Ontario

Health, Not Health Care – *Changing the Conversation*

2010 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

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Letter of Transmission

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Ontario

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The Honourable Speaker
Speaker of the Legislative Assembly of Ontario
Room 180, Main Legislative Building
Queen's Park
Toronto, ON M7A 1A2

Dear Speaker:

I am pleased to provide the 2010 Annual Report of the Chief Medical Officer of Health of Ontario for submission to the Assembly in accordance with the provision of section 81.(4) of the Health Protection and Promotion Act.

Yours truly,

A. King.

Arlene King, MD, MHSc, FRCPC
Chief Medical Officer of Health

Attachment

Letter from the CMOH

"Public health is the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. Public health acts on the knowledge that health is a fundamental resource to the individual, to the community and to society as a whole and must be supported by soundly investing in living conditions that create, maintain and protect health."[1]

Ilona Kickbusch
Director, Division of Health Promotion, Education and Communication
World Health Organization

Imagine engaging any random 100 Ontarians in a conversation about improving health in Ontario. I have done this many times myself and, almost invariably, the response I get involves hospital wait times or doctor shortages or the need for more community clinics. These are valid concerns. These things need to be addressed – no question – if we are to continue effectively treating Ontarians who get sick or injured. But they have little to do with improving health.

What are, generally speaking, the greatest threats to health in our society today? Obesity. Tobacco and alcohol abuse. Chronic conditions like diabetes, cancer, heart disease. Injuries. Put any 100 experts in a room to talk about how to alleviate these threats, and you won't hear about wait times. You won't hear about doctor shortages. You will hear about promoting healthy behaviours. You will hear about reducing poverty. You will hear about healthy child development and eliminating health inequities and food insecurity. You will hear, in other words, a conversation about a great many things, few if any of them related to actual health care.

By way of illustration, in September 2011, the United Nations convened a High-level Meeting on the Prevention and Control of Non-Communicable Diseases. The result was a declaration,[2] endorsed by Canada, that proposes ways to fight obesity and cut tobacco and alcohol use. The declaration calls for targets to be set by 2012 to curb mortality from chronic – and often preventable – conditions like cancer, heart disease, diabetes and chronic respiratory disease. The UN High-level Meeting featured days of intense conversation about a great many things health-related, few of them related to actual health care services.

I am using this annual report to expand on the idea that it is time for a different public health "conversation," and to continue advancing the argument I made in my 2009 annual report – that it is time to shift our focus from health care to prevention. Public health is, quite simply, about prevention. It is about fewer people getting sick. It is about fewer people getting injured. It is about more people living long and healthy lives. We can have better health in Ontario, but it will require the concerted effort of all three levels of government, community leaders, the private sector and all Ontarians. It will require our individual, and our collective, effort. And it will require all of us to acknowledge that the best public health policy is making healthy public policy the focus in everything we do, and to make prevention everyone's business.

Dr. Arlene King
Ontario Chief Medical Officer of Health

In Search of Healthy Public Policy

"We must change our way of thinking and recognize that good health comes from a variety of factors and influences, 75 per cent of which are not related to the health care delivery system. Therefore we must become proactive and support communities, cities, provinces, territories and a country in producing citizens in good health, physical and mental well-being and productivity. Passively waiting for illness and disease to occur and then trying to cope with it through the health care delivery system is simply not an option. Hence, we must address all of the factors that influence health and through a population health approach, overcome inequities and foster well being and productivity." [3]

Final Report of the Senate Subcommittee on Population Health

The above quote is taken from a 2009 report released by the Standing Senate Committee on Social Affairs, Science and Technology. It calls on Canada's prime minister and premiers, mayors, municipal leaders, community leaders and Aboriginal leaders to make prevention a focus – to eliminate disparities, ease the burden of disease and injuries and increase productivity.

The report's call for an integrated, multi-sectoral approach to prevention is being echoed in many jurisdictions around the world. The Public Health Agency of Canada[4] refers to four ways in which prevention can or should occur. The four "faces" of prevention are:

- Clinical prevention – essentially "one-on-one" health care system activities
- Health promotion – encouraging individuals and communities to engage in behaviours that produce positive health effects, and avoid those that produce negative health effects
- Health protection – interventions designed to reduce health risks (e.g., policies, laws)
- Healthy public policy – interventions outside the health sector that generate positive health benefits, but do not have health as the main policy objective[5]

The first of these faces, clinical prevention, falls under the umbrella of primary care or the broader health care system. The next two, health promotion and health protection, occur at both the individual and community levels, and are generally considered to be the purview of public health. The fourth, healthy public policy which is the focus of this report, is less easily pigeonholed. Nobody has responsibility for healthy public policy because we all do.

Healthy public policy is what results when the conversation changes from health care to health. The trenchant point made by the Senate subcommittee and many other health care advocates is that healthy public policy must inform everything we do. Real public health – the kind of public health Ontarians deserve – will only truly be practiced when we apply a health lens to every policy that is implemented in this province, every program that is carried out and every service that is delivered.

Health, Not Health Care

The notion of prevention as a key contributor to health is not a new one. People have known intuitively for hundreds of years that the best way to deal with diseases or injuries is to avoid them. What has changed in recent years is not our understanding of that basic fact, but our understanding of how far outside traditional health care structures the causes of, and solutions to, so many health problems can be found.

By now, many Ontarians are familiar with the concept of "determinants of health." These are the economic, social and environmental conditions that are known to greatly influence health. What is critical to understand about these determinants is that they dictate the extent to which we have health inequity, and health inequality, in our society.

The Public Health Agency of Canada lists 12 determinants of health. They are as follows:

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture[6]

What this list makes clear is that whichever way you choose to look at, think about and itemize the various conditions that affect people's health, health care services are only ever one small part of a very big picture. This can be illustrated by a look at what are widely acknowledged to be four of the most important determinants of health:

Income and Social Status

Income is widely seen as the most important of the critical determinants of health and a glaring cause of health inequity. There is abundant research to indicate that people with lower incomes suffer more ill health and live shorter lives than people with higher incomes.

Fact

About 20 per cent of health care spending in Canada can be attributed to socio-economic factors, such as income-related disparities.[7]

Education and Literacy

Education is another critical determinant of health. People with higher education tend to be healthier than those who have received less.[8] The reasons may seem obvious, but they are no less important for that. Better educated people understand more about their health and how to manage and shape it, and they tend to have more resources and money with which to afford the underpinnings to good health such as food, clothing and housing.

Employment/Working Conditions

We spend an enormous amount of time in our workplaces, and are consequently very vulnerable to any unhealthy factors – such as unsafe working conditions or stress – that may exist there. People who have low incomes and limited education are, not surprisingly, more likely to experience adverse working conditions.

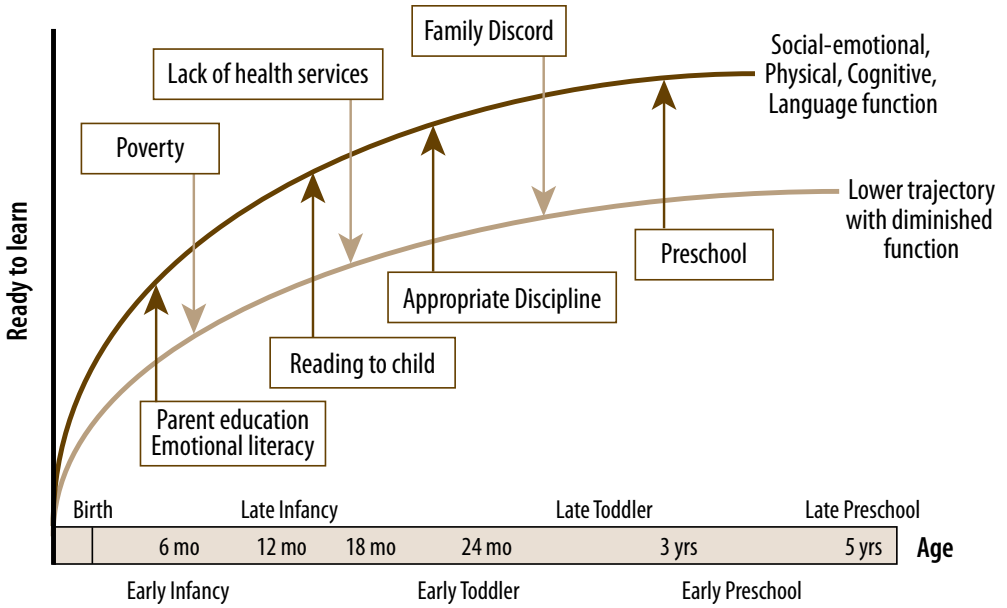
Healthy Child Development

"In Canada, less than five per cent of children at every socio-economic level are born with clinically detectable limitations to their development; but by school age, vulnerability in developmental health grows to over 26 per cent (Council for Early Child Development 2009) and profound socio-economic inequalities in development emerge (Council for Early Child Development 2009). In this respect, Canada is like most societies on the planet, where regardless of national wealth, inequalities in socio-economic resources among families are associated with inequalities in developmental health."[9]

Clyde Hertzman
Canada Research Chair, Population Health and Human Development

Children's earliest years pave a road for them to walk all their lives, and it is a very difficult road to get off. It is a road that leads towards, or away from, good health. We are all born with essentially the same potential for good health. As figure 1 illustrates, it is the life we are born into – the road we are given to walk – that immediately begins acting on that potential for good or ill.

Figure 1: Strategies to Improve School Readiness Trajectories



Source: Halfon N. Building public & private capacity to improve early childhood initiatives. In: Building Public & Philanthropic Partnerships in Early Childhood; 2006 Jan17; Los Angeles, CA. Silver Spring, MD: Grantmakers for Children, Youth, and Families; 2006 [cited 2011 Oct 19]. Slide 23, Strategies to improve school readiness trajectories.

This is evident from the outset: children born to mothers with low income and educational levels are more likely to be premature or of low birth weight, and these factors are strong predictors of lifelong health.[10] In addition, we know that children's nutrition varies with parents' income and education and can have lasting effects on health throughout life.

Clearly, there is a relationship between socio-economic status and children's developmental outcomes, both physical and mental. Just as clearly, our responsibility as a society is to ensure that, regardless of their parents' income level, all children benefit from proper nutrition, receive high quality early childhood education, and live in communities that are safe and nurturing.

Canada – A Long Way to Go in Early Childhood Development

- 15 per cent of Canadian children are living in poverty
- Only 17 per cent of Canadian families have access to regulated child care
- The Organisation for Economic Co-operation and Development (OECD) rates Canada last among 25 wealthy nations in meeting various early childhood development objectives[11]

Healthy Child Development – The Manitoba Example

Healthy Child Manitoba (HCM) is the Government of Manitoba's nationally recognized long-term, cross-departmental strategy for putting children and families first. Launched in 2000, HCM researches best practices and models and adapts these to Manitoba's unique situation. The stated HCM vision is to achieve the best possible outcomes for Manitoba's children, and the guiding principle at the heart of the initiative is that the best and most successful programs are community-based and inclusive. This nationally recognized strategy was set in legislation under The Healthy Child Manitoba Act in 2007.[12]

Led by the Healthy Child Committee of Cabinet, the objectives of Healthy Child Manitoba are to:

- Develop, fund and evaluate innovative initiatives and long-term strategies to improve outcomes for Manitoba's children
- Coordinate and integrate policy, programs and services across government for children, youth and families using early intervention and population health models
- Increase the involvement of families, neighbourhoods and communities in prevention and early childhood development services through community development, and
- Facilitate child-centred public policy development and knowledge exchange across departments and sectors through evaluation and research on key determinants and outcomes of children's well being[13]

What is interesting, and from a public health point of view, frustrating, about the above four determinants is how little anyone involved with health care can do about them. Doctors can't do much about employment and working conditions. Hospital administrators don't have any influence over the quality of education people receive. And the Chief Medical Officer of Health may understand very well how devastating an effect on health a low income might have, but there is little that he or she can do about it. In the one area where the health care system could make a difference – by implementing comprehensive early childhood prevention measures that would be available to all children – we lack the clear goals, targets, indicators and, above all, integration and collaboration that would allow us to do so effectively and efficiently.

The United Nations identified this dilemma in a different way when it set the priorities for a High-level Meeting on Non-Communicable Diseases. The stated objective of the summit was to galvanize action at global and national levels to halt and address the health and socio-economic impact of cardiovascular disease, cancer, diabetes and chronic respiratory diseases through multi-sectoral approaches.[14]

The need for multi-sectoral approaches becomes especially clear when one looks at the four risk factors the UN identifies for these diseases: unhealthy diet, harmful use of alcohol, tobacco use and physical inactivity.[2] Clearly, addressing those risk factors is well beyond the scope of our current health care system.

The Looming Threat of Chronic Disease

The United Nations High-level Meeting on Non-Communicable Diseases is also important because it speaks to the growing concern around the world about non-communicable chronic diseases. Where infectious diseases were once the leading cause of death and disability, that dubious title now belongs to non-communicable chronic diseases. These now account for 59 per cent of the world's 57 million annual deaths and 46 per cent of the global burden of disease.[15]

In Ontario, the story is much the same. Heart disease is the leading cause of death in this province, followed by cancers, stroke and chronic obstructive lung disease.[15] Chronic diseases are particularly insidious because they so often lead to other chronic conditions. In 2003, 70 per cent of chronically ill Ontarians over the age of 45 had multiple conditions.[15]

Fact

Ontarians with diabetes account for 32 per cent of heart attacks in the province, as well as 30 per cent of strokes and 70 per cent of amputations.[15]

Modern health care systems do very well when it comes to treating chronic conditions, but preventing them remains an overwhelming challenge. For health providers this is particularly vexing because these diseases are in so many cases preventable. Consider the four risk factors identified by the United Nations High-level Meeting. Consider that in a world without tobacco, 90 per cent of lung cancer deaths would be eliminated, as well as 30 per cent of other cancers.[15] Healthy eating, regular exercise and eliminating tobacco would prevent up to 90 per cent of type 2 diabetes cases and 80 per cent of coronary heart disease.[15]

The Cancer Quality Council of Ontario recently looked at what it called modifiable risk factors for cancer in Ontario – behaviours and physical conditions that can lower or raise a person's risk of cancer – and the extent to which Ontarians have in fact modified them in recent years. The factors identified, which closely mirror those of the UN, were smoking, obesity rates, physical and sedentary activities, fruit and vegetable consumption, and alcohol consumption high enough to increase the risk of cancer.[16]

The findings are not good news for anyone who believes that simply explaining to people that something is bad for them will bring about a change in behaviour.

- Physical activity and vegetable and fruit consumption rates are higher than in 2000/2001 but lower than in 2005[16]
- Overall smoking rates have remained essentially the same since 2005[16]
- Obesity rates have risen from 16 per cent in 2000/2001 to 17 per cent in 2007/2008[16]
- Alcohol consumption high enough to increase risk of cancer has risen from 17 per cent in 2000/2001 to 20 per cent in 2007/2008[16]

The inescapable conclusion? Chronic diseases are preventable. But we are not yet doing a good enough job of modifying the risk factors that cause them. Doing so will require looking beyond our health care system and taking a broader, more comprehensive approach to public policy development – to *healthy* public policy development.

Modifying Risk – the British Columbia Example

ActNow BC is that province's cross-government health promotion initiative that supports schools, employers, local governments and communities to develop and promote programs that will help British Columbians achieve certain specific goals. These are:

- increase the percentage of the B.C. population that is physically active by 20 per cent
- increase the percentage of B.C. adults who eat at least five servings of fruits and vegetables daily by 20 per cent
- reduce the percentage of B.C. adults who are overweight or obese by 20 per cent
- reduce tobacco use by 10 per cent, and
- increase the number of women who receive counselling about the dangers of alcohol and tobacco use during pregnancy by 50 per cent

The government is committed to monitoring and reporting regularly on the progress B.C. is making towards achieving its targets for physical activity, healthy eating, healthy choices in pregnancy and living tobacco free.[17]

What is Healthy Public Policy?

"Government objectives are best achieved when all sectors include health and well-being as a key component of policy development. This is because the causes of health and well-being lie outside the health sector...Although many sectors already contribute to better health, significant gaps still exist."[18]

Adelaide Statement on Health in All Policies

Healthy public policy has two overarching and closely linked goals: the prevention of illness and injuries, and reducing health inequities. There are a number of core assumptions that must be at the heart of all healthy public policy. The Robert Wood Johnson Foundation released a report in 2010 called *A New Way to Talk About the Social Determinants of Health*,[19] which can be usefully adapted to express those core assumptions:

- Health starts, long before illness, in our homes, schools and jobs
- All people should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background
- Your neighbourhood or job shouldn't be hazardous to your health
- Your opportunity for health starts long before you need medical care
- Health begins where we live, learn, work and play
- The opportunity for health begins in our families, neighbourhoods, schools and jobs

Healthy public policy is also frequently referred to as Health in all Policies. The World Health Organization held an international meeting on Health in all Policies in Adelaide in 2010. What emerged from that meeting was a report called *The Adelaide Statement: Moving Towards a Shared Governance for Health and Well-being.*

The Adelaide Statement speaks of the absolute need for what it calls "joined-up government" which is a partnership between government, civil society and the private sector. The statement advanced the following strategies, or drivers, for achieving Health in All Policies:

- creating strong alliances and partnerships that recognize mutual interests and share targets
- building a whole of government commitment by engaging the head of government, cabinet and/or parliament, as well as the administrative leadership
- developing strong high-level policy processes
- embedding responsibilities into governments' overall strategies, goals and targets
- ensuring joint decision-making and accountability for outcomes
- enabling openness and full consultative approaches to encourage stakeholder endorsement and advocacy
- encouraging experimentation and innovation to find new models that integrate social, economic and environmental goals
- pooling intellectual resources, integrating research and sharing wisdom from the field, and
- providing feedback mechanisms so that progress is evaluated and monitored at the highest level[20]

Applying a Health Lens

There is widespread agreement that any serious healthy public policy undertaking requires policymakers to, in a sense, own the impact that their policies have on people's health. Put another way, those responsible for establishing a policy must also be responsible for understanding its health effects, be they positive, negative or absolutely neutral. The point is to know.

A good example of this would be transportation policy. Traffic accidents and air pollution have a major impact on public health, so it is critical to understand exactly how programs designed to improve transportation affect health positively or negatively.

Health Impact Assessments (HIAs) are one form of a health lens used in many jurisdictions. HIAs are a means of assessing the potential health effects of any policy, program or project on a population, using quantitative, qualitative and participatory techniques. There should be a particular focus on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders with the aim of maximizing the program's positive health effects and minimizing its negative health effects.

Applying a Health Lens – Quebec Health Impact Assessments

The province of Quebec has institutionalized Health Impact Assessments by including them in the province's Public Health Act (PHA). The Quebec PHA assigns two critical responsibilities to the Minister of Health and Social Services:

"[...] advisor of the Government on any public health issue. 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.

In the Minister's capacity as government advisor, 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."[21]

What that means in effect is that any government department or agency involved in formulating a legislative or regulatory proposal must assess the potential impact of its actions on the health of Quebecers.

Healthy Public Policy in Ontario Today

Smoke-Free Ontario

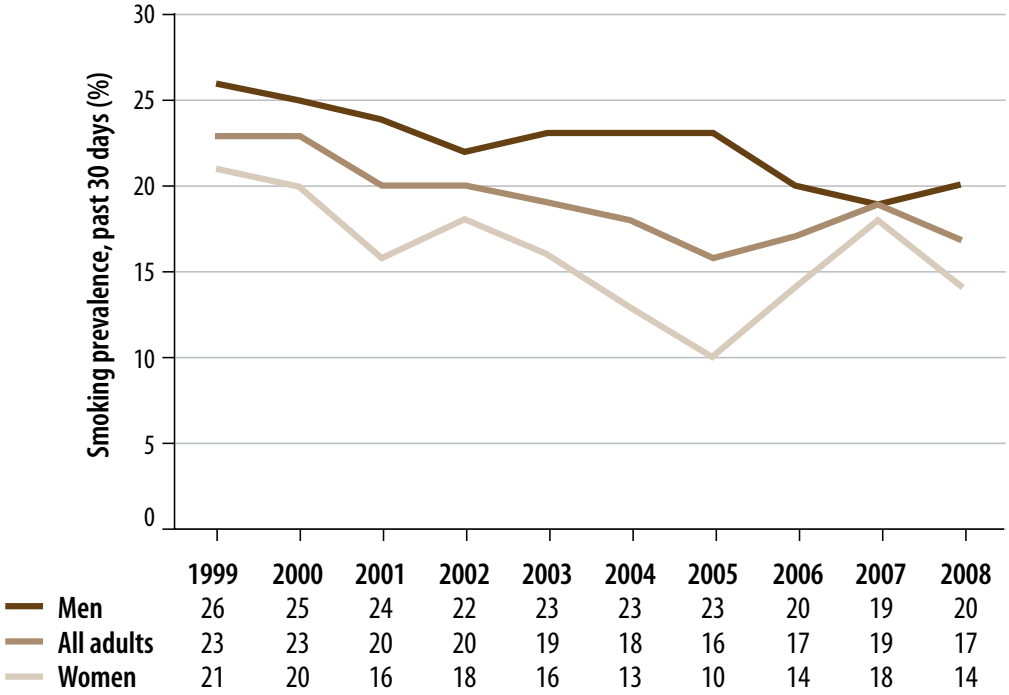
In Ontario today there are several excellent examples of programs or initiatives that work across government ministries, involve municipalities and engage communities in the business of making Ontarians healthier. The most well-known of these initiatives is Smoke-Free Ontario.

The groundbreaking tobacco control program was launched in 2005. Built on the foundation of groundbreaking municipal bylaws, it immediately made Ontario one of the world leaders in the fight against smoking. As a result of the Smoke-Free Ontario Act, all of Ontario's enclosed workplaces and enclosed public spaces are now smoke free. Stores no longer display cigarettes on shelves where children can see them. Youth smoking rates are down and, between 2005 and 2009, more than 1.25 million smokers were helped by Smoke-Free Ontario support and cessation initiatives.[23]

Fact

The Ontario Tobacco Research Unit estimates that for every dollar invested in addressing tobacco use, the government saves three dollars in health care spending.[22]

Figure 2: Current smoking (past 30 days), by sex, ages 18+, Ontario, 1999 to 2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Men	26	25	24	22	23	23	23	20	19	20
All adults	23	23	20	20	19	18	16	17	19	17
Women	21	20	16	18	16	13	10	14	18	14

Ontario Tobacco Research Unit. Indicators of Smoke-Free Ontario progress. Monitoring and Evaluation Series. 2010; 14/15(2):1-38. Figure 12, Current smoking (past 30 days), by sex, ages 18+, Ontario, 1999 to 2008, %, p.13.

These accomplishments were the result of widespread consultation and cooperation between several Ontario ministries, as well as municipal governments, community leaders and the retail industry. While legislation was one of the principal levers employed, the groundwork was laid through increased public awareness and careful engagement. It is very important to remember, however, that with more than two million people in Ontario still smoking, many of them youth, we have an extremely long way to go.

Ontario Road Safety Successes

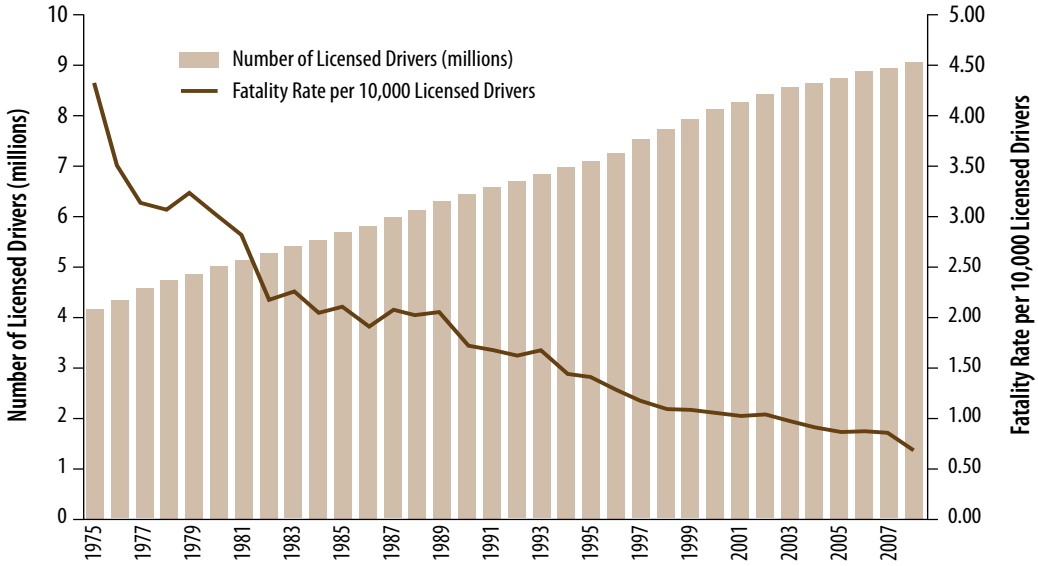
One of the great healthy public policy successes in this province is our record on road safety. For the past 10 years, Ontario, though the Ministry of Transportation and various partners and stakeholders, has pursued an aggressive road safety agenda. Measures that have been taken include, but are not limited to:

- Ignition interlock for impaired drivers (2001)
- Booster seat requirement (2005)
- One Person, One Belt (2006)
- Street racing legislation (2007)

- Speed limiters for large trucks (2009)
- Ban on hand-held devices (2009)
- Increased fines for serious traffic offences (2010)
- Tougher sanctions for graduated licensing violations (2010)
- Ongoing infrastructure improvements (e.g., rumble strips, shoulder paving)
- Ongoing efforts to improve emergency response times

The results have been dramatic and are inspiring testament to what can be accomplished by non-health care players in the area of improving health. While Ontario's licensed driver population has increased by 135 per cent over the past 35 years, the number of fatalities has dropped steadily from 1,959 in 1973 to 631 in 2008. In 2008, Ontario had the lowest traffic fatality rate among North American jurisdictions – the 10th year in a row this province has ranked either lowest or second-lowest in this area.[24]

Figure 3: Ontario Fatality Rate per 10,000 Licensed Drivers



Source: Adapted from Ministry of Transportation. Ontario road safety annual report 2008. Toronto, ON: Queen's Printer for Ontario; 2008.

It is important to remember, of course, that we still have a long way to go. Traffic collisions remain one of the biggest causes of death and injury in this province. There is a collision in Ontario every 2.3 minutes, a person is injured every 8.4 minutes and someone is killed every 14 hours. Healthy transportation policies must continue to be our focus in Ontario if we want that picture to improve.[24]

Ontario Poverty Reduction Strategy

While Smoke-Free Ontario is a great example of a multi-sectoral initiative aimed directly at accomplishing a health care-related goal, there are also clear examples in this province of healthy public policy – programs that do not have better health as the primary objective, but which have been informed at every stage of development by the awareness that there must be health in all policies. Ontario's Poverty Reduction Strategy is an example of just such a program.

Launched in 2008, the strategy, entitled *Breaking the Cycle*, sets a target of reducing the number of children living in poverty by 25 per cent over five years – that would translate into 90,000 kids being lifted out of poverty.[25] The strategy involves key investments such as the Ontario Child Benefit, the Student Nutrition Program, the Youth Opportunities Strategy, funding to improve education and after-school programs, training and mentorship programs and a range of community supports.

All of these investments will have the effect of helping lift children out of poverty, which in turn will dramatically improve their chances of living longer, and in better health. Health outcomes were not the primary objective but there was recognition that a healthy start in life can lead to better outcomes later in life and break the intergenerational cycle of poverty.

The strategy was released by the Government of Ontario and led by the Minister of Children and Youth Services, with support of partners at the Ministry of Education, Ministry of Health and Long-Term Care, Ministry of Training, Colleges and Universities, Ministry of Community and Social Services, Ministry of Health Promotion and Sport, Ministry of Municipal Affairs and Housing, and Ministry of Finance as well as community leaders and stakeholders. The good work they began must continue, and the beneficiaries will be healthier, happier children and their families.

Other Ontario Initiatives

Places to Grow

Ontario's Places to Grow initiative was launched in 2004. It is backed by legislation which allows the province to identify growth plan areas and develop strategic growth plans for those communities by engaging local officials, stakeholders, residents and other public groups. The goal is to create well-designed, vibrant communities, surrounded by green spaces and supported by amenities such as modern hospitals and schools. A key objective is promoting active and public transportation to reduce traffic, smog and stress – a healthy environment, in other words, in which to raise healthy children. The Growth Plan for the Greater Golden Horseshoe was launched in 2006 and is already seeing results.[26] For more details, please visit www.placestogrow.ca.

Healthy Child Development

In June 2009, Dr. Charles Pascal released a report entitled "*With Our Best Future in Mind: Implementing Early Learning in Ontario*."[27] Dr. Pascal presented a bold vision for early learning and care. His recommendations included the implementation of full-day kindergarten in Ontario, as well as a comprehensive approach to seamless child care, a common early learning curriculum, streamlined and improved access to a broad range of services for prenatal women, young children and families, and the establishment of public policies that support families.

In response to the Pascal report, Ontario has moved ahead with full-day kindergarten – half the province's kindergarten students will be enrolled in a full-day program in the 2012-2013 school year. Dr. Pascal advised the Minister of Children and Youth Services on plans for integrating services for children and families through Ontario Best Start Child and Family Centres. An updated report, released in June 2011, shared a working vision and guiding principles for Best Start Centres based on the findings from a parent and stakeholder consultation process.

In addition, Ontario has released a comprehensive mental health and addictions strategy that recognizes the critical link between mental health and healthy child development.[28] The strategy helps children in three key areas: fast access to high-quality services, early identification and support, and helping vulnerable kids with unique needs. Ontario kids and their families will now have quicker and easier access to the mental health supports they need.

Ontario Public Service (OPS) Diversity Office

Ontario is one of the most diverse jurisdictions in the world. This diversity is one of its greatest strengths. Working in partnership with key stakeholders, the OPS Diversity Office is leading the OPS' transformation towards becoming a diverse, accessible and inclusive organization that reflects and responds to Ontario's rapidly changing demographic.

About 15.5 per cent of Ontario's population, or 1.85 million people, have a disability. Researchers expect that number to grow to 20 per cent in the next 20 years.[29]

It is anticipated that the proportion of seniors will grow to 17.2 per cent by 2021,[30] while visible minorities will make up almost 29 per cent of Ontario's population by 2017.[31]

While the link between diversity and better health is not as obvious as the link between poverty reduction and better health, it is a key aspect of healthy public policy: health benefits need not be enormous to be important. In the case of diversity, employees who feel more included are almost certain to feel less stress, which can often be related to, or directly cause, certain health problems.[32]

Healthy Public Policy in Ontario Municipalities

As has been made clear throughout this report, one of the most important aspects of healthy public policy is that it must cross government and sectoral lines. Several Ontario municipalities have clearly taken this to heart, as the following examples make clear.

Peterborough Community Food Security Partnership

Food insecurity is the term applied when the availability of nutritionally adequate and safe foods, or the ability to acquire those foods in socially acceptable ways, is limited or uncertain.[33] In September 2006, the Peterborough County-City Health Unit launched its Food Security Community Partnership Project (FSCPP) to address the problem of food insecurity. The goal of the project is to bring together community members and organizations to develop a coordinated and innovative system of food security programs that help ensure that low income people in the region have access to affordable, nutritious foods. The community partners work with the health unit to deliver these programs. This partnership has now spawned a larger Community Food Network, composed of over 40 agencies, partners and stakeholders, addressing food insecurity as part of Peterborough's poverty reduction efforts.[34] For more information, please visit www.pcchu.ca/food.

Fact

In Peterborough, food insecurity affects 7.3 per cent of the population with 2.4 per cent categorized as severe.[35]

Halton Our Kids Network

It is beyond dispute that the very earliest childhood experiences, from the prenatal period through a child's early years, have a truly significant influence on that child's future health. In recognition of this crucial fact, the Halton Our Kids Network was established in 1996. The initial focus was creating awareness of the value of the early years and providing care and support to families and children in the prenatal period through to age six. The initiative has since been expanded to include children as old as 18 years. More than 90 individuals from community-based groups and agencies work together to make sure that Halton children and youth have the help they need to do well in school and in life. For more information about the Network go to www.OurKidsNetwork.ca.

Toronto Shade Policy and Guidelines

Skin cancer resulting from overexposure to ultraviolet radiation (UVR) is the most common cancer in Ontario, representing one third of all new cancer cases. An effective way to prevent skin cancer is to reduce overall exposure to sunlight. From a public policy point of view, there are two ways to limit this exposure. One is by raising public awareness of the dangers of ultraviolet radiation and outlining measures for personal protection, and the other is by providing more shade. In 2007, the Toronto Board of Health approved the *Shade Policy for the City of Toronto*.[36] The policy is the first of its kind in North America. It stipulates that the provision of adequate shade, either natural or constructed, should be part of planning the design of any new municipal facilities, or the refurbishment of existing sites, especially where children are in attendance. *Shade Guidelines* were developed in 2010 to assist City of Toronto agencies, boards, commissions and divisions with the implementation of the policy (www.toronto.ca/health/resources/tcpc/shade_guidelines.htm). An evaluation plan is being developed to assess uptake and outcomes from implementing the policy.

Sudbury & District Health Unit Video

This last example is a little different, highlighting as it does less a specific initiative than a clear understanding of the need for healthy public policy. In fact, this video, produced by the Sudbury & District Public Health Unit, helped inspire the title of this report. The video is called "Let's Start a Conversation About Health...and Not Talk About Health Care at All," http://www.sdhu.com/content/healthy_living/doc.asp?folder=3225&parent=3225&lang=0&doc=11749#video and it is inspiring in a number of other ways as well.

The video was developed as a tool to engage individuals and organizations from all sectors in thinking about ways to achieve healthier communities. It lists five key messages that need to be understood if we are to have conversations about health that will really improve the lives of Ontarians.[37] They are:

- Health improves at every rung up the income and social ladder
- Everyone has different opportunities for health, largely influenced by their social and economic conditions
- Social and economic conditions are the result of actions that all of us can take. Individually and collectively, we CAN make decisions and choices that are good for our communities and good for our health
- Health care alone cannot fix our health problems

= WE ALL HAVE A ROLE TO PLAY

Conclusion

"You have to look at health systems, you have to look at essential medicines, you have to look at tobacco control, at the gender unit, at the laboratory services, at the nursing training, at human resource development, at nutrition, at urban planning and urban health...we got ourselves in this mess and it will take all of us to get out of it."[38]

Dr. Mirta Roses
Director, Pan American Health Organization

It is time for a new conversation about health in this province and, as the Sudbury & District Public Health Unit video points out, very little of that conversation is about health care. It has to involve every government ministry, every government stakeholder, every community leader and every Ontarian. This conversation has to have, as a starting point, a clear understanding among all parties that the factors that influence health, and the ways through which we can improve health, lie for the most part outside the traditional health care and health promotion sectors.

When I suggest that we need to start a conversation about health without talking about health care, I am not in any way suggesting that we should lessen the quality of health care of which Ontarians are proud and fortunate to receive. What I am saying instead is that the world-class health care system that we have in Ontario cannot be held solely responsible for improving the overall health of our population. Good health starts long before we visit doctors. It starts in childhood, in our homes, in our schools, our workplaces and our communities. Health care systems exist to help people after they get sick or injured. This conversation needs to be about giving Ontarians a head start on good health, and preventing them from getting sick or injured in the first place.

Ontario's Operation Health Protection (OHP) was launched in 2004, after SARS, in order to revitalize a public health system that was badly in need of renewal.[39] It has been, in my view, a real success. As a result of the initiative, infectious disease control in this province has been greatly improved, as has the management of health emergencies. Ontario's public health laboratories are being modernized and strengthened, and the Ontario Agency for Health Protection and Promotion, now called Public Health Ontario, which was created as part of OHP, links public health practitioners, front-line health workers and researchers to the best scientific intelligence, evidence, and knowledge from around the world. This is not to say that Operation Health Protection has run its course. We need to keep the pedal to the floor when it comes to protecting the health of Ontarians, and no one must read anything to the contrary into my arguments for better prevention. But what I want to see in this province is a new initiative, as successful and effective as Operation Health Protection, that is geared towards health promotion, chronic disease and injury prevention.

Sixty per cent of Ontarians are overweight or obese.[40] Many of these people will develop health problems as a result. Injuries are the biggest cause of death for Ontarians under 45.[41] Thirteen thousand smokers in Ontario die every year – that is a death every 40 minutes.[42] Most of these deaths are preventable.

As outlined earlier in this report, most chronic diseases can be avoided through an improved diet, more activity and sensible attitudes towards alcohol and tobacco. Cancer, heart disease, diabetes, mental health issues – none of these need to be exacting the toll that they do. But they do. And our health system, including the public health system that I am fiercely proud to oversee, can do little to change that.

Whether we call it Operation Healthy Ontario, Operation Health Promotion, Operation Prevention or something else entirely, we need to re-engineer activity back into the lives of Ontarians. We need to encourage and enable them to eat more fruit and vegetables, drink less alcohol and not smoke at all. We need to provide them with safer roads and workplaces, and help them modify the behaviours that cause them harm.

In this report, I have described a number of initiatives here in Ontario and across Canada that prove that there are ways of accomplishing these things. They can be done. They are being done, repeatedly and with great success. Governments and their partners are doing great things. They are implementing healthy public policies, but these policies are not being framed as such, and they are not part of any kind of overall comprehensive plan.

There isn't a doctor alive who wouldn't agree that ensuring children are eating fruit and vegetables is a great way to improve their health, but there is seldom anything that a doctor can do about it. Similarly, a Health Minister, or a Chief Medical Officer of Health, might be very clear on the fact that poverty is causing ill health in the population, but solving that problem lies well outside his or her sphere of responsibility and influence. What we need in Ontario, and in Canada, is a comprehensive plan to address the disconnect between what we know needs to be done and our ability to do it.

What follows are a number of suggestions that might serve as a starting point here in Ontario.

Health Lens – We need to start applying a health lens to every program and policy in this province, at the provincial, regional and municipal levels, so we can be clear on the health benefits or potential impacts of everything we do. Whether it is a variation on the Health Impact Assessments that are being used successfully in other jurisdictions, including Quebec, or a made-in-Ontario lens, it is badly needed.

Goals and Targets – What gets measured gets done. There need to be clear goals and targets for every single health benefit we want to achieve and every single health problem we want to prevent. ActNow BC, described earlier, is a good example of that kind of thinking.

Health Indicators – Health indicators are measures of health and of the factors that affect health. They range from infant mortality rates to numbers of injuries to hospital readmission rates to fruit and vegetable consumption. We need to settle on a finite list of these indicators that, studied properly, will paint for us a picture of how healthy we are, where geography, gender, culture and economic status are causing health inequities in our province, and how we might try to address these inequities.

More Collaboration – The key to the development and implementation of healthy public policy is the development of relationships to enable collaboration across government, different sectors and communities. We need to tear down the structural impediments to collaboration that are in place throughout our province. These are created by the lack of alignment of boundaries between the municipal sector, health sector, education, social services, environment, transportation – some of the key sectors/ministries that need to work together to improve health. Co-terminus regional administrative boundaries would greatly facilitate the collaboration needed to address the risk factors related to chronic diseases and injuries, and would enable the development of effective, efficient, synergistic and longer lasting relationships, partnerships, and regional planning, all of which would contribute to better health in this province.

Harnessing the Full Potential of Our Health Care System – A similar situation exists within the health sector itself. Our health care system does not make the best use of its available resources to support prevention – to seize every patient interaction as an opportunity to inform patients about health promotion and disease prevention strategies. Greater collaboration between public health, primary care and acute care would enable the health care system to leverage its resources to dramatically reduce the health burden and health care demands of preventable chronic conditions.

We Need to Catch People Doing the Right Thing – Put another way, we need to recognize, celebrate and reward the health achievements of both the health and non-health sectors. By way of example, our impressive record in reducing traffic fatalities is not well recognized, nor are the specifics of how this was achieved well understood.

I believe we all want an Ontario in which every child that is born starts out and remains on the road to lifelong good health. It is a road that starts with a healthy, safe and loving home environment in an equally healthy, safe and generous community. It is a road along which he or she is introduced early to the concept of good nutrition and the glory of regular physical activity. It's a road that goes through good schools where diversity is celebrated, inclusion is supported, and tobacco and harmful alcohol use are discouraged. It is a road where learning is everything, and leads eventually to a good job, in a healthy workplace, and a good home. We can build this road – for ourselves and our children. All our children. So let's have a new conversation about health, and let's develop a strategy to become the healthiest people in the world.

Appendix

Ontario Health Units with Vacant Medical Officer of Health (MOH) Positions Filled By Acting MOHs as of October 20, 2011

Chatham-Kent Health Unit
Elgin-St. Thomas Health Unit
Haldimand-Norfolk Health Unit
Lambton Health Unit
The Regional Municipality of Niagara
County of Oxford Department of Public Health and Emergency Services
Perth District Health Unit*
Porcupine Health Unit*
Thunder Bay District Health Unit*
Timiskaming Health Unit
Total = 10

**Vacancies include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*

Ontario Health Units with Vacant Associate Medical Officer of Health (AMOH)* Positions as of October 20, 2011

Windsor – Essex County Health Unit
Total = 1 Health Unit with an AMOH Vacancy**

**Under 62. (1)(b) of the Health Protection and Promotion Act, every board of health may appoint one or more associate medical officers of health.*

***Vacancies may include less than or more than one FTE position per health unit and include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*

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