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Stepping It Up:

Moving the Focus from Health Care in Canada to a Healthier Canada

Health Council of Canada
Conseil canadien de la santé

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Online appendices: This report has been produced as an online document with hyperlinked appendices. If you have printed the document and wish to view the appendices, they are posted with the report at www.healthcouncilcanada.ca.

If we want Canadians

to be the healthiest people in the world … we have to cure 'hardening of the categories' which has over the years drastically compartmentalized many of the policy and programmatic tools that must be brought together to move us along the health outcome continuum."

A Cure for the Hardening of the Categories, The Honourable Roy Romanow, keynote remarks at the inaugural meeting of the Health Council of Canada, January 29, 2004

FOREWORD

What will make Canada a healthier country?

It may not be what you think. We all know we should eat a healthy diet, exercise, and not smoke. These lifestyle choices matter, but research shows that the socio-economic, cultural, and environmental conditions of our lives – called the determinants of health – have just as strong an impact, if not stronger. This is most starkly evident among those who are struggling in or close to poverty, and who are much more likely than other Canadians to suffer from chronic diseases, to use the health care system more frequently, and to die prematurely.

As you'll see from the quotes we have used throughout this report, the importance of addressing the determinants of health is not new. But in Canada, we have a mindset that the health of Canadians is the responsibility of the ministry of health or health promotion, when in fact the majority of factors affecting our health require the problem-solving skills of multiple government departments, multiple levels of government, and other sectors of society. Existing health promotion efforts that encourage people to adopt a healthy lifestyle may be beneficial, but there are limits to what that kind of approach can achieve.

The determinants of health have been described as a "wicked problem," requiring a whole-of-government approach in conjunction with the rest of society. In this report, we present what we learned from senior officials and researchers from across the country, many of whom have built – or are trying to build – such alliances. They are gathering around an issue that severely affects health, such as poverty or obesity; around a population, such as children or the elderly; or around a process, such as health impact assessment, used to evaluate the potential health effects of government policies and regulations before they are put in place. And while working on these issues together, people are also beginning to change government thinking about what truly affects our health and what it means to govern collaboratively.

Are we there yet? No. But many people told us that the determinants of health are being discussed with a new urgency. I have seen that myself at conferences across the country this year. There is a real appetite for action. The time has come to implement what we truly believe will change the health of our country. Although a healthy living strategy is important in its own right, all of us must address the larger issues.

It's my hope that this report will help to inform Canadians about the importance of addressing the determinants of health, and the efforts that governments can make (and are making) in this direction.

As a former deputy minister, I also like to imagine this report on the desk of a senior official in a ministry unrelated to health. She (or he) doesn't know why she has received something from the Health Council of Canada, but opens the cover. She reads this foreword. Then she reads on. And six months from now, when she is asked to participate in a task force to discuss health impact assessment or poverty reduction or mental health or better housing – she steps up, because she knows that she has a place at the table to create a healthier Canada.

Sincerely,
John G. Abbott
CEO, Health Council of Canada

TOWARDS A
HEALTHIER CANADA

WHAT AFFECTS OUR HEALTH?

> "...we cannot invite people to assume responsibility for their health and then turn around and fault them for illnesses and disabilities which are the outcome of wider social and economic circumstances."
>
> The Epp Report, *Achieving Health for All: A Framework for Health Promotion,* 1986

TOWARDS A HEALTHIER CANADA

Canadians have a great deal of interest in our health care system, but a limited understanding of what contributes to good health. When asked in a national survey, most respondents said that good health was the result of making healthy lifestyle choices such as eating well and exercising.[1] The reality is that our health – and our ability to live a healthy lifestyle – is affected by a much broader range of factors.

These factors, called the determinants of health, include how much money we have, our early childhood experiences, and our level of education. They include whether or not we work (and the kind of work we do), our relationships with family and friends, how connected we are to our communities and society, whether we have easy access to affordable healthy food, and the quality of our health care services. Belonging to a specific racial, ethnic, or cultural group can also influence our health. The physical environment plays a large role as well: we are affected by factors such as air and water quality, the climate and the environment, and the safety and quality of our housing, workplaces, schools, and communities.[2,3] (See Figure 1, page 8.)

It's not that lifestyle choices such as good nutrition and exercise don't matter – they do. But a substantial body of evidence has shown that the broader determinants of health have an impact on our lives that is just as strong, if not stronger.[4]

Thirty-five years of developing knowledge in the health promotion field has unequivocally shown that taking action on the broad conditions that affect people's lives offers the greatest improvement in the health of the population.[3] But this knowledge does not appear to be translating into action. In 2009, the Institute of Wellbeing stated that Canada is falling behind other industrialized nations in

INEQUITY OR INEQUALITY?

The term inequity has often been used interchangeably with inequality, but it's critical to differentiate between the two.

Inequality refers to health differences that may be possible to reduce but not eliminate, such as those related to genetics or aging; *inequity* refers to differences that are unfair and preventable. Governments cannot necessarily fix all inequalities, but they can take action to reduce inequities.[5,6,7]

Unless we are referring to work that specifically discusses inequalities or disparities, we use the term inequities throughout this paper.

A SEPARATE REPORT ON ABORIGINAL HEALTH

In Canada, there are significant health differences between Aboriginal peoples and the rest of the population. This crisis in Aboriginal health and the unique interests and specific needs of Inuit, Métis, and First Nations people merit a more comprehensive review.

To that end, the Health Council of Canada has established a separate project to critically examine these issues and will release a report in 2011.

More information about the Council's plans can be found in our October 2010 *Update: Improving the Health and Well-Being of Aboriginal Peoples in Canada, (www.healthcouncilcanada.ca).*

measures such as levels of poverty, the degree of inequality between the rich and poor, and investments in social programs.[8, 9]

In 2009, the Canadian Senate also had some strong words for this lack of progress: "... it is unacceptable for a wealthy country such as Canada to continue to tolerate such disparities in health."[10]

Canada was once an innovative leader in promoting the importance of the determinants of health, starting in 1974 with a landmark report, *A New Perspective on the Health of Canadians.* The report stated that health was related not only to health care but also to other factors – human biology, the environment, and lifestyle – that lay outside of the health care system. In 1986, Canada was host of the first international conference on health promotion, held in Ottawa. The resulting Ottawa Charter for Health Promotion, endorsed by the World Health Organization, declared that, "Health promotion goes beyond health care – and puts health on the agenda of policy-makers in all sectors and all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health."[11] A federal report released at the conference, *Achieving Health for All: A Framework for Health Promotion,* also emphasized these messages and questioned the emphasis on lifestyle strategies.[12] Stating that prevention is "a far more complex undertaking than we may at one time have imagined," the report stressed that the current challenges were to reduce inequities, increase efforts in prevention, and enhance people's abilities to cope with stress.

As a result of the Ottawa Charter, many countries began to look more closely at the determinants of health and the way public policy can help. But Canadian governments and health promotion officials

THE HIGH COSTS OF POVERTY

Although statistics show that the overall health and life expectancy of Canadians is improving, health improvements are not shared by everyone.

People who live in poverty are more likely to live in poor health and to die earlier than those who live in more affluent communities.[3] They suffer from more chronic illnesses, more obesity, and more mental distress.[3, 8] Living with the chronic stress of disadvantage can have an effect on both cardiovascular and immune systems. Over time, this can leave people more vulnerable to chronic diseases and infections, and to mental health conditions such as depression.[4]

International research indicates that to reduce gaps in health, the health of the poorest 30–40% of the population must be improved at a faster rate than the health of the rest of the population.[13]

Consider these statistics:

- While the overall poverty rate was estimated at close to 11% in Canada (in 2005), poverty rates are much higher for specific sectors of society: lone-parent families (26%), work-limited people (21%), recent immigrants (19%), and off-reserve Aboriginal people (17%).

According to the same 2005 statistics, 11.7% of Canadian children under 18 were living in poverty.[3, 14] Reporting on more recent 2008 statistics from the Organisation for Economic Co-operation and Development (OECD), the Conference Board of Canada indicates that child poverty rates in Canada are even higher, at 15%.[15]

- When Canadians are divided into five income groups, the rates of diabetes and heart disease among the poorest 20% of the population (the working poor and those on social assistance) are more than double the rates of the richest 20%,[8] while the plight of many of Canada's Aboriginal peoples is even worse (see *A separate report on Aboriginal health,* page 5).
- Although all developed countries have health inequities, income inequality is growing in Canada, which is creating greater health inequities. After 20 years of decline, both inequality and poverty rates have increased in Canada in the past 10 years; they are now higher than the OECD average.[8, 9]

largely focused their health promotion efforts on lifestyle issues, developing programs to address factors such as tobacco use, activity levels, and healthy eating.[16, 17] For the most part, Canadian governments have not focused on the determinants of health and on implementing population health policy.[10, 17, 18] Overall, a gap exists between the findings of accepted research and putting public policy interventions into action.[19, 20, 21]

Canada can no longer afford to delay taking these steps. Health care spending in Canada more than doubled between 1997 ($79 billion) and 2007 ($160 billion).[22] In 2010, spending is expected to reach $192 billion.[23]

Direct health care spending is projected to grow even more and potentially crowd out other necessary public investments in areas that are important to the determinants of health – unless we refocus our spending priorities. Senator Wilbert Keon, chair of

"Best practices for addressing poverty point to a broad, integrated approach that engages community partners as well as all orders of government…The province's Poverty Reduction Strategy is a government-wide integrated approach, based on the principles of social inclusion and collaboration…Poverty is a multi-dimensional problem."

Reducing Poverty: An Action Plan for Newfoundland and Labrador, 2006

Income inequality affects health care costs

- A Saskatoon study compared actual health care utilization rates, high health care utilization patterns, and overall costs between income groups. The study showed that residents from lower socio-economic neighbourhoods use a disproportionately high amount of doctors, medications, and hospitals due mainly to their increased prevalence of disease.

  The study showed that low-income residents consume 35% more health care resources than middle- and high-income residents, which translated into nearly $179 million more in health care resources than they would have used if they were in the middle-income bracket.[24]

- A study in Winnipeg looked at health information from 1995–1999 to identify the cost savings that could be found by reducing inequalities in health. Results showed that eliminating the gap between the poorest and wealthiest neighbourhoods in Winnipeg would reduce heart attacks by 22% and hip fractures by 20%. Bridging the gap between the wealthiest neighbourhoods and all other neighbourhoods would have resulted in a savings of about $62 million in 1999 – or 15% of all hospital and physician expenditures in Winnipeg that year.[25]

- Estimating the cost of gaps in health as a result of unequal socio-economic status can be difficult because of the complexity of the problem. Few studies have attempted to translate the gaps into an actual dollar figure. However, the Public Health Agency of Canada is working on a report on health status and health care cost by income level in Canada, which will be released in 2011.

Poverty-reduction strategies in Canada

In recent years, a number of Canadian jurisdictions have launched poverty-reduction strategies that have significant potential to improve the health of many Canadians and reduce health inequities. This marks a new and positive development in the ways that some Canadian governments are rethinking their policies to address the determinants of health.

Information about these poverty-reduction strategies is available in an online appendix of jurisdictional initiatives.

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the Senate Subcommittee on Population Health and a noted cardiac surgeon, went so far as to state that "increased expenditures on health care are likely impacting negatively on the general health of our population by virtue of diminished investments in other areas like education (especially early childhood education), public housing, income security, and other public services."[26]

Health inequities play a significant role in these health system costs. Canadians with the lowest incomes are more likely than other people to suffer from chronic conditions such as diabetes, arthritis, and heart disease; to live with a disability; and to be hospitalized for a variety of health problems.[3] They are twice as likely to use health care services as those with the highest incomes.[3, 27] This is not a simple case of poverty versus affluence: there is a gradient in inequalities in health.[3] People tend to be less healthy than those above them on an income scale, but healthier than those below.[3, 13] An estimated 20% of total health care spending may be attributable to income disparities.[28]

Serious and pervasive concerns about growing health disparities, the increasing prevalence of chronic conditions, and the sustainability of the health care system are converging to create a sense of urgency about health promotion and disease prevention in Canada. This was recently reflected in a statement by Canada's federal, provincial, and territorial ministers of health and health promotion / healthy living, titled *Creating a Healthier Canada: Making Prevention a Priority,* which outlined their collective intention to increase the emphasis on prevention and health promotion.[29]

The urgent task governments face is translating principles into practice and stepping up the action to make Canada a healthier nation.

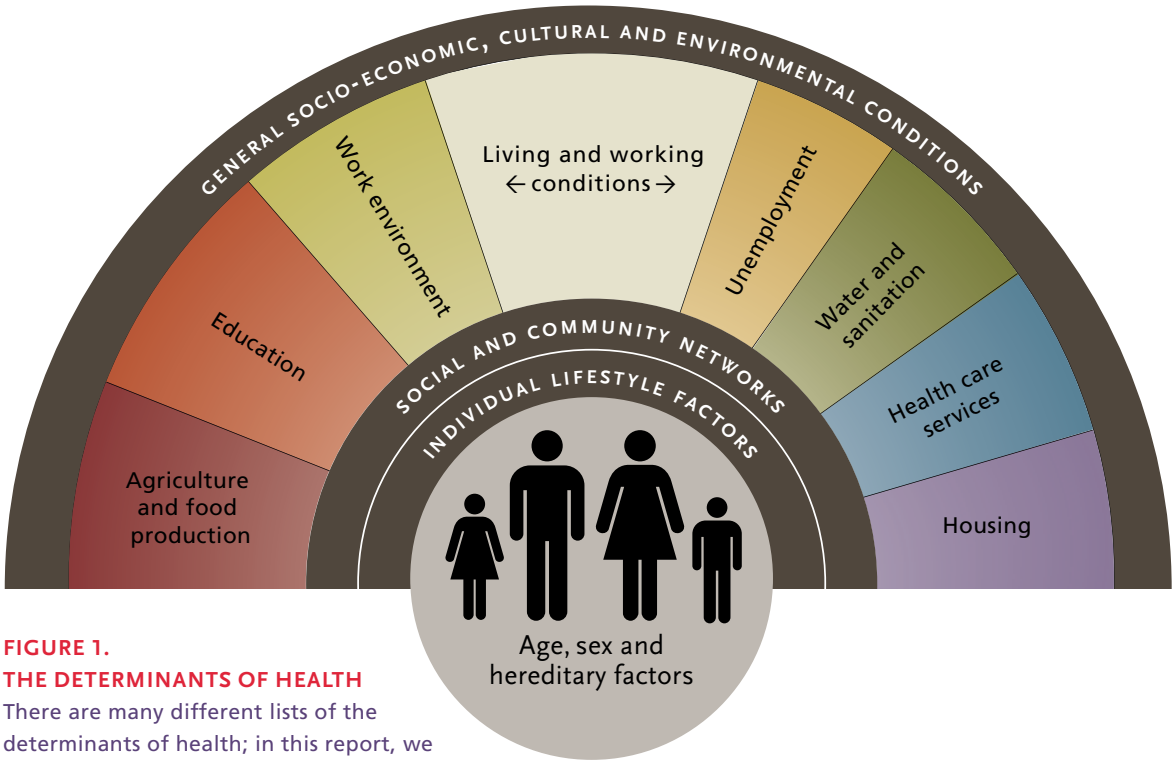

FIGURE 1.
THE DETERMINANTS OF HEALTH
There are many different lists of the determinants of health; in this report, we present one widely recognized model that illustrates many of the socio-economic, cultural, and environmental factors that affect our lives.

For a greater understanding of how these determinants of health affect health outcomes, visit www.who.int to read the World Health Organization's 2008 report, *Closing the gap in a generation: Health equity through action on the social determinants of health.*

Adapted from Dahlgren, G. and Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health.* Stockholm: Institute for Futures Studies.

ABOUT THIS REPORT

As stated earlier, most of the factors affecting health lie beyond the reach of the health care system alone, and actions to change them require the efforts of all levels of government, multiple government departments, communities, researchers, the non-profit sector, and the private sector.

Many reports and studies state that intersectoral action and whole-of-government approaches – which link many of these players together – show promise for making an impact on the determinants of health and improving population health.[8, 10]

The Health Council was interested in learning about how these approaches are emerging, and how they are being implemented and adapted across Canada. Part of our mandate is to report to Canadians on the progress governments have made in health

"The prevalence of poor health or poor health behaviours is less common at every step up the socio-economic scale. This is a critically important fact to acknowledge and address as programs that fail to address these factors can inadvertently increase disparities in health status or behaviours."

Curbing Childhood Obesity: A Federal, Provincial, and Territorial Framework for Action to Promote Healthy Weights, Ministers of Health and Health Promotion/Healthy Living, 2010

PAN-CANADIAN HEALTHY LIVING STRATEGY

Many sectors – governments, non-governmental organizations, the private sector, Aboriginal organizations, and others – are partners in the Pan-Canadian Healthy Living Strategy. The strategy focuses on preventing chronic disease and promoting good health by helping different sectors align and coordinate their work to address common risk factors for poor health such as physical inactivity and unhealthy eating.

The strategy is a culmination of consultation and input from a wide variety of people and organizations across all sectors. Together, partners target the entire population, with particular emphasis on children and youth; those in isolated, remote and rural areas; and Aboriginal communities. The goal is to improve overall health outcomes and to reduce health disparities among Canadians.

Federal, provincial and territorial ministers of health first endorsed the Pan-Canadian Healthy Living Strategy in 2005. In 2010, the Pan-Canadian Healthy Living Strategy framework was strengthened, and in support of this step, the ministers of health and of health promotion/healthy living endorsed two new initiatives:

- *Creating a Healthier Canada: Making Prevention a Priority* is a declaration on prevention and promotion from the ministers of health and health promotion / healthy living, outlining their shared vision to work together to make health promotion and the prevention of disease, disability and injury a priority.
- *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights* focuses on reducing the prevalence of childhood obesity in Canada, with strategies and priorities for federal, provincial and territorial government collaboration.

Both documents are available on the Public Health Agency of Canada's website, www.phac-aspc.gc.ca.

care renewal, based on commitments made in 2003 and 2004 health accords.

To conduct this analysis, the Health Council established an expert panel and contracted a consulting firm, the Todres Leadership Counsel, whose consultants worked in partnership with Dr. Dennis Raphael, one of Canada's top researchers on the social determinants of health. The consultants conducted a review and analysis of the literature and of policies, initiatives, and programs across Canada and abroad. They held 35 key informant interviews with senior officials in all provinces and territories, ranging from deputy ministers and assistant deputy ministers to medical officers of health, directors and program coordinators, and leading academics. An expert panel provided additional context about what is happening across Canada and around the world. The direction of this report and the comments within it reflect

"Some Canadians live their lives in excellent health with one of the highest life expectancies in the world ... others spend their life in poor health, with a life expectancy similar to some third world countries. We cannot correct this inequity through the health care delivery system itself, regardless of the expenditure we devote to it."

A Healthy, Productive Canada: A Determinant of Health Approach, Senate of Canada, 2009

> “Income is a determinant of health in itself, but it is also a determinant of the quality of early life, education, employment and working conditions, and food security. Income is also a determinant of the quality of housing, the need for a social safety net, the experience of social exclusion, and the experience of unemployment and employment insecurity across the lifespan.”
>
> *Social Determinants of Health,* Dr. Dennis Raphael, 2009

the Health Council's conclusions about the information and recommendations that were received.

Our findings show that there are many efforts to promote health and reduce health inequities at the federal, provincial, and territorial levels. At the federal level, the Public Health Agency of Canada, along with Health Canada, is taking a leadership role on many fronts, including research and the development of knowledge and provision of health programs for Inuit, Métis, and First Nations people. At the national level, significant data collection, research, and policy work has been undertaken by organizations and agencies such as Statistics Canada, Health Canada, the Public Health Agency of Canada, the Pan-Canadian Healthy Living Strategy, the National Collaborating Centres for Public Health, the Pan-Canadian Public Health Network, the Canadian Institutes of Health Research, the Canadian Institute for Health Information (including its Canadian Population Health Initiative), as well as by public policy think tanks and institutes such as the Canadian Institute for Advanced Research, the Canadian Public Health Association, the Conference Board of Canada, and the Chronic Disease Prevention Alliance of Canada.

All jurisdictions have been working to strengthen Canada's public health system, to support early childhood development, and to implement healthy living strategies and other initiatives that support health promotion and disease prevention. In addition, significant work has taken place at federal/provincial/territorial policy tables.

In this report, our focus is on provincial and territorial efforts; however, the Health Council recognizes that a great deal of intersectoral and whole-of-government action happens at the local level, particularly

MAKING THE CASE: PREVENTION PAYS

A first study of its kind in Manitoba looked at the economic benefits of investing in primary prevention, focusing on the potential savings in direct and indirect health care costs to Manitobans when risk factors such as smoking, physical inactivity, and obesity are addressed by implementing programs proven to be effective.

The analysis estimated the current health and economic costs of risk factors, modeled the longer-term economic benefits of reducing risk factors, estimated the costs of implementing selected (proven) interventions, and combined information to determine the longer-term costs and benefits.

According to 2008 statistics, 55% of the population is overweight or obese, 45% is inactive, and 27% smokes. The total direct (health care) costs related to these factors are estimated at $492 million, while indirect costs are estimated at $1.12 billion, yielding total attributable costs of $1.62 billion. If the proportion of the population with the risk factors remains at 2008 levels, the annual economic burden associated with these risk factors would increase from $1.62 billion in 2008 to $2.13 billion in 2026. The cumulative increase in economic burden between 2008 and 2026 would be $4.7 billion.

Study researchers found that just a 1% reduction per year in the proportion of the population with the risk factors (starting in 2011), using a sample investment of $529 million in effective programs, would result in $540 million saved in direct health care costs. When indirect costs are taken into account, the savings to the Manitoba economy would be nearly $1.8 billion – a better than 3-to-1 investment.

If the number of people with these risk factors was reduced by 2% per year starting in 2011, the cumulative reduction in economic burden would be $3.58 billion by 2026.

The report is a call to action, noting that investing heavily in primary prevention is a challenge that will require:

- a paradigm shift from treatment to prevention;
- broad partnerships and collaborative efforts across sectors to address the determinants of health; and
- research and evaluation to address the knowledge gap about which programs are most effective (program outcomes and costs).[30]

through the Healthy Cities/Healthy Communities initiatives and public health authorities. This report discusses some of the preconditions, structures, processes, tools, and other factors that enable governments to successfully take action on the determinants of health through whole-of-government or intersectoral approaches. We have set out to understand the governments' initiatives in broad-brush terms, rather than through in-depth case studies. More information is available in an online appendix which provides a summary of selected key initiatives by the federal government and in the provinces and territories.

Despite the extent of this cross-Canada activity, our analysis confirms what the literature has already told us: research and analysis about health promotion and the determinants of health are not being translated into public policy and program action in Canada to the degree that was expected.

We asked the jurisdictions directly: What major factors have made a difference in your ability to move forward with collaborative and coordinated approaches to promoting health and reducing health inequities? What has worked well? What have you learned?

We hope their answers and our insights will advance the discussion – and action – on this important health policy issue.

LEADING CHANGE

MAKING AN IMPACT ON THE DETERMINANTS OF HEALTH

> "Change will demand the attention of all individuals, NGOs, business, communities, all levels of government and all sectors of our Canadian society. Success will require leadership from our prime minister and first ministers, from our mayors, municipal leaders, community leaders, and the leaders of our Aboriginal peoples. A whole-of-government approach is required with intersectoral action embracing business, volunteers, and community organizations. This will not be easy, but it can and must be done. We cannot afford to do otherwise."
>
> *A Healthy, Productive Canada: A Determinant of Health Approach,* Senate of Canada, 2009

LEADING CHANGE

The determinants of health fall under the category of what are called "wicked problems" – complex social issues that cut across government ministries and can involve confusing information, multiple decision-makers, and conflicting values.[31, 32, 33] Making an impact on these determinants of health requires integrated government action across departments and agencies within a single government, often across levels of governments, and typically in collaboration with other sectors such as the non-profit and private sectors.

For this report, we reviewed four countries that have received attention for their success in improving health and reducing health inequities: Norway, Sweden, the United Kingdom, and Australia. All these countries have a concerted approach to dealing with the determinants of health: they have implemented initiatives involving all relevant government ministries and departments, and have taken bold steps towards implementing whole-of-government approaches to close the gap in health outcomes between healthier and more vulnerable populations. Australia is particularly relevant because it has a government system similar to the Canadian model. An overview of these international initiatives is available in an online appendix.

We asked our key informants how broadly Canadian jurisdictions were using a whole-of-government approach for health promotion, and specifically for improving the determinants of health.

We learned that the provinces and territories vary widely in the types of structures and processes they use to improve the health of the population, such as ministries of health promotion, wellness, or healthy living; initiatives that focus on whole-of-government approaches (supported by legislation

UNDERSTANDING WHOLE-OF-GOVERNMENT

Whole-of-government is the term for a movement that is attempting to change the work of the public sector from a focus on the individual work of ministries or departments – sometimes described as a silo mentality – to a focus on complex issues that can only be addressed through a collaborative, integrated approach of multiple government ministries or departments with a common goal.[32, 33]

Many approaches go beyond government to include partnerships with non-governmental organizations, including the private sector.[32]

It can be a challenge to define whole-of-government because there is no single explanation, either for the term or the way it should be put into practice.

In the process of preparing this report, experts expressed differing opinions about which Canadian efforts could be described as a whole-of-government approach.

In addition, different labels have been adopted in different countries: *whole-of-government* is commonly used in Australia; the British use the term *joined-up government;* and in Canada, we are more likely to use the terms *intersectoral initiatives* and *horizontal management.*[32, 33]

A call for more whole-of-government approaches in Canada

The Senate Subcommittee on Population Health's 2009 report on the determinants of health recommended that the prime minister of Canada take the lead in developing and implementing a population health policy at the federal level. Recognizing that population health policy is by nature intersectoral – it is designed to address, in a coordinated fashion, the range of determinants that influence health – the report recommended a "profound structural change in the government's approach to the development and implementation of public policy, namely, a whole-of-government or horizontal approach to break down silos."[10]

in some cases); and other ministerial collaborations. Much of the government activity in health promotion is focused on behaviour modification of lifestyle factors (such as smoking, lack of physical activity, poor diet, and excessive alcohol use). But little attention has been paid to the environmental, social, economic, cultural, and other factors that shape these behaviours in the first place – or to a deeper analysis of these issues, which can be strongly affected by government policies.

In recent years, there has been considerable activity in some jurisdictions focused on poverty reduction, and programs directed towards children and families. Most jurisdictions also support community development, because it is well recognized (by our informants and in the literature) that some of the most important work dealing with health inequities and the determinants of health happens at the community level.[10, 34, 35]

Some informants believe that a focus on encouraging Canadians to live healthier lifestyles has reached a plateau. There is growing recognition that focusing on lifestyle and behaviour alone is not enough to improve the overall health of the population. Several informants echoed the sentiments of one respondent: "We have already picked the low-hanging fruit." This attitude is reflected in their increased interest in whole-of-government and intersectoral approaches to tackle what they recognize as "wicked problems."

Although a whole-of-government approach is often seen as the recommended ideal for tackling the determinants of health, our respondents (and indeed the literature) were clear that it does not necessarily work for every issue or every jurisdiction.[35] We noted a growing interest in the use of *health impact assessment* – a method of considering the potential or actual impact of a policy or program on

THE IMPORTANCE OF COMMUNITIES

Whole-of-government work that originates at a national, provincial, or territorial level may be limited in its capacity to influence the determinants of health unless the efforts are supported by comprehensive local initiatives, developed from the ground up. Communities require support from a range of departments and agencies from different levels of government.[10, 14]

In addition, local governments and organizations have a history of success with the development and implementation of whole-of-government and intersectoral approaches.

Higher levels of government could learn a great deal from working with local-level governments and organizations.[10]

Many successful examples of intersectoral action and whole-of-government approaches at the local level have been inspired by the Healthy Cities and Healthy Communities movements, which stress the importance of improving the determinants of health at the community level.[14, 34] A primary philosophy underpinning this focus is that communities – even the most disadvantaged ones – can tap into their own strengths to make positive changes.

The Healthy Communities movement is strongest in Ontario, Quebec, and British Columbia. Efforts in Quebec and Ontario are largely or entirely provincially funded, but the provincial funding for the BC Healthy Communities initiative was eliminated in 2009. The organization continues to operate in a reduced form.

Many other efforts in community engagement follow the same principle of tapping into community strengths, such as Vibrant Communities and Inclusive Cities Canada.

the public's health – as a way to promote whole-of-government thinking. Some respondents also noted that poverty-reduction strategies (launched in recent years by several jurisdictions) are helping to educate governments about the value of a whole-of-government approach.

GETTING IT DONE: PRECONDITIONS FOR SUCCESS

Respondents emphasized that there are different political and cultural factors to consider in each jurisdiction, and that one size doesn't fit all. Context matters. That being said, our informants provided similar lists of conditions that are essential for success, which echoed what is in the literature.

Strong political and bureaucratic leadership. Political leadership has been at the heart of every successful jurisdictional effort to reduce health inequities. Strong committed people, working as elected officials or public servants, serve as both leaders and champions to create vision and momentum for the strategy, and to support the decision-making structures that need to be put in place. Several informants noted that this element was the single most important factor behind a successful effort.

A strong and compelling case for support, accompanied by clear, bold numerical goals and targets. Jurisdictions have to be clear about the problems that they are trying to solve, and their goals and objectives, desired outcomes, tactics, and timelines. There is often a defining document that serves as a call to action. However, several informants noted that goals and targets or a defining document trigger change only when strong leadership is in place. And in every jurisdiction that has successfully undertaken these activities, communicating with the public has been an essential part of its activities. Informants

> "The determinants of health are long-term social issues that need to transcend politics and outlast four-year political terms."
>
> *Act Locally,* a report for the Senate of Canada, Dr. Trevor Hancock, 2009

said that governments will act on these issues only if they are assured that the public understands and supports what they are trying to do.

Appropriate government structures to facilitate the initiative and support action.
Having appropriate supportive government structures might mean setting up a dedicated authority within government to coordinate activity across ministries or departments. It may also involve assigning authority to an existing ministry or department. This authority, with the explicit support of governmental leaders, must be responsible and accountable for recommending policy priorities, ensuring that efforts are made to achieve these priorities, and evaluating the outcomes. However, several informants stressed that these administrative structures should serve the project, not oversee it. As one informant said, bold goals and clear targets need to be accompanied by a "willingness to get out of the way;" administrative structures must encourage innovation on the front lines, rather than micro-manage ways to reach the goals.

GETTING IT DONE: VOICES OF EXPERIENCE

Our informants provided some rich information about the factors that can have an impact on the successful implementation of intersectoral or whole-of-government approaches. Their feedback serves as real-world information about how to launch and sustain these initiatives. What they said:

The case for support for the determinants of health is complex and as a result is a tough sell.
Officials say it can be difficult to make the case to politicians about the need to invest across the board to address the determinants of health because the issues are complex, long-term, and intertwined. One respondent noted that talk about the determinants of health can be paralyzing to some government officials.

THE ROLE OF THE HEALTH CARE SYSTEM IN ADDRESSING HEALTH INEQUITIES

The health system has been recognized as a key determinant of population health. To quote *Reducing Health Disparities – Roles of the Health Sector: Recommended Policy Directions and Activities,* by the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security:

"If health care and public health programs and services do not include a focus on the needs of disadvantaged individuals, populations and communities, there is a risk of increasing rather than reducing health disparities.

The health sector also has an important role to play in mitigating the causes and effects of other determinants of health through interventions with disadvantaged individuals, populations and communities."[28]

Taking action on the determinants of health requires leadership in the health sector, together with leadership in the other sectors whose work is aligned with the broad determinants of health.

Building a disparities perspective and focus into health care planning and delivery should be part of an integrated and comprehensive approach to reducing health inequities.[29]

One way to approach this is through a health equity audit, a process that considers how to address inequities in health service planning and delivery.[36] The UK's Department of Health offers a guide on health equity audits, available at www.dh.gov.uk.

What seems to work better is a well-developed business case around one major issue, such as poverty reduction, homelessness, or child development. To be effective, such a business case must provide information about how investing in these issues will address the immediate problem and also provide a range of social and economic benefits, including benefits to the health of the population. It's also important to show how the plan will resonate with the overall policy agenda of the government.

It's a seismic shift in organizational culture.
It takes time for decision-makers across governments to shift to the philosophy that improving the health of the population is a job for the government as a whole, not just the responsibility of the ministry of health or health promotion.

Several officials mentioned the challenge of communicating with ministries that don't normally work on health issues (such as those involved in industry, regulation, and natural resources), because the link between their work and the determinants of health is not always obvious to them. In such cases, officials feel they are in what one described as "perpetual Population Health 101-mode," explaining the case for support.

Informants spoke of the need to frame health issues in ways that make sense to non-health sectors. As one respondent said, "There are many deputy ministers with no idea that they have an impact on population health." Many officials suggested that the champion leading an effort to improve health or reduce health inequities should not always be the ministry of health or health promotion. They said one of the keys to success is convincing other departments that health is an investment, not an expense – and that it's everyone's investment, not just the health ministry's.

> "Bringing about action requires more than good ideas or honourable ideals … ultimately, high-level leadership in all sectors – health and otherwise – is crucial to reducing health inequalities."
>
> *The Chief Public Health Officer's Report on the State of Public Health in Canada 2008: Addressing Health Inequalities*

Some officials mentioned that deputy ministers' performance agreements and mandate letters from the premier to ministers clearly spell out expectations for inter-ministerial collaboration. One jurisdiction said these accountability mechanisms underscored the importance of inter-ministerial collaboration when it was a fairly new concept by tying a substantial portion of the deputy ministers' performance compensation to their participation in cross-departmental initiatives.

Health impact assessment "has huge potential to change government thinking."

Several informants spoke about the power of health impact assessment to help government officials understand how their ministry's work can have an effect on health. A health impact assessment is a structured method to evaluate the potential impact of policies or programs on the population's health and health inequities. Quebec is Canada's leader in this area. The province's *Public Health Act* requires that legislative and regulatory proposals from all departments be subject to a health impact assessment; for example, it has been used to regulate asbestos mining and ban cellphone use in cars.[10] Alberta, Ontario, and Saskatchewan all mentioned that they are developing some form of health impact assessment (sometimes called Health in All Policies). One respondent said that health impact assessment has "huge potential to change government thinking," a sentiment repeated by other officials. (See *Health impact assessment growing in popularity,* page 20.)

The structures for this work can vary within governments and can vary over time.

Many informants stressed that jurisdictions need to customize the way they do this work to fit the issues. Most jurisdictions that do intersectoral work have ministerial committees and supporting senior officials' committees. Some of these are ad hoc; some are permanent. In one jurisdiction,

> “Shifting attention to strategic investments in the socio-economic determinants of health promises to deliver not only improvements in health outcomes, but also cost-savings and economic benefits.”
>
> *Healthy People, Healthy Performance, Healthy Profits,* The Conference Board of Canada, 2008

a standing committee of cabinet deals with its most significant intersectoral activities. Officials told us that effort has to be expended continuously to ensure that the committees are meaningful and not perfunctory.

Some jurisdictions enjoy the full support of their premiers in leading intersectoral committees. In some cases, intersectoral approaches began with special cabinet committees, and some of these structures have been absorbed into existing governmental structures and budgeting systems. Our findings show many different ways of organizing and budgeting for intersectoral work.

Informants stressed that the project launch may require a different type of political and bureaucratic oversight mechanism than the implementation phase. The challenge lies in maintaining momentum. As with all matters relating to influencing change, informal networks are just as important as formal networks in organizations like government bureaucracies if a new activity is to succeed.

Success with inter-ministerial work breeds more success. Some jurisdictions have more experience than others in inter-ministerial work, and they say that each success story prepares the way for the next initiative. Once a culture shift begins to take hold, people are ready to work together on other issues. One example of this dynamic is British Columbia’s ActNow BC, a broad whole-of-government healthy-living program. It has been used as a model for other collaborative inter-ministerial work in mental health and addictions, as well as chronic disease management.

Work conducted around federal/provincial/territorial policy tables is significant. For many senior officials, work done around federal/provincial/territorial policy tables is very important, as are regional meetings. As one example, a meeting

HEALTH IMPACT ASSESSMENT GROWING IN POPULARITY

Health impact assessment is "a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a popu–lation, and the distribution of those effects on the population."[37]

Health impact assessment first originated in the environmental field. As part of conducting environmental-impact assess-ments, governments also began to look at the potential impact of their projects on human health.

In the last 15 years, the application of health impact assessment has expanded, and there is increasing interest in using it to evaluate a wide range of potential policies that might affect health.[38]

In 2009, the National Collaborat-ing Centre for Healthy Public Policy launched a series designed to help Canadian policy makers gain a better understanding of health impact assessment (available at www.ncchpp.ca).

While it is growing in popularity in Canada, health impact assessment is already well under-way in several other countries. In Australia and the UK, the concept has been expanded to include equity-focused health impact assessment; it examines the potential impact of policies, programs, and projects on the health of the population and specific groups, which may be affected differently. Equity-focused health impact assessment also looks at whether differences in health are avoidable and unfair.[39]

"The complexities of the social, political economic and environmental factors that influence health and inequities in health and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector, necessitate working across sectors of government and society."

Health equity through intersectoral action: An analysis of 18 case studies, Public Health Agency of Canada and the World Health Organization, 2008

of the Atlantic health ministers led to the development of the first Atlantic Mental Health Summit in October 2010. At a more technical level, the Population Health Promotion Expert Group and the Healthy Living Issue Group for the Pan-Canadian Public Health Network developed a comprehensive set of indicators of health disparities. These indicators can be used to measure and report on inequalities in health and on key determinants of health in Canada, which, according to the Senate,[10] is a critical next step in supporting a pan-Canadian population-health approach to public policy. The Population Health Promotion Expert Group and the Surveillance and Information Expert Group are pursuing discussions on how to advance their work in this field.

Over the years, there have been significant federal/provincial/territorial agreements relating to health promotion. For example, between 1994 and 2004, one of the main vehicles for intergovernmental

> "We collectively declare our vision for a Canada in which governments work together and with private, non-profit, municipal, academic and community sectors, and with First Nations, Inuit and Métis peoples, to improve health and reduce health disparities and to build and influence the physical, social and economic conditions that will promote health and wellness and prevent illness, so that Canadians can enjoy good health for years to come."
>
> *Creating a Healthier Canada: Making Prevention a Priority,* Ministers of Health and Health Promotion/Healthy Living, 2010

coordination and dialogue in population health was the Advisory Committee on Population Health and Health Security which advised the Federal/Provincial/Territorial Conference of Deputy Ministers of Health and played a key role in taking a long-term and integrated view of the health of the population, ensuring policy coherence across issues.[40]

Between 1989 and 1998, each jurisdiction implemented health goals, but these are no longer being applied. In 2005, federal, provincial, and territorial ministers of health established health goals for Canada, but these have not turned into measurable actions or a national strategy. In addition, no national targets have been set to reduce health disparities.[10] A lot of good work has taken place at the federal/provincial/territorial tables, such as sharing information and developing data, goals, and policy frameworks, but no large-scale efforts have been made to put this information into action.

The most recent federal/provincial/territorial work is represented by a declaration of prevention and promotion, titled *Creating A Healthier Canada: Making Prevention a Priority,* released in September 2010. In the document, ministers of health and health promotion/healthy living acknowledged the importance of the determinants of health and stated that "health promotion is everyone's business" and that many approaches should be used.[29]

This declaration is a positive direction for the country, raising expectations that governments will soon turn their intent into action.

More public engagement is needed on the determinants of health.

Many respondents spoke about the importance of educating the public about the determinants of health, which they believe would increase the degree of public and political support for government efforts. This public education involves finding ways

PUBLIC HEALTH NETWORK

The Pan-Canadian Public Health Network was established by Canada's federal, provincial, and territorial health ministers in 2005.

The Network has many roles, including facilitating the sharing of information among jurisdictions, providing policy and technical advice to deputy ministers of health on public health matters, and supporting jurisdictions in the public health challenges they may face during emergencies or crises.

The Network is led by a council with representatives from each province and territory, and from the federal government. The council reports, on behalf of the Network, to the deputy ministers of health, and then to the council of ministers.

Three key pieces of work by the Population Health Promotion Expert Group of the Pan-Canadian Public Health Network were used for this report:

- *Closing the Health Gap: Synthesis of the Significant Population Health Reports of 2008*
- *Indicators of Health Inequalities: A Report from the Population Health Promotion Expert Group and the Healthy Living Issue Group for the Pan-Canadian Public Health Network* (2009)
- Final report of the Senate Subcommittee on Population Health – *A Healthy, Productive Canada: A Determinant of Health Approach* (2009)

All three reports are available at www.phn-rsp.ca.

to convey important messages about the determinants of health, and the roles played by government, society, and individual people in achieving better health. It is also important to communicate with and report to the public about strategies. Every jurisdiction that has successfully undertaken work on the determinants of health has included communication with the public. But engagement means more: it provides opportunities for the public, including advocacy groups, to have meaningful impact.

Work at the community level is critical.
Much of the important intersectoral and whole-of-government work related to health promotion and the determinants of health occurs at the municipal and community levels. Most provinces and territories provide funding to help community efforts. Many informants expressed a deep commitment to the philosophy that community involvement and development are critical to improving people's health.

All jurisdictions said they had launched major consultations within their communities before developing policy. Most of those engaged in intersectoral work have established and helped to establish mechanisms for stakeholder involvement, such as advisory councils or other bodies. Some exist at the provincial/territorial level; many exist at the community or regional level. Officials said it was important to ensure that meetings with stakeholders were true to the principles of community development. In many jurisdictions, there is an ongoing requirement to consult with such groups on a regular basis and to report results.

You can't manage what you can't measure.
Many officials talked about the importance of good data for building a business case and setting targets,

LAYING THE FOUNDATION FOR GOOD HEALTH

It's something we know intuitively, but it's also supported by evidence: A child's living conditions and experiences – the determinants of health – shape his or her physical health, development, and well-being, affecting not only childhood but the foundation of their health as adults.[41, 42]

Parental income is an important marker for a cluster of life conditions that affect a child's development. How much money the family has affects their nutrition, clothing, housing, and educational and recreational opportunities. The socio-economic position of a child's parents also usually affects the quality of the community where the family lives, which is typically associated with a corresponding quality of day care and schools. Parents who are struggling day-to-day may also have difficulty providing supportive, nourishing and stimulating environments.[41]

The effects of these life conditions are cumulative. Research shows that the longer children live in deprived conditions, the more likely they are to have health and developmental problems such as not managing well in school, exhibiting emotional immaturity and poor social skills, and suffering poorer physical health and well-being.[41]

Two child health issues that are strongly related to parental income are used as important markers for the overall health of the population. The first is the infant mortality rate, which refers to deaths in the first year of life. The second, low birth weight, is also an important indicator of health because it is associated with a wide range of health problems across the lifespan.[43]

Recent research on children's health shows that the incidence of infant mortality and low birth weight is worse in Canada than in many other developed countries such as Sweden, Norway, and Denmark.[43] These countries are well known for their poverty-reduction policies and supportive programs such as family-friendly labour policies, employment policies for parents who need retraining and support, a social safety net, and early childhood care and education.[41] The research shows that supportive policies and programs that help to shape better living conditions can reduce the incidence of infant mortality and low birth weights.[44]

as well as evaluating and refining the program. The government of Newfoundland and Labrador is considered a leader in this area for its development of Community Accounts, a free online database that provides a single source of community, regional, and provincial statistics on issues such as health, income, education, employment, resources, and crime. Nova Scotia and Prince Edward Island have also implemented similar databases.[10] In 2009, the Senate called for a pan-Canadian system of Community Accounts.

GETTING BUY-IN: WHAT MAKES THE MOST DIFFERENCE?

How and why did governments move towards a whole-of-government or broad intersectoral approach to addressing the determinants of health? Some officials said that over time their ministers and deputy ministers came to understand that they could achieve more for the health of their populations with cross-ministry cooperation and collaboration. But some other clearer turning points led governments to realize that they could work differently and more effectively on these issues.

Presentations by thought leaders

When asked to describe their "aha!" moment of recognition about the need for inter-ministerial and intersectoral work in health promotion, some officials referred to a series of cabinet retreats and presentations by thought leaders. These led to a significant and almost seismic shift in thinking, and also to the creation of a number of intersectoral initiatives.

A powerful presentation: the knockout slide

Other officials mentioned a compelling presentation with a "knockout slide" at a meeting of the British Columbia cabinet that ultimately led to the premier's decision to launch ActNow BC.

> "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."
>
> *What Does it Take to Make a Healthy Province?* Institute for Clinical Evaluative Sciences, 2009

A compelling business case

In Newfoundland and Labrador, anti-poverty advocates had been speaking with the government about their issues for a long time. A new premier arrived on the scene and asked for a compelling business case, which ultimately led to the development of the province's acclaimed poverty-reduction strategy.

It's important to note that speakers, presentations, and compelling business cases are successful only when governments develop plans to put the ideas into action. In the words of one informant, "After the presenters leave the room, what are you going to do?"

Fiscal forecasts and budget concerns

For many, the current fiscal climate has dictated a re-thinking of province-wide spending strategies. One respondent said, "In 2003, we realized that if we did not think differently we would be bankrupt." For others, bending the cost curve in health has been the subject of many cabinet discussions – about issues such as the cost of the acute care system, ways to find solutions through primary health care, and re-thinking the role of health promotion.

A CHECKLIST FOR WHOLE-OF-GOVERNMENT OR INTERSECTORAL WORK

The checklist on this page synthesizes key pieces of information from Canadian and international reports and documents about implementing intersectoral and whole-of-government approaches; our consultants' experience working with Canadian governments, agencies, and organizations; and the information we gathered from our interviews with officials from across Canada.

Values and Commitment

- ☐ An overriding philosophy that health initiatives will be viewed through a population health lens.
- ☐ Leadership at the top from the prime minister, premiers, ministers, cabinet secretaries, and others.
- ☐ Recognition and awareness among elected representatives of the importance of the determinants of health for promoting population health and reducing health inequities.
- ☐ Recognition that it may take years, even decades, for benefits to materialize.
- ☐ Willingness to name the difficult problems and barriers that exist, and to provide the resources necessary to transcend them.
- ☐ Commitment of civil servants to undertake a broader approach to addressing population health and reducing health inequities.
- ☐ Willingness and commitment to ensure a structural approach to placing health projects on the public policy agenda.
- ☐ Allocation of significant funding that allows for governmental commissioning of research, analysis, and policy implementation.

Information and Data

- ☐ Decisions should be made and actions taken based on available evidence without necessarily waiting for conclusive evidence.
- ☐ Information and evidence on the state of population health and the presence of health inequities is presented in a government-instigated integrative report or statement.
- ☐ Development of clear, identifiable, and measurable goals and targets.
- ☐ Focusing on explicit concrete objectives and visible results. Ensuring transparency in governmental efforts and activities.
- ☐ Messaging to the public, including media support, about the importance of dealing with population health and reducing health inequities through action on the determinants of health.
- ☐ Development of practical models, tools, and mechanisms, such as health impact assessment, to support the implementation.
- ☐ Setting of realistic timelines.
- ☐ Support for academic and agency researchers who provide data and evaluation.
- ☐ Provision of ongoing public reports that document successes and challenges.

Governmental Infrastructure

- ☐ Governments must establish the means for society's participation in the initiatives.
- ☐ Establishment of an independent authority within government that will be responsible for coordinating activity across ministries and departments.
- ☐ Cross-ministry structures and processes that provide a basis for these kinds of whole-of-government or intersectoral approaches.
- ☐ Contacting and drawing support from various external organizations that would be responsive to governmental action on the determinants of health.
- ☐ Government civil servants' capacity to carry out the task.
- ☐ Ensuring that leadership, accountability, and rewards are shared among partners.
- ☐ Provision of adequate resources to sustain activities beyond the tenure of the present governing authority.
- ☐ Establishment of a balance between central direction and discretion of local authorities to implement goals and objectives.
- ☐ Establishment of accountability and evaluation frameworks.
- ☐ Building of stable teams of people who work well together, with appropriate support systems.

CONCLUDING COMMENTS

WHERE DO WE GO FROM HERE?

As we have pursued

our work we have become convinced that it is possible to close the health gap in a generation. It will take a huge effort but it can be done."

Closing the gap in a generation: Health equity through action on the social determinants of health,
World Health Organization, 2008

CONCLUDING COMMENTS

Some readers will skim this report with a skeptical eye, unconvinced of the need to create policies that address the roots of health and social inequities or to shift resources into prevention and the determinants of health. But the numbers tell us that Canada can no longer afford to delay taking these steps. Health care spending is expected to reach $192 billion in 2010. An estimated 20% of total health care spending may be attributable to income disparities. Increasingly, studies show the potential cost savings that could be realized by investing in prevention and in reducing health inequities, and that tackling the determinants of health is necessary to improve the overall health of the population.

Clearly, Canada needs a better balance between investing in the acute care system and investing in the determinants of health. Finding this balance is likely to mean a shift in the way governments allocate health care dollars. Health promotion efforts have largely been viewed as a side dish to the main meal of the existing health care system. We must be prepared to ask tougher questions about the health outcomes of our spending on the health care system and on existing health promotion strategies, and we must be prepared to reallocate dollars to the strategies that work, rather than continue with the status quo.

To date, Canadian governments have largely focused their health promotion efforts on strategies to encourage Canadians to adopt healthier lifestyles. But healthy living strategies can go only so far towards improving the health of all Canadians, and health inequities are on the rise. There is a growing sense, expressed by some of our informants, that the healthy living focus has reached a plateau.

What's needed now is a stronger focus on improving the health of Canadians and reducing health inequities through concerted action on the determinants of health. We are not suggesting that governments abandon their healthy living programs, but these initiatives could be more focused on reducing health inequities and integrated into a policy approach that will have an impact on the determinants of health. We support the conclusions of the Senate's 2009 report, *A Healthy, Productive Canada: A Determinant of Health Approach,* that the "reduction of inequities and improvements to population health can only be tackled through population health policy and a whole-of-government approach that targets health disparities in all policies." (For more of the Senate's recommendations, see page 30.)

The two recent major pieces of collaborative work – the declaration on prevention and promotion, and the framework for reducing childhood obesity – are a clear signal that ministers of health and ministers of health promotion/healthy living understand the importance of addressing the determinants of health, and the need for intersectoral collaboration.

In the framework for reducing childhood obesity, ministers have stated that a complex and interacting system of factors contributes to childhood overweight and obesity, and that addressing this issue calls for a sustained, multisectoral response. The Health Council commends the ministers for their leadership. As we heard from many of our informants, success ultimately depends on the quality and commitment of this type of leadership and a clear plan of action.

It is clearly time for seismic shifts in how government works, and in how politicians and government officials think about health. Multiple factors – from the environment to poverty – play a significant role in Canadians' health. We believe a healthy population should be the responsibility of the government as a whole, not just that of the ministries of health and health promotion/healthy living.

Our conversations with informants for this report indicate that this shift in thinking is underway across Canada, although there is no one ideal model and jurisdictions are at different stages in their understanding and advancing of whole-of-government or intersectoral approaches. Many noted that a whole-of-government method will not necessarily work for every jurisdiction or every issue. Using health impact assessment or a framework of Health in All Policies seems to be an effective way to encourage governments to move towards a broader understanding of the importance of the determinants of health, and to encourage a culture shift and a mindset that health is everybody's business. Rallying governments around a specific major issue such as child health, mental health or poverty reduction is another way to use a whole-of-government approach to address the determinants of health.

Where do we go from here?

The Health Council supports the Senate's conclusion that we already know enough about the determinants of health and that to continue making investments in this learning is taking the easy route.

What we need now is to take action with the knowledge and the experience that we do have, and to share this knowledge and experience. The Public Health Agency of Canada, the Pan-Canadian Public Health Network, the Centre for Health Promotion, and the National Collaborating Centres for Public Health, in concert with governments, could contribute significantly to this effort.

The September 2010 declaration by the ministers of health and health promotion/healthy living, *Creating a Healthier Canada: Making Prevention a Priority,* acknowledged what the Senate and others have been saying: "Canada's current health care system is mainly focused on diagnosis, treatment, and care… to create healthier populations and to sustain our publicly funded health system, a better balance between prevention and treatment must be achieved."

We conclude that with this declaration, governments are embarking on an agenda for a new, healthier Canada. We urge them to develop a plan to put their statements into action. Canada has a history of producing landmark documents on health promotion that are greeted with enthusiasm but don't stimulate as much action – or the kind of action – as expected. We recognize that all ministers of health and health promotion/healthy living are committed to an increased focus on prevention, but they cannot do it alone. We call on other government ministries to join them by lowering traditional ministry drawbridges and bureaucratic barriers, and moving to an integrated, collaborative way of governing that is focused on common issues and goals – particularly reducing health inequities and achieving a healthier Canadian population.

RECOMMENDATIONS FROM A HEALTHY, PRODUCTIVE CANADA: A DETERMINANT OF HEALTH APPROACH

In this 2009 report, the Senate stated that work in a number of key areas was required to move forward. Some of their recommendations are summarized below, as they were echoed by many of our informants:

1) a more integrated set of actions across Canada aimed at revitalizing the national health goals and matching these goals with indicators and targets for health disparities;

2) a reinvigorated approach to fund and encourage health impact assessment within all governments to assess their policies for their potential impact on health;

3) conducting research that identifies which public policy interventions work and how to do the research, followed by the dissemination of this information about what works best. More specifically, there need to be methods to advance the collection and sharing of best or promising practices around whole-of-government and intersectoral approaches;

4) providing a database infrastructure to ensure the collection, monitoring, analysis, and sharing of health equity and population health indicators, at national, regional, and local levels;

5) increasing the Canadian public's understanding of the determinants of health and the economic costs to society of not acting on these determinants; and

6) enabling and supporting communities to manage situations locally.

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