Korean Journal of Health Education and Promotion
Vol.3, No.1, 2001, pp. 47 53

Health Promotion in Canada

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Ⅰ. History

Canada has a rich history in the theory and development of the field of health promotion. Over 25 years ago, in 1974, the Canadian government produced the first government policy document that identified health promotion as a national strategy. The document, which came from the national Health Minister, was entitled *A New Perspective on the Health of Canadians* (Lalonde, 1974). It led the way for other governments to produce similar documents, and to many western countries embracing the ideas and ideals of health promotion. In 1986, the first International Conference on Health Promotion was held in Ottawa, Canada, at which time the Ottawa Charter for Health Promotion was endorsed (WHO, 1986). The Ottawa Charter noted that improvement in health requires a secure foundation in basic prerequisites, noting that:

> *The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.*

Fifteen years later, and even with the advancement of 4 more international conferences, we are faced with the same challenges. The Fifth Global Conference for Health Promotion in Mexico in June 2000 reiterated the same challenges and these remain the same

for Canada, a technologically and economically advanced nation. Many of our main illnesses have their roots in socially issues, including AIDS, drug and alcohol misuse, and tobacco use, but we also face problems related to clean air so that our children have growing rates of asthma. These are the proximal causes of illness, but the determinants of those problems lie in the fundamental conditions and resources for health, including income, social justice and equity.

II. Theory and Practice Evolves

Canadian government politicians and practitioners have not left the field from those early and important developmental stages. Besides the early documents mentioned, we have had offices of health promotion in our federal government, and the leadership has not been stagnant. Government policy has evolved as we learn more.

We continue to work on developing the concepts and practical applications. Canadians have used various definitions of health promotion (Rootman et al, 2001). These include:

- **Lalonde, 1974**: Aims at "informing, influencing, and assisting both individuals and organizations so that *they will accept more responsibility* and be more active in matters affecting mental and physical health."

- **Ottawa Charter, 1986**: "Health promotion *is the process of enabling people to increase control over*, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment..... Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being."

The Lalonde definition says that people should accept responsibility, while the Ottawa Charter definition specifies that individual control is important. The Ottawa Charter definition adds other important elements in that it defines *a process*, and it embraces *empowerment* as key to health promotion.

Other definitions that have influenced our thinking:

- **Labonte & Little, 1992**: "An activity or program designed to improve social and environmental living conditions such that people"s experience of well-being is increased."

- **Green & Kreuter, 1999**: "Any planned combination of educational, political, regulatory, and organizational support for action and conditions of living conducive to the health of individuals, groups or communities."

It is notable that both these more recent definitions add the element of "programs" or "supports" to help individuals accomplish this control over their health, and both mention conditions of living. Our thinking is evolving in that we now understand better the process by which to achieve the goal of individuals taking control over their health. Whereas we once believed that we could teach or educate people to take responsibility of their own health, we are now fully aware that individuals can take that responsibility only if governments or communities provide conditions and supports enabling those lifestyle and behavioural changes. Control over one's life requires political, organizational and other supports of the individual and the community in which they live. The emphasis on lifestyle and behaviour has not been dropped, but with the Ottawa Charter a social component was added. Our more recent thinking, as seen in Green's definition, notes that political supports might also be required. People who are less educated, more disadvantaged socially continue to remain in poorer health. Canadians assume a societal responsibility for improving those conditions, and prefer to treat the disadvantaged as victims of our inadequate systems rather than to blame them for their inadequacies.

Most recently, it has become well recognized that income disparity within a nation is a determinant of poor health, so that when we compare communities, provinces or nations, those with the greatest inequalities in income have the poorest health. Nations with the highest incomes do not necessarily have the best health, those with the smallest gaps between rich and poor do. This holds true for nearly all diseases, including heart disease and most cancers. The rates of disease rise as the inequity gap increases. While Canada has many distinguished academics who research and publish on this topic of the importance of income disparities on the health of populations, we have yet to provide solutions (e.g., Evans et al, 1994). Even in a wealthy country such as Canada, it is well understood that bridging the inequity gap is a major challenge for both provincial and federal governments. Health promotion has a contribution to make, mostly because of our goal of identifying and addressing determinants of health. It is rare for more advantaged individuals to relinquish power, control and financial resources, but it is the responsibility of the state to redistribute those resources so that everyone has adequate living conditions, including the prerequisites noted by the Ottawa Charter, including social justice and equity. In

times of economic uncertainty as we have had recently, we have not yet found solutions to the fact that even in Canada the gap between the rich and the poor continues to increase, which from an academic perspective, we know has dire implications for our population's health.

Some of the aspects of health promotion in Canada that contribute to its success are:

- that it has had an extensive history of government supports,
- there is training at the university level,
- research funding is available nationally, and
- national consumer health information access.

I have already described the history of our governmental leadership in this area.

Ⅲ. Training at the University Level

Another important aspect of Canadian health promotion is that of training. In the early 1990's federal and provincial governments provided funding so that people could be trained at the masters and doctoral levels of university. Six universities across Canada set up centres of health promotion, including one from the University of British Columbia. That university hired Dr. Lawrence Green to head the centre, and as you know, he is one of the foremost writers and theorists in the field, known in Asia for the "Green method" or elsewhere for the "Precede, Proceed method" of health promotion planning. I am a PhD graduate from that Centre, trained under Dr. Green's leadership.

One other aspect of our health promotion is worth mentioning. There are very few medical people who work in health promotion in Canada. Generally, the role of the medical profession is curative and those working in that field work on a one-to-one basis with their patients. Those in health promotion work on a community or population level and their focus is *health* rather than *illness*. Canada has a national universal health care system, which means that everyone is insured and everyone has free access to medical care, including hospitalizations and visits to the physician of their own choice. This government-funded health insurance has been in existence for many decades, so that we know from experience that even when everyone has free access to doctors, some sectors of society get sick more than others. We are able to examine the determinants of health from the perspective of what contributes to good health, rather than what determines fewer complications from illness, fewer ill days or lower rates of death. That is not to imply that there is truly equal access to health care, since there remain some inevitable

inequalities in health care; for example in remote rural areas people may have to travel further to doctors or hospitals. However, we continue to attempt to provide equal service, regardless of income or resources, race, gender and so on. This universal access to health care allows health promotion planners and practitioners to concentrate on determinants of health, and the examination of ways to enhance the health of the population.

Ⅳ. Research Funding

Our new major health research funding in Canada has population health promotion as one of its four major pillars. Funding is granted across types of research, from basic research to population health. It is expected that researchers across Canada will collaborate on topics of importance to the health of Canadians, so that, for example, in the area of diabetes research teams of researchers will work together and those teams should include population health promotion researchers. Recently some national funding agencies have accepted proposals for "participatory action research" which is a approach to research which involves community participants helping with the design of the research and with moving the research results into action to solve their own particular health issues (George, et al, 1999).

Ⅴ. Health Information

The Canadian government has developed a national information centre for consumer information. Called the Canadian Health Networks, it provides consumers with health information about diseases, prevention, resources and organizations or other contacts who may be useful in their communities. It is available for everyone either through free telephone or on the internet.

Ⅵ. Health Promotion Practice

I would like to finish be describing briefly how this conceptualization of health promotion translates into practice. Some key components are:

1. To think globally, but act locally. As I have told you, there has been strong leadership from our governments in the area of health promotion. However, health promotion practice is centred on the local level. It is expected that local citizens will know best how to solve their own health problems. For example, native Canadian populations have the highest level of tobacco use. There are many policy initiatives developed at the federal or provincial level, such as the

pricing of cigarettes and where cigarettes can or cannot be smoked. However, to be effective, we also need community-level planning of the development of programs. Community-level planning means that each community will focus on its own needs. Funding is provided to communities for such initiatives. While there may be a common message regarding health, the actual programming is very different depending on the region of the country and the target population within those communities.

2. Citizen participation is considered key to the success of health promotion practice. At the local level, partnerships are made with organizations, and citizens are included in the planning, implement and evaluation of programs.

3. Programming requires multiple strategies. It is well understood that solutions to health problems must take many forms. For example, we know that tobacco smoking is a major contributor to many health problems. We also know that that the adverse effects of smoking tobacco are well-known to most people, even young people, and that knowledge alone is not enough to stop people from taking up the habit of smoking. We have reduced the rate of smoking by nearly half because of multiple efforts. These include new very strict laws prohibiting the sale of tobacco to people under age 19 years, discarding all tobacco vending machines, increasing the price of tobacco, and restricting smoking in any public places including the workplace, restaurants and pubs. Our strategies also includes extensive health education in schools. In addition, we have subsidized farmers to replace their tobacco crops with other crops. Any one of these initiatives alone could not have lead to the success rate in reducing tobacco use.

4. Theoretical foundations must be the basis of health promotion practice. Programming must have strong theoretic foundations and must be evidence-based. In health promotion we use many theoretical models, based both in psychology and sociology. To make real and lasting change, programs must focus on addressing the social determinants of health, especially including poverty, housing, education disparities, powerlessness, if and so on.

Thank you for the opportunity to speak about health promotion from a Canadian perspective.

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