research assumptions.²¹ In 1996, in an effort to build on the complementarity of these two approaches, Health Canada produced a synthesis “population health promotion” model,²² which combined the strategies of the *Ottawa Charter* with a list of major health determinants and population groups. The model has been well received by health promoters across Canada and much of the initial discomfort with the population health discourse has dissipated. The phrase, “population health promotion” is becoming more commonly used and may become the

Health Care Reform

By the mid-1980s, it was apparent that Canada's health care system had reached a crossroads. The system was financially strained and in need of reform. Generally, provincial/territorial governments arrived at the conclusions that there was a need to:

- focus on health promotion, disease prevention and population health status
- place greater emphasis on community-based rather than institutional care
- decentralize and regionalize the health care system
- emphasize primary care and move away from fee-for-service structures
- place greater emphasis on self-care and personal responsibility for health maintenance.

Proposals for health reform within the provinces/territories generally included a focus on health and its determinants, the development of health goals and objectives, a commitment to health promotion principles, the creation of new infrastructures to plan healthy public policy and a redefinition of the role of provincial/territorial health ministries.

By 1996, most provinces/territories had established some form of regional health system responsible for managing hospital care, home care, public health and other services, although none of them were given the mandate to manage physicians' services. The net impact of these initiatives remains unclear. While in some places a strong health promotion/population health approach underlies the work of regional and district health boards, there is also some concern that the traditional illness care model often dominates and health promotion and public health receive only nominal support.

4. Taking Stock: Reflecting on Health Promotion in Canada Today

One way to take stock of the situation of health promotion in Canada is by using the five strategies as identified in the *Ottawa Charter* as a framework. Another is to look at changes in the health status of Canadians. Each is examined briefly here.

Health Promotion Assessed Through the Charter

a. Building Healthy Public Policy

Over the years, there has been mixed progress among the federal, provincial and territorial governments in putting in place policies, programs and mechanisms to address the determinants of health of the Canadian population. There has been significant progress on some program fronts as demonstrated, for example, in children's initiatives designed to enhance healthy child development and to eliminate child poverty. There have been successes in other sectors as well. For example, the National Crime Prevention Council, which is funded by the federal government, has adopted a social development rather than an enforcement approach to preventing crime. At the same time, there has been little progress in establishing national health goals and commitments to building mechanisms and structures for healthy public policy and, at present, processes for health impact assessment have had only limited

application. British Columbia has some experience in this area and although the federal government's commitment to developing tools and mechanisms is in the initial stages, it holds promise.

There are a number of examples of more focussed, government-led healthy public policy initiatives in such areas as tobacco control, drinking and driving, nutrition, family violence and injury prevention. Several provinces have also had limited success in their attempts to integrate and coordinate healthy public policy across government (e.g., Ontario, Saskatchewan, British Columbia and New Brunswick).

Municipal governments may provide a more favourable setting for the development of healthy public policy, including the more intimate policy-setting of smaller governments, resulting in greater citizen involvement and closer connections between citizens, politicians and civic servants.²³ The "Healthy Communities" approach has contributed to the relative success of healthy public policy at the local level.

Three additional points are particularly relevant in relation to healthy public policy:

- **Experience with Intersectoral Action**

In the past ten years, much has been learned about intersectoral action. Alliances have consisted of four types: government-led intersectoral collaboration (e.g., National Drug Strategy); grassroots-led alliances (e.g., child poverty); issue-driven collaboration (e.g., breast cancer); and systems-driven alliances (e.g., Ontario Premier's Council).

- **Health Impact Assessment**

The concept involves examining the broad environmental, social and economic determinants of health that might be affected by any new policy. Most provinces/territories link health impact assessment to healthy public policy and to provincial/territorial health goals, but in practice it seems that health impact assessment receives little attention. It is difficult to operationalize at a high level in a comprehensive way.

- **Health Goals**

Although every province/territory in Canada has developed health goals, national health goals still do not exist.

b. Create Supportive Environments

There has been a wide range of initiatives related to the creation of supportive environments, from the immediate personal environment of the home to the global environment. In general, establishing the relationship between healthy environments and healthy people has been an effective strategy for health promotion. Some of that experience includes:

- Initiatives related to the physical quality of housing and buildings.
- Health Canada's Healthy Environment Program encourages Canadians to adopt practices that are both healthy and environmentally-friendly.

- The “Active Living/Go for Green” program, a joint effort of Health Canada, provincial and territorial governments and numerous non-government organizations, stressed the links between creating healthy environments and active living and strongly supported sustainable transportation.
- The work of the International Joint Commission to clean up the Great Lakes.
- The Canadian Global Change Program, established by the Royal Society of Canada with federal government support in 1989, is reporting on the health implications of global change and recognizing health as one of its top four priorities for the next five years.
- Comprehensive school health aims to create healthy social and environmental policies in schools and their communities.
- More emphasis is being given to environmental supports for behavioural change, such as the use of product pricing policies of legislative instruments biased toward healthier choices.²⁴

c. Strengthen Community Action

Most health promotion agency support for community action takes the form of funding, human resource development, strengthening health-specific knowledge, access to infrastructure supports, knowledge on how to access bureaucratic and political decision-makers, access to other groups and organizations working on similar concerns, aid in resource mobilization, technical assistance in organizational development and a political legitimization of the issues.²⁵

An important strategy for strengthening community action has been the “Healthy Communities” approach. Experience has shown that its value lies in its ability to involve multiple partners at the community level to build a shared vision, seek consensus and take action on local concerns. Further, provinces/territories have supported various kinds of community action for health through a wide range of actions.

d. Develop Personal Skills

The development of personal skills in the area of health has continued to be an important element of health promotion, with a broad approach being taken:

- More attention is being placed on improving personal resources for change, such as increasing people’s self-efficacy, self-esteem and social supports.²⁶
- There is an increased use of computerized health risk assessment programs which allow individuals to assess their own health risk profiles without professional assistance.²⁷
- The range of personal skills supported has expanded beyond those connected to health behaviours and includes programs and projects addressing literacy, numeracy, mutual support, self-help and organizing/lobbying skills.²⁸ These skills are seen to provide the foundation upon which individual and community capacity to take action to improve health is built.

- Self-help and mutual aid has grown and been shown by research to be effective at helping people cope and to take control of health problems.

e. Reorient Health Services

The health care reform process now underway in all the provinces/territories has begun to move toward “integrated health systems”. Provincial/territorial governments are establishing regional health systems that integrate hospitals, home care and public health services. However, it appears that generally the public health/health promotion voice is weak and the hospital and biomedical perspectives continue to dominate. Some distinct progress has been made in enhancing preventive practices among health professionals, spearheaded by professional associations.

While most provincial/territorial plans on health reform include statements in support of health promotion, the driving force continues to be cost reduction. The net effect has been hospital bed closures and significant staff layoffs. It is not clear that the institutional savings are being redirected into community-based programs.

Health Promotion Assessed Through Health Status and Inequalities

a. Health Status

By most measures, health status in Canada has generally improved over the past two decades during the coming of age of health promotion. However, it may be too soon to detect changes in mortality or even morbidity resulting from health promotion activities especially since changes in economic, social and environmental conditions are also occurring.

For many health status indicators such as life expectancy and infant mortality rates, Canada ranks among the best in the world. The *Report on the Health of Canadians (1996)*, prepared by the Federal/Provincial/Territorial Advisory Committee on Population Health presents the following data:

- Male life expectancy at birth increased from 70 years in 1971 to 74.3 years in 1991, while female life expectancy increased from 77 years to 80.8 years.
- The infant mortality rate declined from 15 per thousand births in 1974 to 6.3 per thousand births in 1993.
- For some indicators, such as low birth weight and potential years of life lost, Canada is only average among OECD countries.
- In the area of workplace injury, Canada fares poorly in comparison to other industrialized countries—rates in Canada rose by one-third between 1955 and 1987, while they declined in most other OECD countries.

Several of the key socioeconomic determinants of health are poverty, unemployment, education and the natural and built environments. While there have been positive trends in the area of education and mixed trends with respect to the environment, both poverty and unemployment levels are worse in the 1990s than in the 1970s.

Moreover, there are indications that with the erosion of the “social safety net” and transfers to lower income families, income gaps between the lowest and highest

income groups are beginning to grow. This is resulting in greater income inequities and in the future may contribute to a poorer quality of life for the population. In 1990, nearly 10 million Canadians reported improvements in their personal health practices, such as reduced alcohol consumption, improved eating habits and increased physical activity. Sixty-seven per cent of Canadians attributed this to increased awareness of health risks.

With respect to other key risk factors, there appear to be some positive trends in the areas of seatbelt use and breastfeeding. There are, however, mixed trends in the area of tobacco consumption and most recently negative trends in the area of physical activity.

In this regard, it may be reasonable to assume that health promotion measures aimed at tobacco reduction are responsible for some of the decline in heart disease and in male lung cancer. It is equally clear that health promotion has been less successful in addressing female smoking behaviour. The dramatic decline in cardiovascular mortality is likely attributable to a combination of reduced smoking, improved diet, increased exercise and improved medical care. In other cases, attribution may be even more difficult; for example, the reduction in long-term disability among seniors and the reduction in infant mortality to health promotion, although health promotion probably played a role. It can also claim some credit for reduced accident mortality (particularly in the case of motor vehicles); however, there has clearly been a failure to address suicide.

b. Health Inequities

Health promotion is particularly concerned with reducing inequities in health by addressing factors that result in inequitable health outcomes (e.g., economic, social, political and environmental).

The most dramatic examples of inequity in health in Canada are found among Aboriginal and First Nations peoples. Historical records indicate an indigenous population of about 500,000 at the time of the first European contact with the area that later became known as Canada. By 1871, this number had fallen to 102,000 due to the effects of colonization and exposure to new infectious diseases. By 1996, the population had rebounded to more than 800,000 and it is expected to top one million by 2010. The growth rate in the Aboriginal population is significantly higher than for other Canadian populations.

Although Aboriginal health status has improved in recent years, it continues to lag well behind the Canadian average. Life expectancy is seven to eight years less than the overall population. This is due in part to infant mortality rates twice those found in the general Canadian population, as well as higher rates of injury and accidental death among Aboriginal children, youth and young adults. While death rates for neoplasms and male (but not female) circulatory diseases are lower in the Aboriginal population than the Canadian average, death rates are significantly higher for infectious and

parasitic diseases, diabetes mellitus, alcoholic psychosis and alcoholism, pneumonia, kidney disease, accidents and violence, and higher disease rates for anemia, respiratory illnesses, arthropathies, hearing and vision impairment and dental problems.

Directions for the Future

a. Perspectives on Health Promotion

The *Perspectives on Health Promotion* project was undertaken by the Canadian Public Health Association (CPHA) from 1994 to 1996, with Health Canada support. This project consolidated health promotion experiences in the ten years since the unveiling of the *Ottawa Charter* and included:

- a commissioned background report²⁹
- a key informants survey
- a national workshop
- regional consultations involving more than 1,000 practitioners across Canada and
- the creation of the *Action Statement on Health Promotion in Canada*,³⁰ which was released at the 1996 CPHA annual meeting.

The *Action Statement* addressed the need to affirm the values of health promotion and to focus its strategic efforts. The *Action Statement* identified the core values and assumptions of health promotion as follows:

- Individuals are treated with dignity and their innate self-worth, intelligence and capacity of choice are respected.
- Individual liberties are respected, but priority is given to the common good when conflict arises.
- Participation is supported in policy decision-making to identify what constitutes the common good.
- Priority is given to people whose living conditions, especially a lack of wealth or power, place them at greater risk.
- Social justice is pursued to prevent systemic discrimination and to reduce health inequities.
- Health of the present generation is not purchased at the expense of future generations.

The *Action Statement* urged a renewed emphasis on three of the Charter strategies in particular: building healthy public policy, strengthening communities and reorienting health systems. It suggests that this requires a focus on advocacy, building alliances and developing knowledge and skills.

b. The National Forum on Health

The National Forum on Health was established by the Government of Canada in October 1994, “to involve and inform Canadians and to advise the federal government on innovative ways to improve our health system and the health of Canada’s people”. Chaired by the Prime Minister, with the federal Minister of Health as vice-chair, the

Forum had 24 volunteer members who had extensive experience in the health system. The provinces/territories did not formally participate in the National Forum on Health.

The Forum's final report which was released in February 1997, addressed five main issues:

- preserving and protecting medicare
- transforming the health system
- funding
- action on non-medical factors affecting health
- making better decisions on health and health care

In addressing the non-medical factors affecting health, the Forum stressed that work on the determinants of health and health promotion has shifted the focus of government policies from lifestyle choices to “the societal level, beyond factors that are within the immediate control of individuals, professionals and communities”. The Forum placed particular emphasis on the social and economic determinants of health (i.e., the impact of poverty, unemployment and cuts in social supports on the health of individuals, groups and communities). The Forum also stressed that “a better balance must be struck between short-term economic imperatives and the long-term health and well-being of Canadians”, and that governments need to “recognize that improving the health of the population depends above all on achieving the lowest possible unemployment rates (and) that all government economic policies...be analysed explicitly from the perspective of their impact on health”.

The Forum focussed its determinants of health recommendations on the need to improve the health of children and families (especially Aboriginal children) through the development of a broad, integrated child and family strategies.

It also stressed the importance of strengthening community action through the establishment of a national foundation that would reward and recognize communities for their leadership, stimulate the development of the required leadership and share best practices and information. It was also proposed that an Aboriginal health institute to support Aboriginal communities in taking action to improve their health be established.

While the Forum did not specifically address the role of the physical environment as a determinant of health, the Forum's recommendations support a health promotion approach that addresses socioeconomic factors that affect health, particularly the health of children and young people. The recommendations represent a positive contribution to the future development of health promotion in Canada.

The Forum also called on Canadians to acknowledge and act on the links between economic policies (particularly employment policies) and health and social impacts. Further, it recommended the creation of a National Population Health Institute to strengthen data collection, report on national health status and system performance and to act as a resource for the development and evaluation of public policy initiatives.

Part Two: Factors Contributing to Success or Failings

Why did health promotion develop the way it did in Canada? To answer this, an attempt has been made to step back and identify a list of issues which address both the factors that have contributed to the success of health promotion in Canada and the factors which have limited health promotion's attaining its full potential as a means of improving the health of the population. This approach was taken because a contributing factor in one situation is often a limiting factor in another. Also, a more "generic" grouping may invite application to similar case studies in future.

➤ A Conceptual Basis for Action

Health promotion was placed on the political agenda in 1974 with the publication of *A New Perspective on the Health of Canadians*. As was noted earlier, it was the first political document to use the term "health promotion" and place it in the context of strategic thinking on health.³¹ This was followed by the *Ottawa Charter for Health Promotion* and *Achieving Health for All: A Framework for Health Promotion*.

On the basis of these works, and complemented by an ambitious research agenda and infrastructure, a strong conceptual legacy was established which has guided health promotion agendas and actions. The documents served as legitimating sources for health promoters and their agencies concerned with the broader health determinants, as well as with individual lifestyles. They also helped to create a "space" within health agencies and systems in which new strategies could be learned and deployed (e.g., community development, lobbying and advocacy, healthy public policy development), with attention paid to how these strategies transformed unequal power relations (between governments and community groups, professionals and citizens) and increased community capacities to act on a broad range of health concerns.

However, health promotion activity has progressed quite unevenly and at times with heated dispute about whether there has been a comprehensive and unified health promotion paradigm or framework in Canada and, if not, whether this has been detrimental to better progress. Further, there have been concerns that the *Achieving Health For All* (AHFA) framework competed with the *Charter* as a basis for policy and program activity, with the Framework better known and accepted within Canada and the latter, internationally.

Clearly, the Framework contributed immensely to the development of the health promotion field in the mid-80s, aided by an ambitious federal strategy to consult with Canadians and market key health promotion concepts. For example, it consolidated federal program efforts, served as a benchmark for crafting emergent federal-provincial-territorial strategies and guided expanding research and knowledge development. On the other hand, confusion over the prioritizing and application of the key elements and attempts on the part of both government representatives and practitioners to interpret the entire framework literally at the community level may have detracted from better overall progress in health promotion efforts on certain policy and program fronts. The *Charter*, by contrast, may have been underutilized by certain government officials and practitioners as a framework for guiding Canadian health promotion efforts.

➤ **Strong Enlightened Leadership**

Two events took place early on in the evolution of health promotion at the national level that “served to legitimize health promotion and to develop the professional and institutional capacity for its development”³². The first was the creation of the Health Promotion Directorate in 1978. The Directorate was created out of reorganization plans which aligned the objectives of the department with the key themes of *A New Perspective on the Health of Canadians* and acted on a federal-provincial-territorial commitment to health promotion as a priority health issue. It may also have served to compensate for federal withdrawal from more direct intervention in health brought about as a result of a 1977 change in federal-provincial-territorial funding arrangements.

The second major factor was the 1982 Cabinet approval of a health promotion policy and program. The new program was shaped by building selectively on the program experience of the Directorate and particularly the Non-Medical Use of Drugs Directorate, with its strong community development approach to programming, and the broad vision of the first Director General. These assets were reinforced through several new senior management appointments with strong support for health promotion up to the Deputy Minister level. This culminated in 1984 with the appointment of a Minister with a particular interest in health promotion.

This “critical mass” enabled the Canada to play a major role in the first International Conference on Health Promotion in Ottawa, in 1986, including publication of the *Achieving Health for All* framework and active cooperation in drafting the *Charter*. Following the conference, this leadership was manifested in a series of activities which extended into the early 1990s.

➤ **Translating Concepts into Action**

On the release of the *Achieving Health for All* framework in 1985, the Minister of Health stated his intent to provoke a national dialogue among Canadians.³³ An extensive period of consultations and marketing of the document, program announcements and a series of knowledge development and research initiatives followed.

Longer-standing core programs (e.g., nutrition, heart health) along with the national special strategies, built on the Directorate's operating methods and incorporated the actions and strategies of the *Achieving Health for All* framework and *Charter*. These were complemented by new "development" initiatives such as the Strengthening Community Health and the Healthy Communities projects in 1988, which were also cast in the *Charter* and Framework moulds. The result was a strong, and in many cases, "tested" programming mix.

This was reinforced by provincial/territorial health promotion activities. Most had established branches, offices or departments of health promotion. While many remained preoccupied with health communication, social marketing and health behaviours, some had begun to expand activities in such directions as supportive environments and healthy public policy, informed in part by federal leadership and the Framework/Charter. Mechanisms were also introduced in policy-related initiatives in certain provinces/territories (e.g., the establishment of the Premier's Council on Health Strategy in 1987 in Ontario, and later reflected in policy coordinating and steering structures of provincial/territorial cabinets). Concurrently, "other governments, health professionals and community groups were (also) becoming increasingly involved in health promotion".³⁴

Another incentive toward the application of health promotion concepts and strategies was provided through the ongoing process of health system reform.³⁵

➤ **The Influence of Health Reform**

Health promotion's development has been pulled and pushed by health care financing and reform. Clearly, the driving force behind *A New Perspective on the Health of Canadians* in 1974 was political concern about the rising costs of health care. Shortly thereafter, with the federal move from cost-sharing to block funding of health in 1977, health promotion was identified by federal and provincial/territorial health ministers as a priority for joint action. Within National Health and Welfare, officials also saw health promotion as a legitimate federal activity that did not collide with provincial/territorial responsibilities and complemented health care efforts. Accordingly, health promotion was included in the preamble of the new Canada Health Act in 1984, emphasizing its important underpinnings of a broader health system.

During the late 1980s and early 1990s, health care reform has been front and centre in provincial/territorial health agendas to the point of being described as “an extended period of ... review and inquiry which achieved the status of a thriving cottage industry”.³⁶ Recommendations coming out of these exercises are being considered as a basis for new health policy and much of the “language, concepts, principles and strategies of health promotion are being adopted in plans for reform”.³⁷ These are evident in the importance attached to health determinants, goals, reducing inequities, intersectoral collaboration, restructuring and decentralization/regionalization.

Thus, the provinces/territories continue to work toward overall health strategies largely in the name of reform, with health promotion positioned as a complementary effort. However, it remains to be seen if significant changes in the direction of healthy public policy and a reallocation of resources will occur. This situation has contributed to the current perception that health promotion is not “leading”, but simply supporting, health care reform and the articulation of future health systems. Further, as federal involvement in direct health care reform has been limited, for some, it has reinforced the perception of federal withdrawal from the health promotion field.

➤ **Partnerships for Sustainability**

In looking to the future of health promotion in Canada, it has been suggested that leadership might be expected to become more diffused.³⁸ New players will enter the field, in part, as other parties assume a more active role (e.g., provinces/territories and voluntary organizations) and as evidence mounts that many of the determinants of health are outside of the control of the health sector. A strong partnership base among stakeholders has already played an important role in bringing together federal and provincial/territorial governments, voluntary and professional organizations and the private sector and should serve as a sound foundation to build future leadership options.

Cooperative working arrangements were instrumental in shaping Canada’s initial efforts. On the international level, the work of the World Health Organization (WHO) influenced the directions taken. For example, “the (1984 WHO-Euro) definitions of health and health promotion provided the underpinning for the concepts and strategies outlined in the WHO Health-for-All Strategy”. Cooperative working arrangements with the provinces/territories have also contributed to sustaining health promotion efforts. These were initiated through negotiation of formalized planning and program implementation structures on strategies including tobacco, drugs, impaired driving and heart health in the latter part of the 1980s and the environment and early child development in the 1990s.

Energies have also been devoted to enlisting the support and cooperation of other non-government players. Professional and national and provincial/territorial voluntary health organizations have played an important role in the development and implementation of health promotion activities with the success of national efforts such as Canada's Food Guide to Healthy Eating and the Canadian Heart Health initiative highly dependent on collaborative working arrangements for their success. These have included increasing collaboration with the private sector, building on experience gained through social marketing efforts pioneered within the federal Health Promotion Directorate.

Finally, community action has been a hallmark of Canadian efforts. Based on a commitment to public participation, the community action funding has become a critical means of identifying emerging issues and for the translation of health promotion concepts into local action. These and the Strengthening Community Health and Healthy Communities have often operated in collaboration with provincial/territorial funding and support.

➤ **Maintaining the Momentum**

Throughout the 1980s, federal momentum in health promotion was maintained by a combination of the delivery of programs and strategies using the Framework principles and tested Directorate strategies and support for health promotion development including school and workplace health, research and knowledge development and healthy communities.³⁹ This approach was successful overall but did fall short in some respects. For example, the single issue "strategies" (e.g., National Drug Strategy) sometimes "crowded" core Directorate work with their more generous financing and heightened political visibility. Further, some of the Directorate's more formative "development" work could probably have been better translated into a vision and activities to guide programming into the 1990s. Thus, the SCH/HC initiative was never recast from its status as a "funded project" to a way of supporting healthy public policy. This shortcoming suggests the importance of a capacity to translate key concepts into practice (e.g., through "policy and operational guidelines"), as was done by WHO in its "settings" initiatives and in its pilot initiatives on healthy public policy.⁴⁰ Thus while the Directorate clearly did well in translating concepts into action, it might have done some things better.

Moving into the 1990s, the Directorate had begun to ask the right questions: What is the role of the AHFA Framework in further development of the field? What are the desirable roles for the federal government? What is the place of health promotion in the emerging new system for health? Reorganization, policy reviews and jurisdictional considerations continue to dominate the first two. Nevertheless, it may no longer be realistic or appropriate to look to the federal government alone to maintain the momentum (and leadership). On the question of the place of health promotion in the

future, there appears to be some general agreement that health promotion continues to have much to offer in relation to the new systems for health. This is borne out in the observations on provincial/territorial activity associated with health reform where “the language, concepts, principles and strategies of health promotion are being adopted in plans for reform”.⁴¹ What is not clear is what form these changes will ultimately take and what contribution all of the players can make to achieve successful outcomes.

➤ **The Evidence Conundrum**

The need to make fiscal tradeoffs among competing management and policy options and priorities in the early 1990s led to calls for evidence that health promotion initiatives “really worked” and—more specifically—resulted in the improved health status of Canadians.

Social marketing initiatives were enjoying growing political popularity and were often simply assumed to work. This was partially so, for example, as several tracking studies registered “strong awareness and interest levels and exerted a positive influence on individual attitudes, perceptions, beliefs, and behaviours and contributed to health promotion social norms and consensus”.⁴² In addition these initiatives were popular for their strong capacity to lever private sector support and media attention. For other initiatives, however, neither the data nor the methodologies were there to demonstrate that changes in knowledge, attitude and behaviour—and much less, health status—could be ascribed to health promotion activities. Further, the long-term time horizons associated with outcomes often exceeded the short-term decision-making requirements.

Nevertheless, a foundation for building evidence was in place. Health promotion knowledge development and research initiatives were given strong impetus by the Framework as discussed above. For example, it provided the platform for literature reviews, special research competitions, completion of two major health promotion surveys (in 1985 and 1990) and the creation of over a dozen university-based Health Promotion Research Centres across the country. In 1996, a special federal-provincial-territorial report provided a first set of data on the state of Canadians’ health and the major factors that influence health (*Report on the Health of Canadians, 1996*). In 1997, the National Forum on Health recommended that one of the key goals of the health sector in the 21st century be the establishment of a culture of evidence-based decision-making (i.e., “the systematic application of the best available evidence to the evaluation of options and to decision-making in clinical, management and policy settings”).⁴³ It also called for a National Population Health Institute to ensure a nation-wide health information system.

The infrastructure for developing reliable information and evidence is now falling into place for health promotion. However, concerted support is now required at both the federal and provincial/territorial levels for its continuation.

➤ **Fiscal Restraint and Organizational Challenge**

Federal health promotion efforts have been both helped and hindered by fiscal restraint. In the late 1970s and early 1980s, following creation of the new Directorate, financial cutbacks afforded the organization a unique and welcomed opportunity to “think and plan which the Directorate has not been able to do since”.⁴⁴ The late 1980s ushered in another period of restraint, resulting in significant and chronic budget reductions throughout the 1990s. This brought with it pressures for more efficient and effective ways of operating, focussing on the highest priorities, reducing overall levels of activity, and eliminating duplication. It has also changed the way that health promotion is organized and delivered.

Restraint, public service reform and jurisdiction reviews over the 1990s have resulted in a series of major organizational and program reviews at the Directorate, Branch and Department levels, which continue today. This has included reviews of the major “business lines” of the Department. Health promotion and disease prevention was one of about a dozen such lines at the midpoint of the exercise (1994). However, by the time Health Canada had identified five business lines in 1996, health promotion had been incorporated within the Promoting Population Health activity, together with a number of programs which were previously part of the social development component of Health and Welfare Canada. A “restructured” Health Promotion and Programs Branch has now been created around a population health framework with a significantly reduced resource base projected over the next three years as a result of government-wide deficit reduction and the “sunsetting” of some of the time-limited strategies. Health promotion responsibilities still form the foundation for much of the Branch work and have been incorporated into the new Branch functions.

These organizational changes have been protracted and quite unprecedented in health promotion’s brief history. To differing degrees, they have been mirrored in the provinces/territories. They have involved significant changes in personnel with corresponding changes in vision and understanding of health promotion.

➤ **The Emergence of Population Health**

Beginning in the early 1990s, population health began to replace health promotion as the primary discourse in Canadian policy-making circles. One argument given for the growing prominence of population health is that it emphasizes hard, quantitative evidence and uses the language of conventional science, whereas health promotion emphasizes soft quantitative evidence and argues for the importance of community voices in policy making. Another is that the language of population health is more consistent with the understanding of growth and development in the private and public sectors and that this facilitates alliances among important new players outside of the traditional health circles.

The emergence of population health must be considered in the context of many factors. Regardless, by 1996, the federal government had approved a new organizational design and key service elements for the Health Promotion and Programs Branch of Health Canada. Maintaining and enhancing population health was adopted as a focus of Health Canada's mission. These changes do not preclude a continuing strong role for health promotion in Canada. There will continue to be many opportunities for using the principles and strategies of health promotion as work on the determinants of health proceeds. Further, there will continue to be opportunities for leadership from non-government sectors such as the Canadian Public Health Association and the Centres for Health Promotion, including the two WHO Collaborating Centres. Finally, public health and health promotion practitioners in communities throughout Canada have a significant role to play in translating important health promotion concepts into practice at the local level.

➤ **Support for Healthy Public Policy**

Healthy public policy “puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health”.⁴⁵ It is a centrepiece of health promotion and is included in both the Framework and the Charter as the framework within which the other strategies of health promotion operate.

The development of structures and mechanisms to support healthy public policy has been uneven. One of the most promising initiatives was found in the settings approaches, and particularly Healthy Communities, which was funded by the federal government. These movements led “to the establishment of a variety of formal and informal structures that support health promotion both within local government and across communities as a whole”.⁴⁶ However, Directorate support for this initiative was not sustained. The single issue “strategies” are examples of modest successes in such areas as tobacco, drugs, family violence, environment and AIDS. Here the problem has been that on reduction or termination of funding for the special initiative, the structures and mechanisms for intersectoral action have been more difficult to sustain. What has not occurred is wider consultation across the private and voluntary sectors as a natural approach by government “to doing business”. The National Forum on Health provides one example of how the public policy process could be broadened. In addition, collaboration across government sectors to ensure more integrated, coordinated human development planning and programming is essential and is becoming the standard method of operation in the federal government. The recent establishment of an Interdepartmental Committee on Population Health involving 19 departments and agencies, and government's commitment to conducting health impact assessments are promising new steps in this direction.

At the provincial/territorial levels, there are some good examples of integrated, collaborative structures, the most ambitious being the Ontario Premier's Council. Other provinces/territories have created structures at the Cabinet level to conduct health impact assessments and to coordinate public policies. Also, all provinces/territories have worked on health goals as a means to guide policy and program development. This area of policy development is in considerable flux in Canada as governments reorganize their health care systems and try to come to grips with the broad interconnected nature of health promotion work.

Part 3: Lessons for the 21st Century

1. It is vital that a shift occur from seeing health care as the major determinant of health to one where the broader environmental, socioeconomic, political and cultural determinants of health are recognized as the major factors that need to be addressed.

This shift involves:

- further research on the determinants of health to legitimate and expand our understanding
- professional and political vision and leadership
- a public and political process of raising awareness and promoting informed dialogue around the determinants of health
- continued commitment to principles and values associated with reducing inequities in health
- further investigation and validation of health promotion strategies as a way to take action on the determinants of health.

It is also important to recognize that this kind of change is a long-term process.

2. Federal leadership has been instrumental in the development of health promotion in Canada as an essential element of an effective health system. A federal role in and support for health promotion must be continued. Strong provincial and territorial support for health promotion is also essential. These efforts must operate in complementary fashion and should avoid imposing a uniform approach; programs should be tailored to local situations.
3. Government commitment and intersectoral collaboration are essential for the development of healthy public policy which should have as its ultimate goal, sustainable human development. This requires:
 - political commitment to the values of equity and social justice
 - awareness among policy-makers (political and bureaucratic) of the evidence on the determinants of health and the implications of that evidence
 - the establishment of health goals sufficiently specific to enable monitoring of progress
 - the development of health impact assessment processes for public policy, a process that must be developed in collaboration with policy-makers in all ministries
 - accountability mechanisms that are credible and transparent.
4. The development of healthy public policies also requires:
 - structures which support both comprehensive approaches within ministries, as well as a capacity for coordinated, intersectoral approaches, across ministries
 - strong leadership and advocacy for “health” within ministries of health
 - support for independent research and policy advocacy which contributes to public policy from non-government organizations.

- 5.** Governments should ensure that supportive environments are in place to encourage the active participation and partnership in other sectors including professional associations and organizations, the private sector and the voluntary sector. Independent institutions outside of government (such as the Health Promotion Research Centres) and independent “think-tanks” (such as the Canadian Institute for Advanced Research) are also an important means of sustaining population health promotion and as a base for independent training, research and advocacy.
- 6.** Concerns about the impact on health of natural and built environments provide an important and demonstrated avenue of action for health promotion. These initiatives should continue to be supported. Among the lessons learned from Canadian experience in creating physical environments supportive of health are the following:
- the value of health as a measure of public concern about and trigger for, public action on the environment
 - addressing concerns about indoor air quality and other built environment issues in homes, schools, workplaces, hospitals and other settings
 - addressing concerns with traffic and other urban quality of life issues, including linking to movements addressing issues of urban sustainability, safety, liveability and, more generally, the “new urbanism”
 - establishing the relationship between global environmental change and health, particularly in the context of the health of children and future generations, linking those concerns to the economic and social issues encompassed by globalization and the need for sustainability.
- 7.** Healthy child development may provide an important policy and program venue for addressing the environmental, social and economic determinants of health in a holistic and long-term, future-oriented manner. There is strong evidence for early intervention, along with public and political support.
- 8.** Health promotion action takes place where people live, work, play and love—in communities. “Think globally, act locally” is a useful slogan for health promotion. Thus, health promotion at the local level, using the “settings” approach where appropriate, must be supported over the long term at the national and provincial levels. This requires the appropriate devolution of power and resources to the local level, effectively balanced by the continuing leadership, financial and standard-setting activity by federal and provincial/territorial governments.

9. Personal behavioural change is an important facet of health promotion, and personal concern for health remains a powerful motivator of change. A focus on building the capacity for making positive choices is an important strategy.

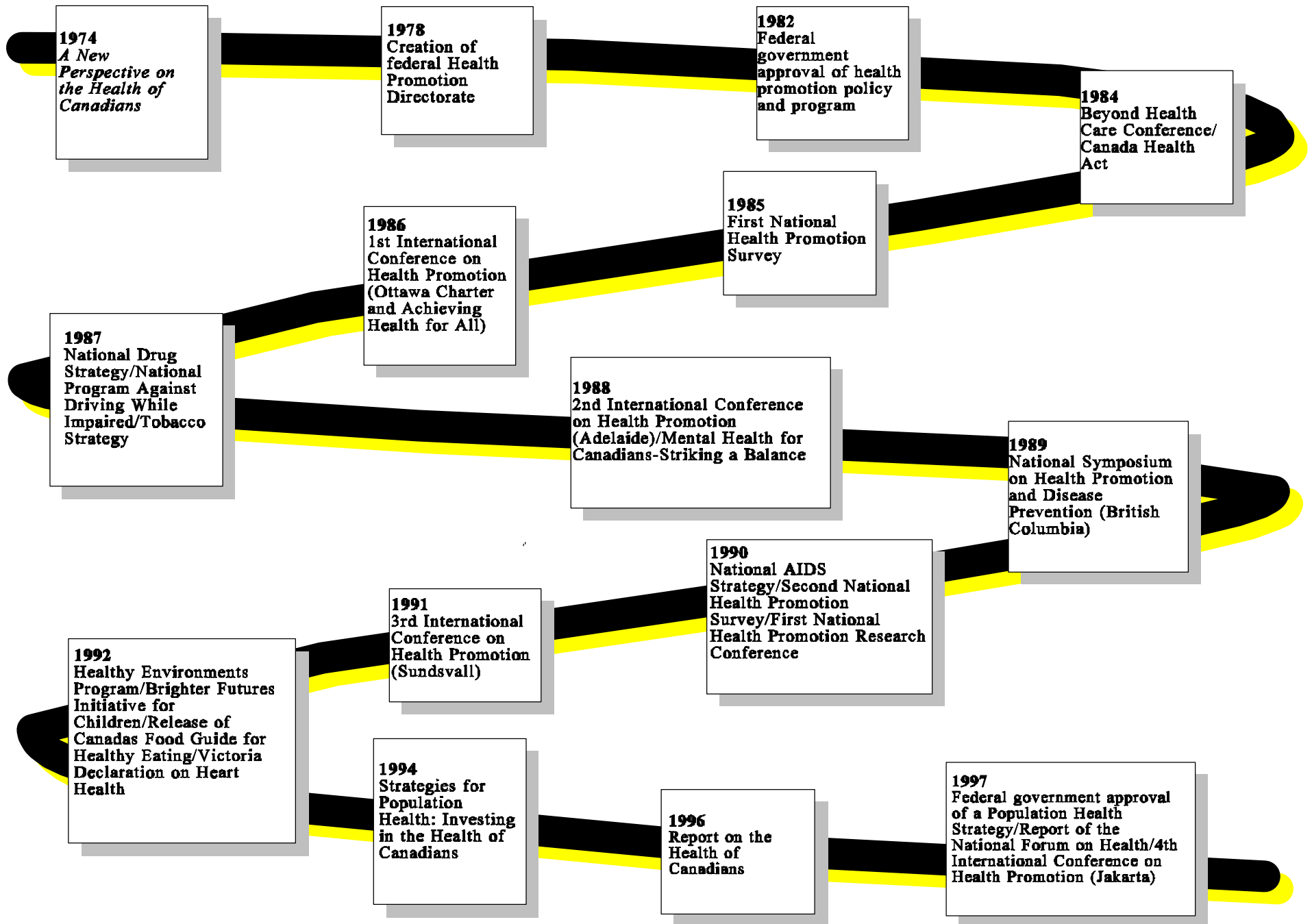
- 10.** Given that many of the determinants of health are found in environmental, social, economic and political conditions, the health sector cannot be accountable for matters beyond its jurisdiction. However, that is not to suggest that the health sector should fail to act on issues of population health promotion. Integrated health systems can and should apply the strategies of health promotion in their own operations. This means that health care systems should:
- be advocates for health-promoting policies and programs in non-health sectors
 - identify and address the environmental, social and economic determinants of health in their community, in partnership with other key stakeholders.
 - ensure their own facilities and operations are environmentally sustainable and healthy for patients and staff
 - work with others in the community to strengthen community action while training and supporting community members to participate in the governance of their health care system
 - work with others to support people in the development of personal skills for health, including patients and staff of the health care system.
- 11.** With the restructuring of the health care system, the focus of health promotion activities at the local level will increasingly be within regionalized health systems. The mandate and role of health promotion and the responsibility of regional health systems to maintain health promotion activities must be assured. Without specific policies, infrastructure and resources for health promotion, the ability of regional health systems to act on our improved knowledge about the determinants of health will be constrained.
- 12.** The funding for health promotion (and public health) represents a very small fraction of the total budget for the health care system, yet it holds great promise as a means of improving population health. Given its low level of funding, that funding should be maintained. Indeed, as health care spending is reduced and reallocated, some of that reallocated funding should be used to support health promotion both within and beyond the health sector.
- 13.** In undertaking evaluation of health promotion approaches, it is important to recognize that:
- since health promotion involves a paradigm shift in our understanding and actions and since health promotion proceeds by small, incremental steps that only slowly results in major change, health promotion can only be evaluated over a time frame spanning decades or even generations!
 - new methodologies, including participatory and ethnographic approaches that emphasize qualitative methods, need more prominence and acceptance in evaluating health promotion practice.
- 14.** There is already substantial evidence of the effectiveness of health promotion, but that evidence needs to be marshalled and presented in a strategic way if it is to influence policy-makers.

- 15.** Health promotion in Canada has benefited substantially from participation in the international arena and Canada has made significant contributions in such areas as policy formulation, program development, training and human resource development, technical support and assistance and research and evaluation. It is important that the international dimension of health promotion activity be continued and supported.
- 16.** Health promotion practitioners must continue to strengthen the field through such activities as storytelling, research, the reframing and testing of strategies and the development of new skills and expertise. These should contribute to a role for health promotion for the 21st century which anticipates changing understandings of growth, development and investment, governance systems (including local governments) and partnerships, as well as for health systems themselves.
- 17.** As Canadians, we must understand that in order for the practice of health promotion to continue to have a positive impact on the determinants of health, especially poverty and income equity, it will take time to realize the accumulative effects. Health promotion in Canada has succeeded in many areas, been insufficient in others and, at times, has been too optimistic about its own potential to create or support healthy social change. In some instances, the successes of health promoters and health agencies in community development or in local and provincial/territorial social action coalitions pressing for policy change have been overshadowed by the impact of larger-scale economic and political forces.
- As a practice, health promotion is and likely will continue to be constrained by limited resources, a dominant medical model and powerful economic, social and political forces. The positive impacts of health promotion will need to continue to be further augmented by the complementary efforts of persons working in the health and other fields with a common understanding of the determinants of health.
 - While health promotion cannot alone create an ideal future, it can help to refocus concern, at all levels from the global to the local, on human rather than merely economic development. By allying itself with and contributing to related social movements, health promotion can help us move toward a more humane, just and sustainable future.

Appendix A

Milestones in Health Promotion: A National Perspective

Milestones in Health Promotion: A National Perspective



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