Health promotion in Canada: declining or transforming?*

MICHEL O’NEILL¹, ANN PEDERSON² and IRVING ROOTMAN³
¹Université Laval, ²B.C. Center of Excellence for Women’s Health and ³University of Toronto, Canada

INTRODUCTION

Canada’s visibility in the field began with the release of the federal white paper, A New Perspective on the Health of Canadians (Lalonde, 1974). Since then, individuals, governments, professional associations, and academic institutions have contributed to Canada’s reputation as a leader in health promotion. For example, in alliance with the European Regional Office of the WHO, Canada helped to accelerate the evolution of behaviorally oriented health education toward a more global, political and environmentally sensitive, health promotion (O’Neill and Pederson, 1994). The federal government created the first national-level Health Promotion Directorate in 1978 and hosted the first International Conference on Health Promotion in Ottawa in 1986. That conference culminated in the ratification of the Ottawa Charter on Health Promotion (Charter, 1986) and the release of Canada’s own ‘Achieving Health for All’ (Epp, 1986). The Healthy Cities movement was born at a conference in Toronto. A generation of students has been trained in health promotion across the country, particularly at pioneering programs at the University of Toronto and Dalhousie University in Halifax, etc. We can be justifiably proud of what has been accomplished. The heady days of the 1980s, however, have been supplanted by more cautious fiscal and political times, and accordingly, health promotion has undergone some significant changes.

In part to reconcile the discrepancy between Canada’s glamorous international image as a leader in the field and our experience of struggles in health promotion within our borders, we decided to stimulate an analysis of the domain in Canada following the Lalonde report (Pederson et al., 1994). Since then, both the Canadian Public Health Association (CPHA) and the Federal Department of Health, Health Canada, have conducted their own appraisals. CPHA marked the 10-year anniversary of the Ottawa Charter with the release of a consensus document (ACSP, 1996a) and an action statement (ACSP, 1996b), while Health Canada prepared a case study for the Fourth International Health Promotion Conference in Djakarta (Santé Canada, 1997). These initiatives are three of the key sources for the reflections in this paper. Our aim is to assess whether health promotion has disappeared in Canada under the pressures of health reform, population health and other developments outside the health field itself or been transformed into something related but different.

This paper maintains the historical and socio-political approach of our book, Health Promotion in Canada. We remain convinced that to understand the ongoing situation of health promotion in Canada—or elsewhere—we need to look at events contextually and to consider how social, political and economic forces are shaping the field. We will thus make our assessment of changes in the infrastructure and strategies for

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health promotion, of patterns of investment in health development and health promotion, as well as discuss collaborative initiatives in light of major social and historical trends.

DEMOGRAPHIC, SOCIAL AND EPIDEMIOLOGICAL TRENDS

Canada is the second largest country in the world, with a rather small population (~30 million people) concentrated in the southern third of the land mass. The population exhibits the health profile of a highly developed country confronting massive reductions in government expenditure: significant (in some cases, increasing) gaps in health status between various segments of the population, with aboriginal groups and children of female-headed families in the worst situation; resurgence of some infectious diseases (e.g. tuberculosis); increasing needs from a rapidly aging population, etc.

Though Canadians mark the birth of the country with Confederation in 1867, in fact the political structure has not been static and continues to be in flux. For the past 50 years, the country has been a federal political system with 10 provinces and two territories, each with their own government, in addition to the national government and various local and regional governmental structures. A third territory in the north, Nunavut, has been proclaimed and came into being in 1999. Sovereignty for Quebec remains a significant possibility. Moreover, the dominance of a neo-conservative political climate since the beginning of the 1990s, regardless of which party actually holds office in Ottawa or in the provinces, has resulted in the familiar processes of downsizing and decentralization of government services (especially in health and education) as well as reconfiguration of economic processes toward world markets and export.

Formal jurisdiction over health is divided between the various levels of government, with the largest responsibility residing with the provinces and territories. The federal government has always played a significant role, however, via its taxation powers. Throughout the 1990s, decentralization has led to regional- and municipal-level political structures throughout the country acquiring greater responsibilities for health but not necessarily the concomitant fiscal resources. Concurrently, institutional mergers and reorganizations have altered the landscape of service providers and communities throughout the country.

RELEVANCE OF INTERNATIONAL FACTORS AND TRENDS

Though a capitalist economy, Canada has established, and continues to support, major elements of a welfare state. These programs have been eroded somewhat in the 1990s, however, under the influence of American policies, the North American Free Trade Agreement and the tide of neo-conservatism that has swept the world. To reduce budget deficits, massive cuts have been made in the health sector which, in the 1970s and 1980s, typically accounted for one-third of provincial and federal budgets. Generally regarded as Canada’s most popular public program, the cuts to health care have elicited strong opposition (particularly in Alberta and Ontario where they have been performed more harshly) and nearly cost the Liberal government the 1997 federal election. At the end of the 1990s, under popular pressure, the federal and most provincial governments are discussing reinvesting in the health sector significant portions of the financial margin of maneuverability generated by their zero deficit policies.

In sum, Canada continues to offer universal health and hospital services to its citizens even as the role of the State has been reduced as a deliverer of social programs and as a supporter of non-governmental organizations, in a generally neo-conservative climate.

Internationally, Canada has been at the forefront of initiatives linking changing global economic institutions to public health (see Extract 1), suggesting that the social democratic flavour which has at times permeated the Canadian political economy has not totally vanished.

Extract 1. Linking macro-economic trends to public health.

Canada has been at the forefront of an international effort to inform the professional associations of public health workers and health promoters about the value of lobbying for the inclusion of clauses directed at ensuring minimal health-promoting conditions in countries who are signatories to multilateral trade agreements (e.g. the World Trade Organization and the Multilateral Agreement on Investments). Ron
Labonté (Labonté, 1998), a leading health promotion advocate, articulated the argument, which was first endorsed nationally by the Canadian Public Health Association in 1997 and then proposed and accepted internationally in 1998 by the World Federation of Public Health Associations and the International Union for Health Promotion and Health Education, both of which are currently developing action plans on these issues.

Communications technologies and media

Though Canada continues its tradition as a resource-based economy, it is also participating in the development and use of the new communication technologies. Canada is home to some of the major global telecommunications companies (e.g. Bell, Stentor) and internally, telephone, cable, computer and satellite technologies are integrating at a rapid pace. Still, the physical and cultural capacity to access these tools remains limited. Though growing quickly, the percentage of the Canadian population having access to the Internet is still limited (31% of households in 1997) and, of course, access alone is no guarantee of profitably using the technology.

Canada has initiated some innovative uses of new communication technologies for health promotion. Health Canada created its own health promotion web site years ago <http://www.hc-sc.gc.ca/hppb/> and is currently stimulating the development of a network of networks of health promotion-related information to be accessible through the Internet, telephone, fax and post <http://www.canadian-health-network.ca>. The most interesting initiative is probably the e-mail discussion list CLICK4HP (see Extract 2).

Extract 2. CLICK4HP: an electronic forum to debate the uses of the Internet for health promotion.

Started in May 1996 out of Toronto as a short-term pre-conference global exchange forum on the role of computer-mediated communication in health promotion, the CLICK4HP e-mail discussion list (often known as a listserv) has mushroomed into a lively international forum with more than 600 subscribers. As well as being a place where information is exchanged, the facilitators (Liz Rykert, a professional Internet activist; Alison Stirling, a health promotion consultant working at the Ontario Prevention Clearinghouse; Sam Lanfranco, a health economist from York University) have created a tone whereby even difficult or contentious topics are debated openly by people all over the world. To subscribe to CLICK4-P, send an e-mail to <listserv@yorku.ca>, leaving the subject line blank; in the body of the message, write SUBSCRIBE CLICK4HP <YOUR NAME> (e.g. subscribe click4hp Michel O'Neill), deleting the signature file if you have one. You will receive a welcome message explaining how to use the list. You can also browse through the thousands of messages exchanged over the years by going through the CLICK4HP homepage at <http://www.opc.on.ca/click4hp/c4hpflyr.htm>.

The general geopolitical, economic and social trends observed in Canada in the 1990s and their impact on health and the health sector are clear: as in the rest of the world, neo-conservative policies have significantly transformed the landscape, albeit with varying speed and through different measures in each province and territory. The general population continues to support a caring society but also the need to rethink the role played by governments as the deliverer and funder of social services.

Organizational and administrative structures

In 1994 (O’Neill et al., 1994) we concluded that the primary health promotion actor in Canada in the 1970s and 1980s, the Health Promotion Directorate of Health Canada, had begun to abandon its leadership of the field under a variety of pressures. Since then, under the restructuring pressures of a ‘downsizing’ federal government, this tendency has accelerated. The Directorate itself was dismantled and the health promotion vision, programs and people integrated under a new label: ‘population health’.

The move toward population health

This trend has also been followed by many provincial Ministries of Health, where the words ‘health promotion’ have fallen into disrepute and where ‘population health’ has become the dominant rhetoric. We suggest two reasons for the shift from health promotion to population health.

First, as already noted, the 1990s have been an era of diminishing resources. Health promotion was largely unable to demonstrate its effectiveness, especially in the financial terms politicians favor. Second, the key book (Evans et al., 1994) developing the population health view proposes...
a vision that is very close to that of health promotion but couches it in a classical scientific vision and in the language of economists, in contrast to health promotion's support of a diversity of scientific paradigms and a more social than economic vision. Moreover, the people who articulated the population health argument, especially the members of an elite think tank, the Canadian Institute of Advanced Research (CIAR), are much more allied to the power system of Canadian politics than the proponents of the health promotion vision ever were, hence their success in seeing their perspective adopted.

The shift from health promotion toward population health, which has had a major impact on the ways the various levels of government have modified their infrastructures for health promotion, has been criticized on several grounds (Labonté, 1995; Robertson, 1998; Poland et al., 1998), especially on its apparent scientific neutrality and on its assumptions about the positive impact on health of the increase of wealth in societies rather than of its redistribution. We think, however, that the rhetoric of health promotion itself has not always offered a clear analysis of the determinants of health, thus opening it to being used and interpreted in a variety of ways, especially in the context of the health reforms (e.g. restructuring, decentralization, amalgamation, de-insuring of services, managerialism) undertaken in Canada since the mid 1980s. Consequently, the move toward population health can be seen as an opportunity for health promotion to strengthen some of its weaknesses. In general, the proponents of population health can be seen as allies in the move towards the new public health, particularly as overall, neither framework has significantly challenged the dominance of the biomedicine in the health field.

Towards new structures?
At the end of the 1990s, the role of government in health promotion is reduced and the role of professional associations and academic institutions increasing. The legacy of the government role in health promotion continues to be felt, however, even as its function as a source of funds and infrastructure diminishes.

CPHA, in partnership with the various provincial and territorial public health associations, continues to support health promotion, notably through its ‘Perspectives on Health Promotion’ initiative. The main organizational structure still carrying the torch of health promotion, however, is probably a country-wide consortium of 15 Health Promotion Research Centers. Initiated through a national research competition which provided infrastructure support for five years (1993–1998) to six centers, this ‘Canadian Consortium on Health Promotion Research’ is now a central mechanism for research, teaching, intersectoral networking and advocacy. Two of its centers are WHO-collaborating centers.

POLICIES, LAWS AND REGULATIONS OF RELEVANCE FOR HEALTH PROMOTION

Trevor Hancock commented in 1994 that the main trend in all policy sectors affecting health was the pursuit of deficit reduction (Hancock, 1994). In Canada, this has now been largely achieved federally and provincially, through heavy cuts in transfer payments to individuals and lower levels of government, downsizing of the civil service, the weakening of environmental regulations, etc. Although research linking these cuts to increases in poverty and ill health (especially mental health) is scarce, there is no doubt that the general policy context has moved steadily towards a less health-promoting environment. Moreover, policy-making structures that seemed promising (e.g. the Premier’s Council on Health in Ontario) have either been dismantled or considerably weakened. The creation in 1998 of the ‘Institut national de la santé publique’ in Quebec, some aboriginal treaty and land claim settlements, new infrastructures for health research, and a massive review of federal health protection legislation (which may entail greater privatization of government responsibilities but which is nevertheless being undertaken in a multi-sectoral and consultative manner) are specific counter trends, but it remains to be seen what impact these policies have on the community’s health. Similarly, all levels of government continue efforts toward reductions in smoking, impaired driving, and injuries. Assessing the balance sheet is thus difficult as the general health-damaging neo-conservative environment is offset by significant health-promoting policy initiatives, both within the health sector and elsewhere.
HEALTH PROMOTION IN SETTINGS

The settings approach advocated by WHO as an entry-point strategy for health promotion policies and programs has not formally been adopted in Canada by either the federal government or the provinces. Both levels of government have been influenced by the population health vision and favor a life stages approach—with particular attention to children. Nevertheless, with provincial variations difficult to explain, the settings approach is still evident. The Healthy Communities movement, though no longer a nationwide venture, continues to be very active in some provinces (see Extract 3). Similarly, the Healthy Schools approach has taken root in some parts of the country (e.g., British Columbia), and there is growing interest in Healthy Hospitals and Healthy Universities in others, especially Ontario. Although the concept of healthy workplaces per se has not been widely adopted, there is considerable interest, in government and the private sector, in workplace health promotion initiatives, with the federal government continuing to promote the Workplace Health System model.


In Quebec, born in 1986 in the wake of the Ottawa Conference under the leadership of dedicated public health professionals, the Healthy Communities movement has grown and matured steadily. Over the years, more than 130 municipalities (representing more than 25% of the population of the province) have joined the network. In 1990, the movement was legally registered as an NGO and political power granted to local politicians rather than to the public health professionals who initiated it. In addition to generating hundreds of activities recorded biannually in a widely disseminated directory (RQVVS, 1997), the RQVVS has developed important international expertise: in 1996, RQVVS, with Laval University, was designated a WHO Collaborating Center. The RQVVS has played a significant role in moving public health practice in Quebec toward a more community-sensitive style. In 1998, this leadership was recognized when RQVVS was awarded the Ron Draper Award by the CPHA.

HEALTH PROMOTION FOR POPULATION GROUPS

In addition to the current priority on infants and youth, a few other population groups have traditionally received attention over the years: women, aboriginal people and people with disabilities. In the wake of the women’s movement, and under persistent pressure from activists and women in all sectors, women’s health issues have perhaps been at the forefront among these groups. This is evidenced by federal funding of two major networks of Centers of Excellence, one on women’s health (see Extract 4) and the other on violence toward women and children. In addition, research centers on women’s health and health promotion have been established at major teaching hospitals (e.g., the Center for Research on Women’s Health at Women’s College Hospital in Toronto) and universities (e.g., the McMaster Research Center for the Promotion of Women’s Health in Hamilton), usually with strong links to grass roots women’s groups (Thurston and O’Connor, 1996).


In 1996, the federal government established a network of Centers of Excellence to promote research on women’s health across Canada. In addition to five research centers (in Halifax, Montreal, Winnipeg, North York and Vancouver), the program includes funding for the Canadian Women’s Health Network as its communications and networking arm. All the centers support policy-relevant research through community–academic partnerships. For example, the BC Center, located in Vancouver with a northern secretariat office in Prince George, is specifically concerned with improving the health of women who face disadvantages due to socio-economic status, race, culture, age, sexual orientation, geography and/or disability. Both health promotion and population health shape the work of the center; two of the main research themes are Healthy Women in Healthy Communities, which looks at how to enhance health in the context of women’s multiple roles, and Health Status and Health Determinants, which looks at the social determinants of health (for more information, see <http://www.bccewh.bc.ca>, <http://www.cwhn.ca>).

SPECIAL HEALTH ISSUES AND TOPICS

Two special issues which have received considerable attention in Canada are HIV/AIDS and environmental health. Both the provincial and federal governments have established programs of research, education and support for people living with HIV/AIDS. In 1996, Vancouver hosted the major international conference in
the field, a boost to local AIDS initiatives. The issue has also stimulated some remarkable inter-provincial academic collaboration between behaviorally oriented researchers, the media and policy-makers (CJPH, 1996).

This same intertwining of various research approaches and paradigms, coupled with strong policy and political work has also been evident in environmental health (CJPH, 1998), recently celebrated with the designation in 1998 of a WHO collaborating center with this specialization in Quebec.

CAPACITY BUILDING, TRAINING, RESEARCH AND EVALUATION IN HEALTH PROMOTION

The Canadian Consortium on Health Promotion Research is currently the major resource for capacity building, training, research and evaluation in health promotion. Born in the wake of the federal Knowledge Development Initiative undertaken in the late 1980s (Rootman and O'Neill, 1994), this network has become the backbone of health promotion training and research in the country, much of it collaborative among the 15 centers (Stewart, 1997). It has stimulated infrastructure development within many provinces (e.g. an inter-university coalition in British Columbia, a network of health promotion practitioners and trainers in Atlantic Canada, etc.) and has become a strong national—and increasingly international—advocate for health promotion.

We have noted the impact of the downsizing of the public sector on health services in general and health promotion already. It is, however, important to mention that this downsizing of governments is also creating new spaces and new opportunities for other organizational actors to engage in health-creating programs and infrastructures, as illustrated next.

COLLABORATION AND PARTNERSHIPS FOR HEALTH

One of the best examples of successful partnerships in health promotion is the Atlantic Health Promotion Research Center which has become a major facilitator of all kinds of joint ventures in its area (see Extract 5). Many others could be presented as well, involving different combinations of older (public, academic) and newer (private, voluntary) health promotion champions.

Extract 5. Stimulating a sustainable web of partnerships: the Atlantic Health Promotion Research Center.

Established in 1993, the role of the Center was to direct and facilitate health promotion research in Atlantic Canada (New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island), and to use research to enhance health promotion policy and practice in the region and nationally. Five years of effort have taught those involved that communication, cooperation and partnering are necessary to improve the health of the region, but that this requires considerable time, trust, ingenuity, resources and well-planned strategies to facilitate the uptake of health promotion research. A test of the efficacy of the Center has been its capacity to be financially sustainable after the end of 5 years of federal funding. Partnerships are the key to its survival. The Center has been successful in generating operational funds from Health Canada, the Departments of Health of the Atlantic Provinces and from a variety of sources at Dalhousie University to sustain operations for an additional 5 years. Conversely, the Center’s research is synthesized and widely disseminated, its policy and practice implications being examined by federal, provincial and local levels of government as well as health promotion agencies and boards.

OVERALL ANALYSIS

New partnerships, new infrastructures, new networks—does this mean that health promotion is thriving in Canada? We have tried to suggest that health promotion is declining in some sectors and growing in others.

While Canadians as a whole are blessed with a high standard of health and well-being when compared with many other places in the world, this good fortune is unevenly and inequitably distributed. Current fiscal and social policy is exacerbating the trend toward a weakening of the social safety net which has helped to promote the health of Canadians. Health promotion, which we see as both an ideology and a practice, has been displaced by population health within federal and most provincial bureaucracies both rhetorically and structurally. In this sense, health promotion has certainly declined in Canada.

However, if we stress the similarities rather than the differences between population health and health promotion, we can see them both as
but two manifestations of the ‘new ecological public health’. If we pay attention to what is happening at the community and local levels, within or beyond formal ‘healthy settings’ programs, and if the champions of population health are acknowledged as allies (in part if not wholly), one thing is clear: the vision and practices traditionally promoted by health professionals, technocrats and activists are being taken up by a more diversified set of actors. The challenges for the future are to maintain as much government commitment to health-promoting policies, however labeled, and to create alliances between the old and the new promoters of health promotion.

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Address for correspondence:
M. O’Neill
Ecole des Sciences Infirmiere
Université Laval
Québec QC
G1K 7PY Canada

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