Health promotion in Canada: 25 years of unfulfilled promise

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Commemorations of the Ottawa Charter have become a bit of a growth industry in Canada. Health Canada organized a Tenth Anniversary Symposium (Potter, 1997) followed by a case study reviewing progress prepared for the Fourth International Conference on Health Promotion in Jakarta in 1997 (Health Canada, 1997), there was a 21st birthday event and series of publications both in Quebec (O’Neill et al., 2007a) and at the IUHPE Conference in Vancouver (Jackson and Riley, 2007; IUHPE, 2007) and most recently a well-attended session to mark the 25th anniversary at the 2011 CPHA Conference (Tomm-Bonde and Kirk, 2011). In addition, there have been two editions of Health Promotion in Canada (Pederson et al., 1994; O’Neill et al., 2007b) and a third edition is due out in Fall 2011. Together, these three books give a comprehensive and evolving view of health promotion in Canada and document the many good things that have happened.

It is not my intention to try to summarize all that has been said elsewhere, but rather to cast a personal and critical eye over what I see to be the general failure of our federal and provincial governments to fully adopt and implement health promotion, and thus to realize the population health benefits that could and should have been achieved.

THE UNFULFILLED PROMISE

The First International Conference on Health Promotion was held in Ottawa mainly because of Canada’s reputation as a leader in health promotion. That reputation rested on the 1974 Lalonde Report, and on the subsequent work of the federal Health Promotion Directorate, which was created in 1978 under the leadership of Ron Draper (Health Canada, 1997). However, after a brief period of exciting initiatives in the late 1980s, following the adoption of the Ottawa Charter and the Epp Report (Health and Welfare Canada, 1986), health promotion in Canada—at least at the federal and provincial levels—became derailed, due in my view to a combination of the advent of population health and significant budget cuts in the early 1990s.

The concept of population health (Evans and Stoddard, 1990; Evans et al., 1994) was a very convenient development for the government of the day because it was congruent with ‘the increasingly dominant neo-liberalism of advanced capitalist countries’ (Labonté, 1997) and because, while it was eloquent in its identification of the social determinants of health, it was relatively silent about what to do about them. For a government looking for budget cuts and wanting to avoid action on the determinants of health—which would have meant challenging the underlying assumptions about the way society is organized—this was a much more palatable approach than health promotion, which questioned the givens and advocated social, political and economic change.

So, in this period (1993–2003), ‘health promotion went largely unnoticed. It was not positioned as a serious strategy within the health system’ (Jackson and Riley, 2007). In 1995, the Health Promotion Directorate itself was
disbanded and this was followed by the creation by Health Canada of a population health promotion model (Hamilton and Bhatti, 1996). While undoubtedly a useful synthesis of the two concepts, in practice the emphasis has been very much on population health and health promotion has never regained the influence or importance it held in its heyday. Thus it has largely failed to realize its promise and Canada can no longer be considered to be a leader in health promotion, at least in terms of implementation at a governmental level and as public policy, which is ultimately what counts.

In stating this, I am not denigrating the many health promotion practitioners who do such good work on a daily basis in developing and implementing health promotion programmes and services, or the many academics engaged in teaching and researching health promotion, nor their public service colleagues at the provincial and federal levels who are champions for population health promotion and continue to push forward innovative ideas and actions, sometimes in the face of political ideologies and leadership that are inimical to improving population health. But too often what we see are pilot projects (former federal Minister of Health and WHO Commissioner Monique Begin has called Canada the land of pilot projects) that do not then become fully taken up and developed even when successful, partial and spotty implementation of what should be comprehensive strategies, and a reluctance to identify and address the root causes of ill health and health inequity.

In my view, this failure can be laid squarely at the feet of the political and the healthcare system leadership at the federal, provincial and regional (health authority) levels in Canada, who have failed to recognize the potential of health promotion to improve the health of the population. They have remained fixated on the healthcare system, misunderstood health promotion as (still) being mainly a matter of exhorting people to behave properly, failed to invest adequately in prevention and health promotion, failed to adopt a ‘whole of government’ approach and thus failed in their duty to the public to improve health and reduce inequalities in health.

In fact, the very concept of inequalities in health and health inequity has been largely ignored, it is the topic that dare not even speak its name; the preferred term in leadership circles is disparity, which is seen as being more neutral, less controversial, less politically troublesome. If we cannot even speak clearly about this fundamental issue, how can we ever begin to address it?

Ecosystem health and resource sustainability— noted as prerequisites for health in the Ottawa Charter—is another huge health issue that has been largely ignored, particularly by the federal government, but also by many provincial and even municipal governments (although municipal governments have generally been much more aware of and responsive to this issue). But as I note in an accompanying commentary declining ecosystem health is by far the most significant threat to the health of the Earth’s population now and in the future.

What this means is that governments at all levels, as well as the international community, have to place ecosystem and human health at the very centre of their decision-making. We need to focus not on economic development but on human development; as the CPHA’s Task Force on Ecosystem and Human Health noted in its 1992 report:

Human development and the achievement of human potential requires a form of economic activity that is environmentally and socially sustainable in this and future generations.

The failure of governments in Canada to put environmentally and socially sustainable human development at the centre of their decision-making, to fully adopt health promotion and reap the population health benefits is readily documented if we look to how—or whether—some of the key concepts in the Ottawa Charter have been developed and applied in Canada. To do so I will cast a critical eye on Canada’s application of the five key mechanisms that in many ways form the core of the Charter, as well as the issue of ecosystem health.

• **Build healthy public policy:** Implicit in this strategy are two key elements: a ‘whole of government’ approach and health impact assessment. Overall, there has been no serious effort to adopt these approaches federally and only spasmodic approaches provincially; the best examples have tended to come from the municipal level, where a ‘whole of government’ approach accords well with a healthy city/community approach. Some notable although often not long-lived initiatives include:
The Ontario’s Premier’s Council on Health set up as a direct consequence of the Ottawa Charter in 1987 and demolished by a reactionary right-wing populist government in 1995;
A brief period in British Columbia in the 1990’s when health impact assessments were required (although not taken very seriously);
Healthy Child Manitoba, established in 2000 as a ‘whole of government’ approach to healthy child development, a fundamental determinant of health;
ActNow BC in the early 2000’, which included a promising cross-government high-level committee (and funding support from the Ministry of Health), to address healthy living and chronic disease prevention (Public Health Agency of Canada and WHO, 2009), but which subsequently was turned into a social marketing campaign for healthy lifestyles and lost its ‘whole of government’ approach;
A recent report from the Senate of Canada’s Sub-committee on Population Health (SubCommittee on Population Health, 2009), co-chaired by one of Canada’s leading heart surgeons, recommended a comprehensive ‘whole of government’ approach, to be led by the Prime Minister and to involve the provincial and territorial Premiers; it sank like a stone.
The most promising ‘whole of government’ initiatives in recent years have not come from the health perspective, although they do address a fundamental determinant of health—poverty. A number of provinces (Newfoundland, PEI, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba) have begun to implement anti-poverty strategies, but Federally, there has been no attempt to link with these actions. Indeed, the Federal government’s policy on poverty has recently been described as ‘to do nothing’ (Toronto Star, 2011).
There is a strong interest in developing healthy public policies in Quebec. The Public Health Act (Government of Quebec, 2001) includes a requirement that
‘the Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population’ and that
‘the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population’ (s54).
In addition, there is a requirement that ‘the Minister, public health directors and institutions operating a local community service centre may… promote … the adoption of public social policies capable of fostering the enhancement of the health and welfare of the population’ (s53(5)).
Create supportive environments for health: The 2010 Framework for Action to curb childhood obesity recently adopted by Canada’s Health Ministers (Public Health Agency of Canada, 2010) contains a number of positive examples of the intent to create supportive environments for health. However, it remains to be seen whether strong action will result, but the omens are not good; in a related area, the Federal government has refused to take regulatory action to reduce the salt content in Canada’s foods, preferring a voluntary approach, which is likely to be as effective as taking a voluntary approach with the tobacco industry. In terms of the built environment, suburban sprawl continues relatively unchecked across Canada despite the growing evidence that it is not only environmentally unsustainable, but also bad for health. The Federal government also continues to support and even promote the marketing of asbestos to low-income countries, recently single-handedly torpedoing an international agreement to list chrysotile asbestos as a hazardous material under the UN’s Rotterdam Convention (Simpson, 2011). And Canada has retreated from its
support (never very strong) for action on climate change, which has profound health implications. Clearly, there is a long way to go in creating environments supportive of health.

- **Strengthen community action**: One telling example of the failure to strengthen community action for health is the general lack of support for the internationally widespread and successful Healthy Cities and Communities movement, which originated in Canada. A small national network was set up in 1989 with Federal funding, but lost its funding in budget cuts in 1992 and has never been re-established. Ontario and Quebec have supported provincial initiatives for more than 20 years, while a small Acadian network exists in New Brunswick; BC has a project which lost its funding in the mid-1990s, was re-established in the early 2000s, then lost all its funding again last year and is now managing to get by as a non-profit consulting and project management group. No other provinces have created provincial Healthy Community projects.

  More generally, there has been a decline in support for community-based organizations of all sorts. A recent report prepared for the Senate Subcommittee on Population Health discusses this issue in more depth (Hancock, 2009).

- **Develop personal skills**: Some 60% of Canadians, and 80% of seniors, have only a level 1 or 2 health literacy score (Canadian Council on Learning, 2008). This means that they lack the necessary skills to understand information for health and thus make good decisions about their own and their families’ health, never mind undertake self-care and chronic disease self-management. Yet, in spite of reports from the Canadian Public Health Association (Rootman and Gordon-El-Bibbety, 2008) and others about the need for a national health literacy strategy, this hugely important issue is receiving little or no serious attention either federally or provincially.

- **Re-orient health services**: The current illness care system continues to be largely focused on hospitals and acute and chronic care. There has been little evidence of a significant increase in funding for prevention or a shift of resources away from illness care and into prevention and promotion, and when that does happen, it is largely in response to infectious disease outbreaks and thus largely focused in that area, rather than on chronic disease and injury prevention, mental health promotion, and a focus on the determinants of health and reducing health inequalities.

In 1993, I wrote in the first edition of Health Promotion in Canada that I feared that we might have won the battle but lost the war:

we are engaged in a power struggle – a battle if you will – with the forces that run counter to the process of enabling people to increase control over and improve their health. The ‘war’ is the war against poverty, hunger, disease, environmental degradation and against militarism and war itself. (Hancock, 1994)

Today, I am not so sure we have even won the battle and, as I argue in an accompanying commentary, I am certain we are losing the war against over-exploitation of the Earth’s ecosystems and the resultant ecological and societal decline, perhaps even collapse—potentially within the lifetimes of many of us today.

So, where does this leave us? It leaves us needing a revolutionary transformation in the political and healthcare leadership in Canada. So far, there has only been rhetoric—useful rhetoric to be sure, in the shape of a Declaration on Prevention and Promotion adopted by all 14 of Canada’s Health Ministers in 2010 (Creating a Healthier Canada 2010), but not enough. Beyond the rhetoric, we need:

- to put sustainable and equitable human development, rather than the economy, at the heart of governance and decision-making at all levels;
- a commitment to a ‘whole of government’ approach in the shape of the structures and processes recommended by the Senate Sub-Committee;
- meaningful national and provincial anti-poverty strategies;
- to change the physical and social structures and governance processes of our communities to create more environmentally sustainable, socially engaging communities that always make the healthy choice the easy choice in the settings where we lead our lives;
- to strengthen the community and NGO sectors so that citizens can play a meaningful role in creating the conditions for healthy living;
- a serious national health literacy strategy that will enable and support people in making healthy choices and keeping themselves and their families healthy; and
• a profound re-orientation of our current illness-care system to be truly a health system; one that invests heavily in prevention, that supports people in appropriate self-care, that emphasizes quality primary care and that not only sees quality of care and the prevention of the adverse effects of health care as a priority, but also creates healing environments for patients and a healthy workplace for staff while being environmentally responsible (Hancock, 1999).

Regretfully, I cannot see much of this happening any time soon, so I do not expect to see Canada re-assume its international leadership in health promotion.

REFERENCES


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