Ontario Prevention Clearinghouse
Centre ontarien d'information en prévention

The Case for Prevention

Moving Upstream
to Improve Health for all Ontarians

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The Ontario Prevention Clearinghouse (OPC) is Ontario's leading bilingual health promotion organization. It helps individuals, groups and communities use health promotion strategies to achieve health and well-being.

For more information:

Ontario Prevention Clearinghouse
180 Dundas Street West, Suite 1900
Toronto ON M5G 1Z8
Tel: 416-428-2249
Toll free: 1-800-263-2846
Fax: 416-408-2122
Email: info@opc.on.ca
Web site: www.opc.on.ca

Ce document est aussi disponible en français.

INTRODUCTION

Why the Ontario Prevention Clearinghouse wrote this report.

Public health is finally in the spotlight, in both Ontario and Canada. The drive to enhance public health measures stems from large-scale concerns about infectious diseases and environmental safety, eye-opening incidences like water contamination in Walkerton and the SARS virus in Toronto. Public health reforms to address such issues can generate great opportunities for society to broadly embrace prevention and health promotion. In Ontario, a number of initiatives – including the 2005 creation of a Ministry of Health Promotion – suggest a renewed interest on the part of Government to work collaboratively with civil society to truly focus on creating health for all Ontarians. Our governments are also showing increased willingness to risk innovative action. Over the past 30 years, Canadians have gained increasing knowledge about the positive and affordable impacts of preventive measures, as well as the social conditions that determine health. However, in spite of these positive steps, we have not yet adequately developed healthy public policies to address health, in addition to health care. The Ontario Prevention Clearinghouse Board of Directors and staff are hopeful that the reform underway in Ontario creates a new opportunity for action and real change. It is towards this opportunity that this report is written.

MOVING UP STREAM

The image of moving upstream in terms of health is best illustrated by imagining a village on a riverbank where increasing numbers of villagers are becoming sick. Day after day the medical clinic treats people. The clinic is overburdened, the ill don't get well, and everyday, more and more people become sick. This could go on for days or years as the local burden escalates. In this story, someone who goes upstream to the next village or the one beyond that, finds a factory discharging chemicals and sewage runoff into the river.

Now comes the interesting part. That traveler must mentally link the discharge upstream with the sickness downstream and must convince others of the association. This is not easy because people have different vantage points and competing interests. For instance, the upstream villagers aren't affected and the owner of the factory saves money by getting rid of spent chemicals this way. It's only the villagers downstream who are ill, and they're not even near the upstream village.

Health returns to the downstream village only when the two villages and the owner of the factory find interests in common, and when the public good takes precedent over individual interests. When the discharge is stopped, the river can return to cleanliness. When the river returns to cleanliness, people return to health. The medical clinic is no longer overburdened, and once again able to meet the demand for treatment.

Governments are increasingly acknowledging a role for prevention in creating and maintaining health. When the First Ministers met in September 2004, they articulated this view more clearly than ever before, when they stated: "all governments recognize that public health efforts on health promotion, disease and injury prevention are critical to achieving better health outcomes for Canadians and contributing to the long-term sustainability of medicare by reducing pressures on the health care system."

We commend the Ontario Government for adding a new focus on health to its high-profile commitments to illness treatment. In the years 2004 and 2005 alone, the Provincial Government:

- established a new Ministry of Health Promotion;
- adopted the Best Start plan and signed a childcare agreement with the Federal Government that will expand childcare spaces and healthy child development programs;
- adopted Operation Health Protection, including the creation of a provincial Public Health Agency, a review of public health capacity, and strengthening the powers of the Chief Medical Officer of Health;
- passed the groundbreaking Smoke Free Ontario Act;
- issued reports such as *Healthy Weights, Healthy Lives*;
- increased funding for homelessness programs and emergency shelters;
- closed the coal-fired Lakeview power generation plant;
- supported renewable energy projects;
- raised spending on immigrant settlement services; and
- proposed reforms to the Ontario land-use planning system.

These achievements are welcome, valuable and exciting. At the same time, we strongly urge the Government to see these actions as *first* steps to creating a policy and social environment that will truly generate widespread health.

Ontario's new Ministry of Health Promotion has an initial budget of $0.259 billion whereas the Ministry of Health and Long-Term Care has a budget of $33 billion[1]. Public Health's budget was just under 1% of Ontario health budget in 2004.[2] Canada is no better off – nationally we spend $142 billion on health care; less than 5% of this investment (or $7.8 billion) is spent on health promotion[3].

To achieve health for all[4] people, provincial and federal governments *must promote health and prevent illness and social problems*. Ontario deserves a better balance between investments for prevention and health promotion and investments for medical treatment, disease management and long-term care.

WHAT CONTRIBUTES TO HEALTH?

Health is much more than the absence of disease. Health results from physical, mental and social well-being. The World Health Organization defines health as a '*resource* for everyday life,' rather than a state of being. Health is a positive concept emphasizing social and personal resources and physical capacities. And it makes just as much sense to talk about the health of a population or community as it does to talk about the health of an individual.[5]

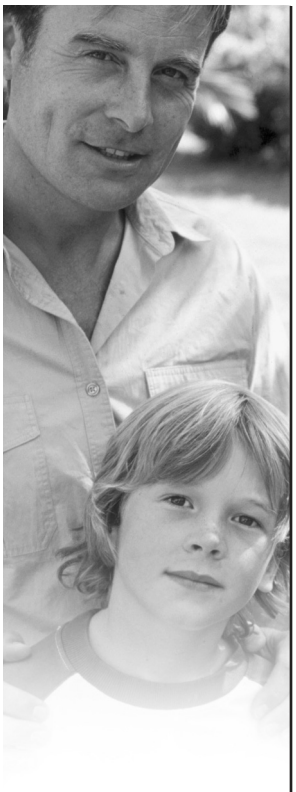
The greatest determinants of health are societal. Provision of quality health care, while very important, is only one factor of many that contribute to a population's health. The general public defines only a small number of key factors as generating good – and bad – health: availability of health care services; good genes (or good luck); and personal choices regarding behaviours such as eating and exercise. Few Canadians identify poverty, housing or environment as important causes of health status.[6] Yet current evidence suggests that while access to health services, genetics and personal behaviours are very important to health outcomes, they aren't as influential as societal and biological factors when considering overall health status and chronic disease conditions.

By observing the health of large groups of people, researchers have come to understand the remarkable sensitivity of health to the social and built environments. They have identified powerful determinants of health in modern societies. These determinants of health include: income and social status; social supports; education and literacy; employment and working conditions; social environments such as housing; physical environments (air, soil, water); healthy child development; gender; culture; biology and genetic endowment; personal health practices and coping skills; and health services.[7]

Personal choice is a misnomer. Although many Canadians define personal choice as a key influence in health status, personal behaviours are greatly influenced by our social and physical environment. It is misguided to identify behaviour as resulting from personal (read 'free') choice. A recent World Health Organization[8] report stresses the importance of recognizing that individual responsibility can have its full effect only where individuals have equitable access to healthy living conditions and lives. In *Healthy Weights, Healthy Lives*,[9] Ontario's Chief Medical Officer of Health describes what she calls 'obesogenic' environments, communities, workplaces, schools and homes that encourage obesity. Too many adults and children don't have adequate income to eat well; low value and high calorie foods are often cheaper and more easily accessible; increasingly communities lack sidewalks, park space, bike lanes and recreation programs; more adults work in sedentary jobs and young people lack opportunities to be active. Defining poor eating and inactivity as 'personal' behaviour masks the social nature of behaviour.

Some populations are healthier than others. Disparities[10] in health by region and among groups of people are dramatic. Here are some examples.

- Northern Ontarians experience 51% higher rates of heart disease than the Ontario average.[11]
- Franco-Ontarians are more likely to be daily smokers, are more likely to be overweight, and are less likely to rate their health as excellent or very good than other Ontarians.[12]
- Non-European newcomers, interestingly, smoke less than the Canadian-born, but within a few years of their arrival in Canada they are twice as likely as the Canadian-born to report deterioration in their health.[13]
- The gap between the health status of Aboriginal Canadians and non-Aboriginals is the most extreme: the average lifespan of Inuit women, for example, is over 14 years less than the average for Canadian women; Inuit infant mortality rates are triple the all-Canadian rate, and First Nations on-reserve people have double the rate of suicide death compared to the all Canadian rate.[14]



Health follows a gradient. Charting the health status of nearly any population shows the fundamental influence of income and education on health. On average, low-income people are less likely to be healthy than those who are wealthier. What's more interesting and surprising to many is that statistics show this pattern holds *within* groups. The very rich are healthier than the rich, even though the rich have every conceivable advantage to achieve health. Researchers call this pattern the social gradient, and Canadian researchers[15] have been at the forefront of helping us understand these influences. The most important learning from this research is that social inequities affect everyone's health, not just those who are obviously disadvantaged.

How a society defines health also defines how that society seeks to improve health. For example, the practice of medicine addresses health primarily as a biomedical state. Doing so means that most physicians emphasize the personal, for example, family histories, clinical tests, surgical and drug treatments, and adaptations that an individual can implement (e.g. changes in diet). Health educators in some jurisdictions also emphasize individuals; these educators tend to focus on personal behaviour. Accordingly, they provide personal counselling and education campaigns to improve diets, smoking behaviour and physical activity. However, over the past two decades, we've learned that health is affected by socio-environmental factors as well as personal. Addressing health from a socio-environmental perspective means adding to the above approaches, particularly systemic policies, community mobilization and mutual aid strategies to address living and working conditions as well as social networks.

In giving credence to social causes of population and individual health, we set the stage to recognize that solutions must be *upstream and systemic*. To really make a difference, Ontario must implement solutions at all levels of society addressing the broad population — to communities, groups, families and individuals simultaneously. Our tax dollars will have only minimal impact if government focuses policy interventions on healthy lifestyle choices without, at the same time, recognizing social and economic factors that are beyond personal control and that affect choice and access.

PREVENTION AND HEALTH PROMOTION MAKE SENSE

In 2004, the Ontario Prevention Clearinghouse resolved to re-focus our efforts and resources towards improving Ontario's health where evidence tells us that we will have the greatest impact. We made an overarching commitment to help put prevention and health promotion in the public eye, and committed to three priority goals, to:

1. Provide our children with the best start in life;

2. Prevent chronic diseases and detect those that occur early;

3. Create an inclusive society that fosters a sense of belonging.

We chose children as a first priority because of the compelling evidence that early investments have the greatest impact over a person's lifetime, yet proven interventions are not generally available and few children benefit. Our second priority focuses on chronic disease prevention because rates are rising rapidly and evidence is strong that we can modify the social conditions and personal behaviours that influence chronic disease. Our third priority goal focuses on 'inclusion' because the income and social inclusion gap between haves and have-nots is widening, and this lessens individuals' health and the health status of Canadians as a population. For each of our three priority goals, the opportunities to improve health are great. Evidence shows that action in these three areas can have a significant and speedy impact on the health status of Ontarians and will fuel momentum toward healthy communities in Ontario.[16] Now let's look at children, chronic disease and inclusion in more detail.

1. HEALTHY CHILDREN GROW UP TO BECOME HEALTHY ADULTS.

The evidence: Why early childhood development is important.

Early child development is the foundation for life-long learning, behaviour and health. Taking steps now to ensure that our children receive the best possible start in life is the most important thing we can do to build a healthy society. Early learning and care shapes the formation of human and social capital – now and in the future. It is vital to the prosperity of Ontario.[17]

Since the release of the ground-breaking *Early Years Study* in April 1999[18], with which Ontario led the world, awareness of the importance of early child development as a foundation for human development has continued to increase. The World Bank[19] is now among those emphasizing the role of early human development in building social capital and equality and thus contributing to prosperity and reducing poverty internationally.

In Ontario, we have begun to address this issue. Our provincial Best Start strategy is one of the most ambitious in the world and our policy makers are showing their willingness to change policies such as allowing schools to open their doors to community groups. Let's do even better. Now is the time to enhance our comprehensive community-based programs and build on some of the high quality services we already have in place. This will lead to improvements in early child development, and will also help break the cycle of social exclusion by connecting families in communities and will ultimately lead to significant long-term health, social *and* economic gain.

As individuals, our brains develop based on the interactions of our experiences and exposures during the prenatal phase and early years of our childhood with our genetic potential. Every day, new and convincing evidence is emerging from neurobiology, animal studies, epidemiological and longitudinal studies of populations, intervention studies and observational studies.[20]

In the short-term happy healthy children are better able to learn and grow. Their literacy levels improve and violent, anti-social behaviours are reduced. Families are happier and more productive. In the longer-term, children who get a best start are more likely to graduate from school and be literate, have decreased likelihood of adolescent delinquency, unemployment or being on social assistance, and have lower rates of suicide and depression. As adults they have lower future rates of heart disease, cancer and diabetes.

The economics: We can reduce costs by investing in early child development.

Investment in early child development means more than just providing better childcare. It also means improving services such as prenatal care, supports for new parents, parenting programs, drop-in centres and libraries as well as parks and recreation programs. It means pulling existing programs and services together to improve children's environments and ensure access to all.

Our investment in these programs will generate significant rates of return. Economists estimate a $2 to $3 return on every $1 invested in quality early learning and care programs.[21] The return is substantially higher for vulnerable children.[22] The return on investment in early childhood is greater than the return on investments made later in life.[23] Early investments in a young child's daily experiences set trajectories for success and compounded benefits. Children who are successful at school entry benefit more from the public investment in education and need fewer expensive remedial supports.

Pictures of Success

The following examples provide compelling evidence of the importance of early child development. These benefits extend to a child's family, their social networks and the communities they live in. They also demonstrate how social policy can have immediate affects on health and well-being.

Community-driven early childhood interventions. Better Beginnings, Better Futures[24] is a primary prevention program initiated in eight Ontario communities starting in 1991. It uses community-driven early childhood interventions to counter negative effects for at-risk children living in poverty. Findings show significant positive impacts from these interventions. Some examples: children and parents experienced greater feelings of social, emotional and neighbourhood support; parent ratings of their children's health improved in several or all communities, depending upon the age of children; children benefited from reduced smoking in the home and improved dietary intake; children had more timely immunizations; children showed decreased anxiety and depression and improved social skills; and/or children experienced better outcomes in school functioning; and parents perceived better access to doctors and social workers.

As well, research found a preliminary indication of cost-saving benefits to the government. The model is affordable, with average cost of $1,000/child/year (modest in comparison to U.S. prevention projects of $4,300 - $16,000/child/year).

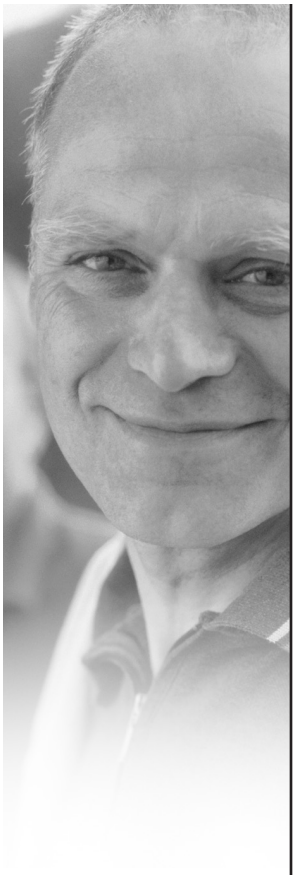
Comprehensive care. Researchers at McMaster University[25] worked with regional services to explore the hypothesis that providing comprehensive care for single mothers on welfare and their children, instead of leaving individuals to fend for themselves in a fragmented system, would produce short-term financial gains as well as long-term social benefits. The results were striking. It is equally effective — and less expensive — to address people's whole circumstance, rather than a specific issue, through proactive, comprehensive health and social services for mothers and quality child care and recreation services for children.

2. PREVENTING CHRONIC DISEASE NOW WILL REDUCE FUTURE SOCIAL AND ECONOMIC COSTS.

The Evidence: Why chronic disease prevention is important.

Chronic diseases are defined as illnesses that are long lasting and extremely difficult to cure; in fact, many cannot be cured at all. In Canada, the top five chronic diseases — cancer, cardiovascular disease, diabetes, kidney disease and respiratory diseases — account for more than 75% of deaths.[26] This percentage is rising.[27] Factors associated with chronic disease development include social, economic, environmental and personal factors, and the social conditions outweigh the better-recognized personal behaviours. These factors work in combination. For example, a family history of cancer or heart disease will not guarantee illness, however, working with harmful chemicals or living in poverty increase the odds of disease. Conversely, removing one or more factors reduces the likelihood of chronic disease.

Chronic disease prevention experts throughout the world agree that chronic diseases can be prevented and controlled. A small decrease in the average population level of several risk factors can lead to a large reduction of the burden of chronic diseases, and it can do so surprisingly rapidly. The World Health Organization recommends that strategies be



comprehensive and integrated -- that is, address common risk factors and conditions across diseases, respond to the needs of the entire population, and have impact at the individual, community and national levels. Population-wide, healthy policy approaches should form the central strategy, in combination with interventions aimed at individuals.

Chronic disease prevention is of growing concern to policy makers because as individuals age, their risk of chronic disease increases. And because the baby boom generation is aging, the incidence and implications of chronic disease will significantly increase in the near future unless we change our focus by investing more to prevent – rather than simply treat -- chronic disease. In addition to the personal, social and economic costs of chronic disease, the greater number of aging Canadians affected will put huge pressures on the treatment and care systems. Demographics suggest that we will pour scarce resources into expanding the availability of facilities and services that won't be needed after the baby boom generation's demand.

The Economics: We can reduce costs by investing in chronic disease control.

Good financial estimates now exist to help us measure the cost of chronic diseases in terms of impacts on the health care system. In Ontario, the economic burden of chronic disease is estimated at 55% of total direct and indirect health costs.[28] Nationally, chronic diseases cost $28 billion each year.[29] At least two thirds of Ontarians over 45 years of age have a chronic condition and, of these, approximately 55% suffer from two or more chronic conditions. The Ontario Ministry of Health and Long Term Care estimates that more effective management of chronic diseases could avoid approximately 29,000 emergency room visits and 67,300 hospitalizations annually.[30] Nationally, in 2005 alone, an estimated $500 million lost income resulted from premature chronic disease-related deaths.[31]

Using tobacco as an example of understanding return on investment, it's been estimated that $1.3 billion healthcare savings can be expected to result from a comprehensive tobacco-cessation program would be more than three times the cost of the program[32] — more than $3 return for every $1 spent.

Pictures of Success

There is strong and compelling evidence that communities can make major gains when they become involved in reducing personal health risk behaviours associated with many chronic diseases.[33] Unfortunately, fewer studies have measured the impact of social interventions to address income, education or social networks in generating improvements in chronic disease rates or outcomes.

Tobacco control in Ontario and elsewhere. The example of tobacco use control shows the greatest impact of how the use of healthy public policies can reduce disease. The new Smoke-Free Ontario Act, that came into effect in 2005, regulates where people smoke and who can legally purchase tobacco products. It also influences promotion by controlling branding by tobacco manufacturers and adding social marketing into the mix. Since the renewal of the Ontario Tobacco Strategy in 1999, smoking rates have dropped dramatically in some populations. For example, between 1999 and 2004, the smoking rate for older teens dropped from 19% to 9%.[34] In homes with small children, the smoking rate dropped 57%, from 23% to 10%.

Curbing heart disease in Finland. The most famous example of successful chronic disease prevention occurred in Finland in the 1970s when the country had the world's highest death rate from cardiovascular disease. The likely culprits were widespread and heavy tobacco use, high fat diet and low vegetable intake. Large-scale community-based interventions and healthy public policies were then introduced, which included banning tobacco advertising, promoting and making readily available low-fat dairy and vegetable oil products, changing farmer payment schemes, and financial incentives for communities. Death rates from heart disease in men have been reduced by at least 65%. Life expectancy has increased approximately seven years for men and six years for women.[35]

3. CREATING SOCIETIES THAT FOSTER BELONGING WILL IMPROVE HEALTH.

The Evidence: Why an inclusive society is important to improving our health.

The concept of social and economic 'inclusion' is fairly new. Inclusion builds on research and debate about social exclusion, the need for improved access to services and, more recently, understanding the personal and societal impact resulting from health disparities. The consequences of health disparities are avoidable 'death, disease, disability, distress and discomfort,'[36] and also the costs to Canadian society in lost social productivity and dollars spent. Steps toward solving these problems include reducing exclusion and, we argue, becoming more inclusive.

In its simplest form, inclusion is about belonging to a family, a community, and a society. Belonging makes us feel good; it also makes us healthy. A recent Statistic Canada study found that significant associations between community belonging and self-perceived general health emerged in most provinces. The study found that Canadians who have a strong sense of belonging to the community in which they live have more positive feelings about their physical and mental health. These findings are important because evidence also exists to suggest that self-perceived health is predictive of chronic disease incidence, use of medical services, recovery from illness, functional decline and mortality.[37]

Because low socio-economic status (SES)[38] is significantly linked with poorer health, both personally and in terms of social disparities, we can use SES to demonstrate marginalization or exclusion and its link to poor health. Although evidence indicates that the overall effect of low SES is negative, we don't fully understand how this happens. Surely, poorer health results because being poor is frequently associated with: living in inadequate housing; food insecurity; precarious employment, low wages, little control over one's own work, stressful working conditions and exposure to high noise, contaminants or physical danger; and less access to recreation, culture and educational opportunities. Being poor also appears to be associated with less tangible challenges, including low self-esteem, inadequate life skills, fewer social networks and less opportunity to engage in community activities. Experiencing low SES is recognized as both a cause and an outcome of poor health for individuals.

Equally important, there is increasing evidence that societies with a wide income spread between the rich and the poor seem to be less healthy than societies with a narrow income range.[39] In contrast, countries that more evenly distribute resources have a healthier population. When societies are more equal, larger portions of the population have positive self-esteem, its members are more empowered, and overall population health status is higher.[40] For example, comparisons of advanced industrial nations, with significant marginalized

populations, show that people living in countries such as the United States have an average lower life expectancy than those in more egalitarian countries such as Sweden and Norway.[41]

The economics: We can reduce costs by promoting an inclusive society.

As long as members of our society are marginalized, our economy is pulled down. We all pay socially in terms of missed opportunities, and we pay economically through higher health and treatment costs and less contribution to the economy. Although both life expectancy and average income have increased in Canada in the last 25 years, health status differences between income groups persist. At low levels of income, Canadians are most vulnerable to poor health.[42]

Analysis suggests that over 20% of health care spending — billions each year — may be attributable to income disparities. These estimates look at use of health care spending by income level and calculate savings if those with lowest income had health status and health care utilization similar to people with middle income.[43] To achieve savings will require a range of policies: policies to improve income and other social determinants of health; policies to create more inclusive societies; and policies that target health promotion and primary care services with preventive components.

Pictures of Success

Community school drop-out prevention program. Pathways to Education[44] in downtown Toronto is an ambitious program to keep teenagers in school. Pathways was initiated by the local community health centre. Its long-term goals are to reduce poverty and its effects. The program offers tutoring in the local community; transit tickets and bursaries for post-secondary education; group and personal mentoring; support workers for students and parents. Since September 2001, Pathways has reduced school absenteeism by over 50%; reduced the percentage of academically at-risk students from 40% to 14%; helped participating students achieve more credits than their peers at all high schools attended, including improved rates of successful completion in English, Science, and Math. Pathways estimates that the first 45 young people to graduate from Pathways will, over the course of their working lifetimes, contribute $10 million tax dollars. Half of this amount will be paid in provincial and federal taxes and half will be realized as savings to public expenditures like corrections, health care and social assistance.

Aboriginal self-governance. Two researchers at the University of British Columbia[45] assessed the intersection of personal identity and cultural continuity in relation to records of suicide in British Columbia's aboriginal communities. A cursory look at provincial data suggests that First Nations groups suffer dramatically. Yet, more in-depth analysis indicates that there were no known suicides among youth 15 — 24 years of age in over half of the 196 communities studied during a targeted 5-year period, while some communities suffered rates of youth suicide some 500 to 800 times the national average. The communities with low rates of youth suicide demonstrate the following to be their protective attributes: self-government; being engaged in land claims; having the majority of youth participating in a band school; exercising some control over health, police and fire services; and having local cultural facilities.

BARRIERS TO SOCIAL POLICY RESPONSES

Public awareness and demand.

The public demands more hospital beds, shorter wait times and doctors closer to home. Unfortunately, the public and media do not also demand improved social conditions and a more inclusive society as ways to improve health. Bodies such as the World Health Organization[1] and the Health Council of Canada[47] have called for increased efforts to increase understanding among the general public and health professionals about the importance of non-health care factors in determining individual and community health.

Inadequate policy influence by non-aligned and non-profit organizations.

Thankfully, government policy is open to significant influence by constituents. However, today corporations, major institutions and professional associations wield immense influence on governments.[48] On the other hand, the voluntary sector that includes charitable organizations and front-line services have limited influence in spite of the fact that they might be expected to advocate for the majority of Canadians. The voluntary sector's ability to contribute to policy development is hindered by restrictions on advocacy activities,[49] and inadequate financial or human resources and skills.[50] Add to this the informal restrictions that arise because many voluntary sector organizations receive some government funding, creating the situation whereby most health, social service and education professionals are funded or directly employed by the very governments whose policies they might choose to target. As a result, society loses out on the expertise held by the voluntary sector that could inform the creation of smarter policy.

This weakness is compounded because each government's over-riding goal is to be re-elected. As a result, each government — no matter its approach or commitment to health — tackles issues with a very short horizon in view. They are most interested in what can be accomplished in 3 - 5 years. Preventing illness and social problems, however, takes one, two and even three generations. It is a challenge for any political party to demonstrate successes that won't be evident for another 20 years. However, without this long-view, our health suffers — both today and in the future.

Silo mentality and fractured infrastructure.

Health and social services are structured into separate and often competing jurisdictions and fields of practice. This occurs by necessity: to support effective practice and policy development, we must institutionalize some degree of specialty. However, most effective solutions are inter-sectoral and multi-faceted.[51] Improving health depends largely on policy that is outside the health portfolio! Just a few examples of the social conditions that contribute immensely to health include: ensuring adequate housing, reasonable incomes, clean environments, socially oriented built environments, quality childcare, effective education, accessible recreation and opportunities for community engagement. The paradox and challenge of addressing these issues is that none fall within the authority of Ontario's two health ministers, nor are they core mandates of health charities or the regulated responsibility of Ontario public health units.

Inadequate application of knowledge.

Although vast private and public dollars are spent on bio-medical research, very little is spent to understand population health. One outcome of this is that all too often the data measuring population health and the influence of social conditions on health is inconsistent, stale, of poor quality or not available at all. As a result, our knowledge about non-medical determinants of health and non-medical interventions is inadequate. This problem is confounded because we too often rely on inappropriate measurements, such as the gross national product, to make judgements about health. We need a nation-wide commitment to put into place new indicators, such as the Canadian Index of Well-Being, and the kind of indicators that will support monitoring of the new Canadian Public Health Goals.

Of equal or even greater concern is that available knowledge is under-used. This happens because of a complex of challenges. Health, social service and education employees and volunteers have little time to read, digest or reflect on available information. Program managers and front-line service staff need support to help them interpret and apply good research findings, yet there is inadequate investment in screening and translating evidence so it can influence knowledge, policies and services in various setting.

TAKING ACTION. RECOMMENDATIONS TO IMPROVE ONTARIO'S HEALTH.

To generate health for all, society must decide that it wants healthy communities and a just society. Canada is recognized internationally as a leader in health promotion and a founder of the healthy communities movement. Canada is looked to internationally because of our strong track record at commit-ting to fundamental change that will bring Canadians towards health. Our signatory to the United Nations Millennium Goals, our 1989 resolution to abolish child poverty, and various formal commitments to Canada's aboriginal peoples are good examples of such commitment.

However, as a society we aren't keeping pace with our reputation. We don't yet do well enough at taking action to fulfill these written commitments. Canadians remain ambivalent about using broad social levers to change the unhealthy living conditions of many Canadians. This must change. We encourage all readers of this paper to collaborate — with friends and neighbours, with service organizations and private companies and especially with Ontario's current Provincial Government, a government that is demonstrating its commitment to health for all.

Achievements are needed in four mutually reinforcing areas.[52] The following recommendations are addressed to our Government colleagues. To fulfill these recommendations will require action and contributions by all sectors — public, private and non-profit.

LEADERSHIP:

1. That the Ontario Government, during this term of office, consult with key partners to design a robust *prevention system* to complement and balance our existing treatment, management and care systems.

a. Key partners should include representation from disciplines beyond those traditionally defined as health, including a mix of practitioners, researchers and the lay public. Organizations and networks such as the Ontario Chronic Disease Prevention Alliance[53] and members of the Ontario Health Promotion Resource System[54] have key contributions to make.

b. The envisioned prevention system should focus on improving population health by improving social conditions as well as influencing personal behaviour; and that this system be comprehensive and integrated, reaching across-issues, sectors and populations.

2. That the Ontario Government actively contribute to development of the Public Health Agency of Canada's National Collaborating Centre on Determinants of Health as well as Canada's participation in the World Health Organization's Commission on the Social Determinants of Health.

LEARNING:

3. That the Chief Medical Officer of Health utilize her annual report to the legislature to report on steps taken to develop a comprehensive and integrated prevention system.

4. That the soon-to-be-established Public Health Agency of Ontario provide leadership in increasing evaluation of prevention interventions perceived to be successful and make an early strong commitment to evaluation and knowledge exchange about interventions to improve family health, chronic disease, community health and social conditions influencing health, in addition to infectious disease control.

5. That the Ontario Government utilize its existing commitment to develop provincial health objectives and targets consistent with Canada's recently approved public health goals to support province-wide learning about prevention and health promotion. Further, that Ontario's targets and indicators include reduction of health disparities and that this work be integrated into the terms of reference of the new Inter-Ministerial Committee on Healthy Living[55] so that targets and indicators can extend beyond traditional measures of health status.

6. That the Ontario Ministry of Health Promotion commission members of the Ontario Health Promotion Resource System to provide education and consultation regarding effective prevention and health promotion for senior political and civil servants participating on and supporting the Inter-Ministerial Committee on Healthy Living and the Boards and staff of Local Health Integration Networks.

ACTION:

7. That the Ontario Government significantly enhance funding to prevention and population health, beginning by doubling the budget of the Ministry of Health Promotion by the close of this term of government[56] and continuing rapid investment in public health units.

8. That the Ontario Ministry of Health Promotion ensure the development of social marketing to help Ontarians understand the importance of social determinants of health in determining population and individual health. As well, that the Ontario Government encourage the Federal Government to create similar marketing in keeping with the advice of the Health Council of Canada.[57]

9. That the Ontario Ministry of Health Promotion and Ministry of Health and Long-Term Care provide sustained and stable financial support to the Ontario Chronic Disease Prevention Alliance to support development and implementation of a comprehensive and integrated chronic disease prevention strategy in Ontario. This strategy should address the two goals of the Pan-Canadian Healthy Living Strategy.[58] It should fulfill Ontario's

soon-to-be-released Chronic Disease Prevention and Management Framework, building on gains in tobacco control and supporting the soon-to-be announced nutrition and physical activity strategy.

10. That the Ontario Ministry of Health Promotion support sustainable expansion of the existing Prevent Stroke[59] website and data repository to broader health promotion and additional chronic diseases, and that the Prevent Stroke resource be well integrated with web-based and other new information management mechanisms to support primary care reform.

ADVOCACY:

11. That the Ontario Government support the Ontario Public Health Association, the Association of Local Public Health Agencies and other key organizations to contribute leadership to the development of a Public Health Mandatory Health Program and Service Guideline and/or Standard to direct public health units to address health disparities and societal determinants of health.[60]

[1] From 2005 Ontario Economic Outlook and Fiscal Review, Second Quarter 2005-2006 released November 1, 2005. Retrieved January 13, 2006 from http://www.fin.gov.on.ca/english/economy/ecoutlook/statement05/05fs-papere.html
[2] From the Ontario 2004 budget. Retrieved October, 2005 from http://www.gov.on.ca/FIN/english/budeng.htm, can calculated by OPC. Public health $273 million of $29.6 billion for Ministry of Health and Long-Term Care (excluding the health premium) = 0.92%.
[3] Health care spending to reach $142 billion this year. Retrieved December 4, 2005 from http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_07dec2005_e
[4] *Achieving Health for All* was the title and rallying call of a key Canadian document *(Achieving Health for All: A Framework for Health Promotion, http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-frame-plan-promotion/index_e.html Retrieved January 17, 2006)* and a central component of the World Health Organization's *Ottawa Charter for Health Promotion* http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf Retrieved January 17 2006. These two documents were seminal in expanding understanding and emphasis from health factors controlled by individuals to societal factors and conditions.
[5] *Ottawa Charter for Health Promotion*, First International Conference on Health Promotion Ottawa, World Health Organization, 1986, retrieved from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf. See also the population health pages of the Public Health Agency of Canada at http://www.phac-aspc.gc.ca/ph-sp/phdd/approach/index.html.
[6] .*Select Highlights on Public Views of the Determinants of Health*, Canadian Institute for Health Information, 2005.
[7] Public Health Agency of Canada, http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#determinants, retrieved January 13, 2006. Lists of determinants of health vary somewhat. For instance, the World Health Organization recognizes peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Dennis Raphael, a Toronto-based health policy researcher, focuses on poverty and to a lesser extent other socio-economic factors, but doesn't include gender, culture, biology and others in his list. We have chosen to use the Public Health Agency of Canada's terms to encourage consistency of approach within Canada.
[8] *Preventing Chronic Diseases: A Vital Investment*, World Health Organization (2005), retrieved from http://www.who.int/chp/chronic_disease_report/en/
[9] *Healthy Weights, Healthy Lives*, Chief Medical Officer of Health Report 2004, Ontario Government, retrieved on Dec. 9, 2005 from http://www.health.gov.on.ca/english/public/pub/ministry_reports/cmoh04_report/healthy_weights_112404.pdf
[10] The words 'disparities,' 'inequalities' and 'inequities' are all used when describing differences in health, living conditions and social economic status among populations. Although there are some distinctions, we have primarily used 'disparities' in this report because it is the language currently adopted in Federal/Provincial/Territorial discussions.
[11] *Report on the Health Status of the Residents of Ontario*, Public Health Research, Education and Development Program, 2000.
[12] Ibid.
[13] *Dynamics of Immigrants' Health in Canada: Evidence from the National Population Health Survey*. Statistics Canada, 2005. Retrieved January 13, 2006 from http://www.statcan.ca/english/research/82-618-MIE/82-618-MIE2005002.htm
[14] *Improving the Health of Canadians*, Canadian Institute for Health Information, 2004
[15] Evans RG, Barer ML, Marmor TR, editors. (1994) *Why Are Some People Healthy and Others Not?: The Determinants of Health of Populations*. New York: Aldine de Gruyter; 1994; J. Douglas Willms (2003), Ten Hypotheses about Socioeconomic Gradients and Community Differences in Children's Developmental Outcomes, Human Resources Development Canada, ISBN: 0-662-33448-5; Cat. No.: RH63-1/560-01-03E. Retrieved from <http://www.hrsdc.gc.ca/en/cs/sp/sdc/pkrf/publications/research/2003-001272/2003-001272.pdf>; various papers from the Canadian Institute for Advanced Research.
[16] By choosing these three areas of focus, we are not suggesting that other health issues are unimportant! Numerous organizations and government ministries are engaged in socially important work on issues that also contribute to health.
[17] Cooke, Keating & McColm *Early Learning and Care in the City*
[18] McCain, M. and J. Fraser Mustard. 1999. *Early Years Study*, Toronto: Publications Ontario.
[19] Young, M.E. 2002. From Early Child Development to Human Development, Washington: World Bank
[20] McCain, M.N. & Mustard, J.F. (2002) *The Early Years Study: Three Years Later*.
[21] Cleveland, G. & Krashinsky, M. (2003). See also Iglesias, E.V. and D.E. Shalala. 2002, *Narrowing the Gap for Poor Children*. In: M.E. Young (ed). From *Early Child Development to Human Development*. Washington: World Bank. p. 373.
[22] Carneiro, P., & Heckman, J. (2003). *Human Capital Policy*. Cambridge, Mass: National Bureau of Economic Research.
[23] Ibid.
[24] http://bbbf.queensu.ca/index_e.html
[25] Brown, G. et al, (2000), When The Bough Breaks: Provider-Initiated Comprehensive Care Is More Effective And Less Expensive For Sole-Support Parents On Social Assistance/Four-Year Follow-Up, retrieved Jan 19, 2006 from http://www.fhs.mcmaster.ca/slru/paper/GWA4yrf.pdf
[26] Statistics Canada, Selected Leading Causes of Death by Sex, 1997. Retrieved August 17, 2005 from: http://www40.statcan.ca/l01/cst01/health36.htm
[27] World Health Organization, *Facing the Facts: The Impact of Chronic Disease in Canada* , 2005. Retrieved January 25, 2005 from http://www.who.int/entity/chp/chronic_disease_report/media/canada.pdf
[28] Direct costs include hospital, diagnostic, physician/other health professionals and drug costs. Indirect costs are related to lost productivity due to short and long-term disability and premature death.
[29] Ontario Chronic Disease Prevention Alliance, based on estimates made by the Centre for Behavioural Research and Program Evaluation, University of Waterloo, 2004.
[30] Ministry of Health and Long-Term Care, slide presentation to the Health Promotion Committee of the Ontario Stroke Strategy, September, 2005
[31] World Health Organization, *Facing the Facts: The Impact of Chronic Disease in Canada* , 2005. Retrieved January 25, 2005 from http://www.who.int/entity/chp/chronic_disease_report/media/canada.pdf
[32] *The Fiscal Impact of Tobacco Control in Ontario*, Ontario Tobacco Research Unit, Special Report Series, December 2003. http://www.otru.org/pdf/special/special_fiscal_impact.pdf
[33] Hancock, L., Sanson-Risher, R.W., Redman, S., et al. (1997). Community action for health promotion: a review of methods and outcomes 1990 – 1995. *American Journal of Preventive Medicine*, 13, 229 – 30. Reference taken from Taylor (2002)., *Building the Case*

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[34] Ontario Tobacco Research Unit. (2005, February). Ontario Tobacco Strategy Progress and Implications, 2003-04. [Special Reports: Monitoring and Evaluation Series, 2003-2004 (Vol. 10, No. 4)]. Toronto, ON: Ontario Tobacco Research Unit. http://www.otru.org/pdf/10mr/10mr_no4_final.pdf

[35] Vartiainen E, Jousilahti P, Alfthan G, Sundvall J, Pietinen P, Puska P. Cardiovascular risk factor changes in Finland, 1972– 1997. *International Journal of Epidemiology*, 2000, 29:49–56.

[36] *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper*, Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005 (ISBN 0-662-69313-2)

[37] Statistics Canada, *Community Belonging and Self-perceived Health: Early Canadian Community Health Survey Findings (January to June 2005)*, article released on 21 December 2005.

[38] We use the term socio-economic status to include income, education and employment.

[39] Dunn, James R. (2002). *Are Widening Income Inequalities Making Canada Less Healthy?* Toronto: Health Determinants Partnership. 85p. http://www.opc.on.ca/english/our_programs/hlth_promo/project_ini/hlth_determ/HDP-proj-full.pdf; *Improving the Health of Canadians*, Canadian Institute for Health Information, 2004. *http://secure.cihi.ca/cihiweb/products/IHC2004rev_e.pdf*; Public Health Agency of Canada, *Are Socially Unequal Communities Less Healthy? Report on the Canadian Population Health Initiative Research Program* Accessed August 19, 2005 from http://www.phac-aspc.gc.ca/ph-sp/phdd/news/feature.html

[40] National Forum on Health (1997), Determinants of Health Working Group Synthesis Report. Retrieved on Dec. 11, 2005 from http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/1997-nfoh-fnss-v2/legacy_heritage4_e.html#list

[41] Wilkinson, Richard, (1996), *Unhealthy Societies: The Afflictions of Inequality, Rutlidge*.

[42] CIHI (2004)

[43] *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper*, Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2005 (ISBN 0-662-69313-2)

[44] See http://pathwaystoeducation.ca/

[45] Chandler, JJ & Lalonde C, (1998), *Cultural continuity as a hedge against suicide in Canada's First Nations*, Transcultural Psychiatry 1998: 35(2): 191-219, retrieved on Jan 21, 2006 from http://web.uvic.ca/~lalonde/manuscripts/1998TransCultural.pdf

[46] Commission on Social Determinants of Health: Imperatives and opportunities for change, February 2005, defines its mandate as including widening societal debate. See www.who.int/social_determinants/strategy/stratdoc18Feb05/en/print.html

[47] *Health Care Renewal in Canada: Accelerating Change*, Health Council of Canada, January 2005

[48] To describe these processes adequately would be another paper. Suffice to consider a couple of examples: Large pharmaceutical firms have invested significant funds to lobby for relaxed direct-to-consumer prescription drug advertising regulations, whereas only a handful of consumer groups address this issue with limited funds. The Ontario Tenant Protection Act changes made in 1997 were, in part, the result of significant lobbying by large landlord associations.

[49] Charities may only spend 10% of their work on advocacy. See *A Code of Good Practice on Policy Dialogue*, developed by the Joint Accord Table of the Voluntary Sector Initiative, October 2002. http://www.vsi-isbc.ca/eng/policy/policy_code.cfm

[50] *The Capacity to Serve: A Qualitative Study of the Challenges Facing Canada's Nonprofit and Voluntary Organizations*, from the Capacity Joint Table of the Voluntary Sector Initiative (p.44): http://www.vsi-isbc.ca/eng/knowledge/pdf/capacity_to_serve.pdf

[51] Many government-sponsored reports and widespread research point the way towards the effectiveness of inter-sectoral solutions. The Symposium on the Effectiveness of Health Promotion (sponsored by the Centre for Health Promotion, University of Toronto, June, 1996) concluded that research demonstrates positive and more substantial outcomes when multiple health promotion strategies are employed.

[52] Thanks to the World Health Organization, Commission on Social Determinants of Health, for the model of structuring recommendations into these four areas.

[53] The Ontario Chronic Disease Prevention Alliance was formalized in 2004; its partners represent Ontario's major voluntary sector organizations addressing chronic disease.

[54] The Ontario Health Promotion Resource System is a network of 23 programs funded by the Ontario Government to build health promotion capacity in Ontario communities through provision of training, consultation, network development, resources, information, research, policy advice and referrals.

[55] The recently announced Inter-Ministerial Committee (IMC) on Healthy Living, chaired by the Minister of Health Promotion, is made up of ministers in Agriculture, Food and Rural Affairs; Children and Youth Services; Community and Social Services; Education; Environment; Health and Long-Term Care; Labour; and Municipal Affairs and Housing. Creation of this Committee is positive breakthrough and provides a long-overdue mechanism to coordinate policies affecting population and individual health.

[56] Prevention and health promotion are so under-funded today that long-term targets to increase funding must be substantive. Increases in prevention should be achieved through targeted financial enhancements in numerous ministries, not just the Ministry of Health Promotion and the Ministry of Health and Long-Term Care. Further, enhancements should include substantial transfer payments and grants so that community organizations can contribute appropriately to prevention strategies.

[57] Health Council of Canada, *Health Care Renewal in Canada: Accelerating Change*, Jan. 2005 retrieved on Nov. 21, 2005 from http://hcc-ccs.com/report/Annual_Report/Accelerating_Change_HCC_2005.pdf

[58] *Integrated Pan-Canadian Healthy Living Strategy*, Public Health Agency of Canada, 2005. Retrieved January 27, 2006 from http://www.phac-aspc.gc.ca/hl-vs-strat/index.html. The goals of the Strategy are to improve overall health outcomes and to reduce health disparities.

[59] Prevent Stroke is a program of the Ontario Prevention Clearinghouse. It is a key mechanism for integrating health promotion within the Ontario Stroke Strategy and supporting clinically-based practitioners with learning and resources to practice health promotion as part of providing stroke services. It has significant potential to perform a similar function in relation to other chronic diseases. See www.preventstroke.ca.

[60] This recommendation supports motions passed at the annual general meetings of the Ontario Public Health Association and the Association of Local Public Health Agencies in November, 2005.