HEALTHY FAMILIES BC POLICY FRAMEWORK

A Focused Approach to Chronic Disease and Injury Prevention
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EXECUTIVE SUMMARY

Over the past few decades, a number of evidence-based public health initiatives have been launched in BC. These initiatives have been instrumental in decreasing the incidence of chronic disease, as well as in reducing premature mortality rates. However, one in three British Columbians is still living with at least one chronic condition, and the burden of preventable injury and disease in the province is significant. Continued and enhanced efforts in prevention are needed to further improve the health of British Columbians, reduce inequities in health and contribute to the financial sustainability of our health care system.

In March 2013, the Ministry of Health released *Promote, Protect, Prevent: Our Health Begins Here. BC’s Guiding Framework for Public Health* (the Guiding Framework), a directional document for the public health system with long-term goals and targets to drive system-wide action and improve health outcomes. In order to reach the ten-year targets, a significant amount of work must be done across the province, at local and regional levels to reduce risk factors and increase protective factors for major chronic diseases and injuries.

The Ministry of Health is building on the original Healthy Families BC (HFBC) platform—introduced in May 2011 as a Key Result Area of Health System’s Innovation and Change Agenda—to operationalize four of the goals in the Guiding Framework. This new HFBC Policy Framework includes seven focused intervention streams under which work will be focused for the next three years, as well as a set of approaches to guide implementation.

The HFBC Policy Framework provides the rationale for each focused intervention stream, sets the foundation of effective evidence-based work in each and identifies the policy direction. The paper also outlines the key approaches that health authorities are encouraged to use to implement the strategy and notes key areas of work that will be required, including data and surveillance, accountability mechanisms, and the development of a performance and evaluation framework.
INTRODUCTION

THE DIRECTION

The Minister of Health’s Mandate Letter includes a requirement to work with health authorities to develop a “preventative health plan” for the province. It also directs the Ministry to continue the Innovation and Change Agenda and drive results for key health system priorities, including prevention.

DEFINING POSITION

Improving overall population health in BC will result in reductions in both chronic disease and injuries; it will also help reduce inequities in health status and health outcomes and reduce the growth of health care costs. Unhealthy eating, physical inactivity, tobacco use and risky alcohol use are all significant risk factors for chronic disease. These behaviours are strongly mediated through known environmental factors, which can be modified to exert significant protective effects. Working on these factors at a population level can help make the healthy choice the easier choice, prevent disease and injury, support healthy growth and development and foster positive mental health across all stages of life.

BC has built a strong prevention foundation and is seeing results; however, sustained efforts are required, and a more focused approach needs to be taken in order to further prevent and reduce avoidable illness, injury and the associated care and treatment costs.

SCOPE

Building on the existing Healthy Families BC platform, this policy framework sets out a focused approach to chronic disease and injury prevention for the province that uses evidence to design interventions that address the major risk and protective factors over the life course and in key settings. The new HFBC Policy Framework more explicitly applies behavioural and public health science to promote health and shift behaviours in order to improve outcomes, reduce the demand for care and treatment, and improve overall health system sustainability.

STRATEGIC ALIGNMENT

Promote, Protect, Prevent: Our Health Begins Here. BC’s Guiding Framework for Public Health

In March 2013, the Ministry of Health released the Guiding Framework, which serves to improve the health and wellness of British Columbians by:

• Developing a long-term vision, goals, objectives and measures for the public health system;
• Formalizing a collaborative priority-setting process;
• Reinforcing core public health functions as the foundation for public health services;
• Supporting a population health approach and the public health role in health equity; and
• Connecting to and supporting self care, primary care and clinical prevention.

The Guiding Framework unifies existing provincial resources and public health strategies and formalizes a collaborative process for identifying and setting new priorities, making strategic investments and increasing focus in key areas that contribute to health improvement. The HFBC Policy Framework serves to mobilize action under four of the Guiding Framework goals and supports progress towards the publicly committed ten-year targets.

Setting Priorities for the BC Health System

The HFBC Policy Framework represents Priority #2 in the new Health System Strategy: Setting Priorities for the B.C. Health System. While the HFBC Policy Framework is based on a three-year planning horizon, it is recognized that many population and public health interventions take sustained effort over much longer time frames in order to have measurable results. Policy actions will need to be scaled by health authorities as appropriate and sustained beyond the three-year window to improve health outcomes and realise cost avoidance associated with a reduced burden of disease.
**CONTEXT**

**PREMATURE MORTALITY RATES**

During the 1990’s, preventable premature mortality rates fell on a consistent basis in BC. This was due to a number of interrelated factors including advances in primary care and stronger efforts in public health and prevention—particularly related to smoking. During the 2000 to 2006 period, however, rates of preventable premature mortality flattened as the impact of earlier successes began to diminish. Then in the latter half of the decade, these rates began to fall again as more recent prevention strategies which focused on a broader range of risk factors began to affect the rates.

This transition was also reflected in the incidence of a number of major chronic diseases, such as those primarily related to smoking (Figure 1). However, additional chronic diseases driven by other risk factors, such as diabetes and hypertension, were slowly rising before reaching a peak in the latter half of the decade (Figure 2).

**Figure 1.**

![Decreasing Chronic Conditions](image1)


**Figure 2.**

![Chronic Disease Incidence Peaked](image2)

During the last five years a decreasing trend reappeared in association with renewed population-based prevention and health promotion activities including Act Now BC and HFBC. However, these trends are not consistent across all regions or socio-economic or cultural groups, and in particular the gap between the North and the other health authorities is growing (Figure 3).

Figure 3.

**BURDEN OF DISEASE**

By far the largest proportion of total health care costs is directly or indirectly attributable to chronic disease (Figure 4). One in three British Columbians is living with one or more diagnosed chronic diseases, and a further 2% of the population is living with four to six chronic diseases. People with multiple complex chronic diseases such as diabetes, heart disease and cancer, use the most hospital, PharmaCare and home and community care services, and are also high users of general practitioner and specialist services. Furthermore, at any given time about 21.4% of the working population experiences mental health challenges, which can directly affect the contribution they are able to make to their job – this costs the BC economy an estimated $6.6 billion in lost productivity each year (not including patient care, insurance for employers, community services, and the many intangible costs for affected individuals and their families).

Reducing injuries can also improve physical and emotional health at a population level. In recent years, the burden of injury has been recognized at the provincial/territorial, national and international levels. The leading causes of death from unintentional injury include falls, transport-related injuries and unintended poisoning. Injuries can be prevented by making homes, communities, schools, work sites and care settings safer; strengthening and implementing community-based prevention policies and programs; and focusing efforts among groups at highest risk for injuries, including children, youth and older adults.

1 Investing in prevention: Improving Health and Creating Sustainability. The Provincial Health Officer Special Report. 2010
MAJOR PROTECTIVE AND MODIFIABLE RISK FACTORS

The main modifiable risk factors for chronic disease and some mental health disorders include unhealthy weight (overweight/obesity), physical inactivity, unhealthy eating, tobacco use and harmful alcohol use. Up to 80% of heart disease, stroke and type 2 diabetes, and over 30% of cancers, can be prevented by eliminating tobacco, unhealthy diet, physical inactivity and the harmful use of alcohol. However, these behavioural risk factors are embedded in, and often determined by, a number of socio-environmental factors (e.g., cultural, environmental, economic, etc.), which makes addressing the issue of chronic disease complex. For example, obesity and other weight-related issues are shaped by the broader social, cultural, economic, political and environmental contexts in which we live, learn, work and play. As such, in order to improve overall health, interventions must recognize and address the complex relationships that exist between the factors that determine our health. Furthermore, these factors can impinge on access and use of services, which can further complicate health outcomes.

BC compares well with the rest of the country on these behavioural risk factors and has the best rates on all except fruit and vegetable consumption (a key marker for healthy eating), where we are a close second behind Quebec. However, there are still over 550,000 British Columbians who smoke, over 1 million people who are overweight or obese and over 1.5 million who are physically inactive. Effectively influencing these risk factors and reducing barriers to access and utilization are key to further improvements in the health of the overall population of BC.

The Guiding Framework sets out ten-year targets for key performance measures. Figure 5 compares BC’s performance on key risk factors with the Canadian average (2011/12 data) and illustrates the targets listed in the Guiding Framework for 2023. As risk factor rates become lower they become more challenging to reduce further and have diminishing returns, so our continued success depends not only on sustained efforts in areas where policy is proven to work, but also on innovation and stronger strategies/approaches that provide additional support to key population groups where necessary.

Investing in evidence-based prevention interventions, effectively supporting individuals in making healthier choices (such as eating healthy foods, being physically active, reducing alcohol consumption and living tobacco free) and reinforcing protective factors (such as those that support healthy early child development) can help prevent the onset of many chronic diseases. We are already realizing a health dividend from past prevention activities that have reduced rates of heart disease and some cancers (e.g., lung, larynx and stomach), but these targets show that there is still progress to be made.

It is estimated that a 1% annual reduction in risk factor prevalence (smoking, excess weight and physical activity) would result in an annual reduction of $286 million in health care costs by 2031 for a cumulative cost reduction of $2.6 billion.4

Figure 5.

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HEALTH INEQUITIES

Evidence shows that vulnerability, especially early in life, is associated with poorer health outcomes, such as shorter life expectancy or more years living with disability. Additionally, social and economic conditions affect people’s lives and determine their risk of illness, their ability to take preventive measures and often their access to care.

For example, social determinants play a part in the likelihood for certain population groups to stop smoking (Figure 6) and the consequent health inequities. Historically, the propensity to start smoking has shown a positive relationship to income and this relationship is present in middle-aged and older persons in the population. More recently, for young adults the gradient across income groups with respect to initiating smoking has largely disappeared, although the rate of smoking remains higher in lower income people.

However, in the population as a whole, lower income people are more likely to be current smokers because they have been substantially less likely to quit than higher income smokers, despite their lower lifetime smoking rates. It is also important to note that there is a strong relationship between smoking and mental health. Persons with fair or poor self-rated mental health are almost four times more likely to smoke than persons with excellent self-rated mental health (Figure 7).

For example, public health makes an important contribution in efforts to ensure every child gets a healthy start in life. All expecting parents are offered prenatal classes, maternity and perinatal care, and a post-natal public health nurse telephone assessment. Many parents and newborns benefit from short-term services with more intensity, such as breastfeeding support. A smaller group, such as young, first-time low income mothers, may participate in a program with longer-term regular public health nurse home visits, while the most vulnerable pregnant women in our province are offered high-intensity supports through pregnancy outreach services. Taken together, this approach is intended to support good health outcomes for all newborns and infants and improve health equity, especially since a healthy start is an important predictor of positive health outcomes much later in life.

Ensuring that vulnerable populations are identified is critical in order to design appropriate interventions, inform decision-makers within and beyond the health system, and support efforts to address the underlying causes of the disparities (see later section “Tailor Actions to Address Specific Health Disparities and Inequities and Maximize Reach”).

Figure 6.

Smoking by Income 2011/12

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Never Smoked</th>
<th>Smoke Daily</th>
<th>Former Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>60</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>55</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>50</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>45</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Highest</td>
<td>40</td>
<td>55</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey 2011/12

Figure 7.

Daily Smoking by Self-Rated Mental Health

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Smoking Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>5</td>
</tr>
<tr>
<td>Very Good</td>
<td>10</td>
</tr>
<tr>
<td>Good</td>
<td>15</td>
</tr>
<tr>
<td>Fair</td>
<td>20</td>
</tr>
<tr>
<td>Poor</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: Canadian Community Health Survey 2011/12

However, promoting health equity and reducing health disparities requires more than just focusing on the most disadvantaged groups. To reduce disparities in access to good health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is referred to as proportionate universality.5

FIRST NATIONS AND ABORIGINAL HEALTH

For many reasons, First Nations experience higher rates of chronic disease and sustain more injuries than other British Columbians. The unique root causes for the health challenges faced by First Nations and Aboriginal peoples today need to be considered when recommending programs and services to improve health outcomes. The Government of BC, First Nations Health Council and the Government of Canada are partners in the Tripartite First Nations Health Plan (TFNHP, 2007) and the Tripartite Framework Agreement on First Nation Health Governance (2011), which provide an important operational platform for taking action based on a commitment to ensuring that First Nations in BC are involved in decision-making regarding their health.

The First Nations Health Authority was established in October 2013 to improve the health of communities by advancing the quality of health care, health promotion and chronic disease/injury prevention programs delivered to BC First Nations and Aboriginal people. The Ministry of Health and regional health authorities will work with the First Nations Health Authority to ensure the HFBC Policy Framework is aligned with the First Nations Perspective of Wellness and can be adapted, if necessary, to fit the unique needs of First Nations and Aboriginal people in BC.
1. USE MULTIPLE TOOLS OF INFLUENCE

Complex health issues require complex approaches to resolve them. To be most effective in addressing the burden of disease, chronic disease prevention initiatives need to utilize multiple tools of influence (i.e., legislation and regulation, taxation and pricing, education and information, programs and services), involve multiple sectors (i.e., whole of government, municipal, business, non-governmental organizations, civil society), be delivered across multiple settings and be sustained over time (Box 1). The HFBC Policy Framework directs health authorities to use a combination of levers across each focused intervention stream in order to most effectively shape behaviour and influence outcomes.

Box 1.

**USING MULTIPLE TOOLS OF INFLUENCE TO SHIFT CULTURAL PARADIGMS – TOBACCO REDUCTION EXAMPLE**

In 2003, The World Health Organization released a treaty in response to the globalization of the tobacco epidemic that reaffirmed the right of all people to the highest standard of health. Signatories of the treaty, of which Canada was one, committed to shift the tobacco use paradigm by addressing a variety of complex factors associated with use and distribution:

- Price and tax measures to reduce the demand for tobacco, and
- Non-price measures to reduce the demand for tobacco, namely:
  - Protection from exposure to tobacco smoke;
  - Regulation of the contents of tobacco products;
  - Regulation of tobacco product disclosures;
  - Packaging and labelling of tobacco products;
  - Education, communication, training and public awareness;
  - Restrictions on tobacco advertising, promotion and sponsorship; and,
  - Demand reduction measures that focus on tobacco dependence and cessation.

Over the past decade, BC (and/or Canada) has taken action on all items under the global strategy. Because of this broad-based, multi-pronged approach, smoking rates have declined from approximately 50% nationally in the 1960s to a low of 14.5% in BC (2012). Other successes include:

- Lowest smoking rate in Canada.
- Lowest rate of children exposed to second-hand smoke in Canada.
- Health care costs legislation upheld by Supreme Court of Canada.
- Over 130,000 have registered for BC Smoking Cessation Program.
- Ban smoking in indoor public/workplace and buffer zones; display and promotion to youth; sales in publicly owned buildings; and tobacco use in schools (except for traditional Aboriginal ceremonial use).

These successes demonstrate that prevention interventions, particularly those that address complex behavioural risk factors, require multiple tools of influence to shift the cultural paradigm. This approach also provides additional supports to high-risk populations and integrates actions across key settings to maximize reach.
2. Tailor Action to Specific Times Across the Life Course

Understanding and responding to the physical, social and emotional hazards that can occur during gestation, childhood, adolescence, young adulthood and midlife can have an enormous impact on chronic disease risk and health outcomes throughout life.

Figure 8.

The life course approach is already being used in the BC Lifetime Prevention Schedule, which outlines key points for clinical prevention, such as cancer screening or immunization, at different stages of life based on age and gender and patterns of risk for these groups. The HFBC Policy Framework directs health authorities to align work with the BC Lifetime Prevention Schedule wherever possible, ensuring the use of a life course approach and focusing attention on preconception, maternal and early childhood interventions to affect the trajectory of a child's life into adulthood. It also requires that health authorities address specific gender and age groups with a high prevalence of risk behaviour (e.g., young men in the trades), or key transition periods, such as school transitions, pregnancy or hospitalization, where prevention or behavioural change is known to be more effective.

3. Deliver Within Key Settings

An effective health promotion approach operates in many settings and considers the social, physical and economic environments of the communities in which people live, work, learn and play. These settings are also key arenas in which multiple risk and protective factors can be addressed at the same time, rather than in isolation.

For example, communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health. Furthermore, schools are a priority setting for the promotion of overall healthy living as they have the ability to reach almost every child, and by extension, almost every family regardless of a child's age, ability, gender, culture, or socio-economic background.

KEY LIFE COURSE TRANSITION: SENIOR YEARS

Changes to establish healthier lifestyles can occur at various key points along the life course. The shift from full engagement in the workforce towards older age and retirement is a particularly important transition point for many people. The ministry is currently developing a toolkit to help pre-seniors prepare for this transition, and encourage them to make plans for the significant life changes that they will likely face. By starting this process earlier, individuals will have more time to make good choices — rather than being forced to act in a time of crisis — thereby having to rely less on support from the system.

6 The Ottawa Charter (1986)
This approach requires the public health system to work closely with local governments, community organizations, schools and employers in delivering consistent healthy living messages across all settings and developing health-promoting environments that maximize the reach and impact of healthy living strategies.

The HFBC Policy Framework builds on the existing settings models of Healthy Families BC Communities, Healthy Families BC Schools and Healthy Families BC Workplaces to influence overall health and support healthy lifestyles through the design and development of healthy built environments. Furthermore, it recognizes that healthy living interventions, such as tobacco cessation, can also be done effectively though primary care networks. Therefore, the HFBC Policy Framework introduces primary care physician offices as a new “setting” for prevention, complementing the work already under way, and directs health authorities to connect more effectively with primary care, community care and acute care networks to design and implement prevention initiatives that better support patients and improve health literacy.

4. **TAILOR ACTIONS TO ADDRESS SPECIFIC HEALTH DISPARITIES AND INEQUITIES AND MAXIMIZE REACH**

Health can vary greatly between individuals and populations for a number of reasons. Unequal or inequitable distribution of economic and social resources in some geographic locations, between men and women or between populations, also contributes significantly to the health status of populations. Additionally, these factors are often interrelated. For example, there might be a higher prevalence of illness in one region; however, there could be several sub-populations within that geographical location, all with varying culture, age, gender, employment, or socioeconomic situations that further influence the well-being of the whole community (box 2). These connections are essential to consider when developing targeted interventions. Therefore, the HFBC Policy Framework directs health authorities to use data in order to understand differences between certain populations and communities in order to appropriately develop supportive policies, scale the intensity of interventions, inform decision-makers within and beyond the health system and support efforts to address the underlying causes of disparity.

**Box 2.**

**HEALTH DISPARITIES IN BC – THE OBESITY EXAMPLE**

While the obesity rate in British Columbia is the lowest among all provinces at 15% in 2011/12, there is considerable variation across the province, ranging from a low of 7.4% in Richmond to rates in excess of 19% in five Health Service Delivery Areas (HSDAs): Northwest, Northeast, East Kootenay, Central Vancouver Island and Northern Interior. All of these rates are significantly higher than the provincial rate. Not surprisingly, these are also the areas of the province that tend to have the highest rates of morbidity and mortality from weight-related causes.

At the same time, the largest number of obese people live in areas of the province that report the lowest rates of obesity. The positive outcomes that BC records on most risk factors mirror those of obesity: they tend to be attributable to the healthier lifestyles that are apparent in the most populated areas of the province—the Lower Mainland and Southern Vancouver Island (regions that also have the highest socio-economic ranking according to census data). These rates can mask the extensive variation that occurs in other areas, particularly in the northern regions. Therefore it is difficult to rely only on provincial or regional rates when designing interventions.

The pronounced variation among HSDAs underlines the need for ongoing strategic initiatives that are directed at lowering risk-related behaviours in targeted areas and within targeted groups. Ignoring this variation can lead to a false sense of complacency, which will maintain the wide geographical variation across BC.
5. **Shift Modifiable Behaviours Using Behavioural Science and A Range of Policy Tools**

Health and well-being is influenced by a wide range of social, cultural, economic, psychological and environmental factors that interrelate across our lives. Insights from behavioural economics indicate that small changes to the environments or information people are exposed to can exert a powerful influence on behaviour. Since not all behavioural risk factors can be successfully addressed using direct techniques like legislation, other cost-effective methods, such as those that make environments more conducive for healthy choices, are required to help drive results for individuals and society. The HFBC Policy Framework explicitly employs this approach by promoting the use of data to understand the determinants of behaviour, and the application of educational and policy interventions designed to improve literacy and shift that behaviour or associated cultural norms or attitudes.\(^7\)

Box 3.

**Social Marketing and Digital Infrastructure as a Key Interface for Health Promotion**

Social marketing is a key element among the many levers available to support behaviour change. Drawing on marketing and behavioural science with regard to lifestyle choices, human reactions to messages and message delivery, social marketing has immense potential to influence behaviour.

The era of engagement has opened up new settings and with that opportunity, the HFBC Policy Framework is taking its cue from behavioural science to help target interventions and engage and incent the population through new channels, such as digital and mobile media.

Since its launch in May 2011, continued investments have been made to ensure that the HFBC digital assets strategy for the healthyfamiliesbc.ca website, blog, Facebook, Twitter and YouTube channels focus on building relevant content to maximize engagement and supporting individuals at various stages of behaviour change. To date, the HFBC site has close to 1.4 million page views, 35% of traffic is returning visitors, average time spent on site is over three minutes (versus industry standard of one minute), over 19,000 HFBC web-registered community members and over 400 blogs on healthy living supported by regular dietitian, certified exercise physiologist and guest bloggers – now expanding to include other “Champions of Health” in the system. HFBC is considered to be among the top BC Government online properties. The social media channels of Facebook, Twitter and YouTube rank high against the most notable health social sites such as NHS, Heart and Stroke Foundation Canada and Michelle Obama’s Let’s Move. Number of followers and reach on social media continues to grow.

Building on this foundation, the Ministry will continue to investigate opportunities with key partners and health authorities to reach the public, promote health and influence social change.

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\(^7\) MINDSPACE Behavioural Economics. [http://www.instituteforgovernment.org.uk/our-work/better-policy-making/mindspace-behavioural-economics](http://www.instituteforgovernment.org.uk/our-work/better-policy-making/mindspace-behavioural-economics)
FOCUSED INTERVENTION STREAMS

Over the past decade, a number of initiatives with substantive prevention components have been initiated in BC, including ActNow BC, Healthy Families BC, the Tripartite First Nations Health Plan and Healthy Minds, Healthy People. This is in addition to the broad range of foundational public health services and programs that are delivered within BC (e.g., immunization, screening, tobacco cessation and control, etc.).

Building on this foundation, the Ministry is setting the policy direction for health authorities through seven focused intervention streams. This direction has been determined based on a combination of evidence, impact on the burden of disease, impact on population (reach), role in reducing health inequalities, implementation requirements and ability to support progress towards goals and targets in the Guiding Framework.

The following section provides a detailed overview of the evidence for each intervention stream, outlines the current state and then provides a high-level description of the general policy outline for health authorities to operate within going forward. The approaches outlined in the previous section will be overlaid over each intervention stream to ensure programs and services are being applied in a way that reaches the right people at the right time with the right services and/or tools. Based on community and HSDA/LHA profiles and the prescribed targets in the Guiding Framework for each, health authorities will be required to identify opportunities to implement new or expanded initiatives that will help achieve their targets. The Ministry will be developing evaluation frameworks and accountability agreements to measure progress.

HEALTHY EATING

Evidence/Rationale:

Food is a prerequisite for, and a determinant of health. The food we eat defines to a great extent our health, growth, and development and our ability to function well in a complex world. Healthy eating promotes and supports social, physical, and mental well-being for all people at all ages and stages of life and contributes to the overall health of individuals, families, and communities.

The consumption of and access to food is related to a complex food system that includes production, processing, distribution, availability and affordability. All of these interrelated components can work to either support or interfere with the access and affordability of healthy food choices for populations. Any barrier, break or weakness along the food system can undermine the ability of the population to access safe, nutritious food, which can then undermine their health and wellness. A focus on the food system is essential to support healthy food choices.

We have seen major changes in our food system and food and eating environments over the past decades. Food is now readily available and accessible in multiple settings throughout the day. More processed and convenience foods are available—in larger portion sizes and at relatively low prices—and are reinforced by strong advertising that is often directed towards children. Parents are working longer hours, there are fewer family meals, and more meals are eaten away from home. Collectively, these environmental changes have influenced what, where and how much we eat and are thought to have played a substantial role in the current obesity epidemic.

OBESITY AND OVERWEIGHT IN BC

Unhealthy eating is one of the most common, yet modifiable, risk factors that contribute to obesity and the development of chronic diseases such as heart disease, diabetes, hypertension, osteoarthritis and certain types of cancer. Overweight and obesity are major risk factors for a number of chronic diseases, including diabetes, cardiovascular diseases and cancer, and it is the second highest preventable, contributing cause of death in BC after tobacco use.

Although BC enjoys the lowest rate of persons with excess weight among the provinces, this provincial average largely reflects the lower rates in the most populated areas of the province: the south western mainland and southern Vancouver Island. There is substantial variation among HSDAs: from a low of 33% in Vancouver to a high of 61% in the Northeast HSDA (Canadian Community Health Survey 2011/12). There is also substantial variation among population groups. For example, males have a substantially higher rate than females and higher income males have a substantially higher rate than lower income males.
Healthy eating contributes to best possible health through positive relationships with food, and diverse and balanced food choices that meet the body’s needs for nutrients and energy. Healthy eating also promotes and supports social, physical, and mental well-being for all people at all ages and stages of life and contributes to the overall health of individuals, families and communities.

Adequate consumption of fruit and vegetables reduces the risk for cardiovascular diseases, stomach cancer and colorectal cancer. BC has high levels of fruit and vegetable consumption compared to other provinces in Canada; however, there are significant areas (Northern Health Authority and Fraser East Health Service Delivery Area) that report rates well below the national average. There are also significant populations (persons with lower levels of income and education) who report relatively low levels of fruit and vegetable consumption.

Targeted healthy eating interventions that address certain micro-nutrients of concern, such as sodium, sugar, and transfat are important to help prevent key chronic diseases. For example, high sodium intake increases blood pressure, which is a major risk factor for stroke, heart disease and kidney disease. The World Health Organization calls high blood pressure the leading preventable risk factor for death around the world. If sodium intake of Canadians is decreased to close to 1,500 mg per day from present intakes, hypertension prevalence would decrease by 30%, resulting in 1 million fewer patients with hypertension. The direct savings to the health system from fewer physician visits, lab tests and drug use would be $430 million.

Current State:
The following are key objectives of a focused approach to healthy eating in BC:

- Providing British Columbians with the knowledge and skills to make the healthy eating choice.
- Providing health-promoting environments to make the healthy eating choice the easier choice for all.
- Acting collectively to implement a comprehensive province-wide healthy eating strategy (common agenda) to optimize the impact on healthy eating outcomes in BC.

An overarching healthy eating strategy (including the initiatives under HFBC) helps to ensure the greatest effectiveness and coordination of healthy eating initiatives across the province. The eight priority areas currently under this strategy include:

1. Maximize Use of Common Healthy Eating Messages and Resources for Consumers and Practitioners.
2. Promote Public Policy that Supports Healthy Eating – Implement a Healthy Eating/Food Environment.
3. Engage the Food Sector to Provide and Promote Nutrition Information and Healthy Food Choices.
4. Expand Food Skills Development.
5. Advance Food Security and Food Safety as Foundational Components of Healthy Eating.
6. Foster Community and Stakeholder Engagement to Achieve the Objectives of the Healthy Eating Strategy.
7. Optimize Province-wide Healthy Eating Programs.

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8 WHO World Health Report 2002, Reducing Risks, Promoting Healthy Life
**Policy Direction:**

Based on the above, one of the main components of this HFBC Policy Framework will be to create supportive environments and opportunities that enable healthy eating. This includes providing people, particularly youth and families, with basic knowledge about healthy eating; targeting information and skill-development for vulnerable groups; and developing policies and practices that target high-prevalence groups with additional supports to help change unhealthy behaviours. It is important that interventions support healthy eating across all settings, particularly with children and youth in schools, so all British Columbians are supported to make healthy choices in all environments.

All work in this area aligns with Goal 1 in BC’s Guiding Framework: *Healthy Living and Healthy Communities* and the following performance measures* will help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of British Columbians (age 12+) who consume at least 5 servings of fruit and vegetables per day.</td>
<td>44% (2009/10)</td>
<td>55%</td>
</tr>
<tr>
<td>The percentage of BC students in grades 3, 4, 7, 10 and 12 who report that at school, they are learning how to stay healthy.</td>
<td>50% (2010/11)</td>
<td>90%</td>
</tr>
</tbody>
</table>

Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

**Physical Activity**

**Evidence/Rationale:**

Physical inactivity is an important risk factor for heart disease, stroke, hypertension, type 2 diabetes, colon cancer, breast cancer, osteoporosis, obesity, depression, anxiety and stress. Regular physical activity helps promote healthy weights and is critical to healthy development in children and adolescents while preserving mobility and independence in older adults.

BC is known for being a leader in physical activity with a consistent reporting of the highest provincial physical activity levels. However, there are currently over 1.5 million British Columbians who are classed as physically inactive. The proportion of the population who are moderately active or active with respect to leisure-time physical activity ranges from a high of 70% in Kootenay-Boundary to a low of 53% in Richmond. Average rates are particularly low among low-income persons and immigrants. It is estimated that physical inactivity costs the British Columbia health care system $335 million a year in direct costs (hospital, physician, drug, institutional and other costs). Physical activity is also becoming a key workplace health concern.

**Current State:**

Physical activity programs, initiatives and strategies in BC strive to help make physical activity the easy choice by providing tools and supports that reinforce the integration of physical activity into a healthy lifestyle. The Ministry, in partnership with ParticipACTION, has established a multi-sector Physical Activity Leadership Table to provide oversight for the development of a Physical Activity Strategy. The proposed five-year Strategy focuses on policy development, change and implementation; targeted information and public education; high quality, accessible programs and services; community design; evidence and knowledge exchange; strategic investments; and mobilization. Health authorities will be responsible for implementing policy and program actions under the Physical Activity Strategy, in accordance with accountability targets set by the Guiding Framework.

The World Health Organization has identified seven evidence-based “best investments” for physical activity, which are supported by good evidence of effectiveness. BC’s Physical Activity Strategy (in development) will also align with these best practices:

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10 Persons age 12 and over who are inactive in leisure time physical activity (Canadian Community Health Survey 2011/12).
11 Canadian Community Health Survey 2011/12
• Whole of School programs.
• Transport policies and systems that prioritize walking, cycling and public transport.
• Urban design regulations and infrastructure that provide for equitable and safe access for recreational physical activity, and recreational and transport-related walking and cycling across the life course.
• Non-communicable disease prevention integrated into primary health care.
• Public education (e.g., mass media) to raise awareness and change social norms on physical activity.
• Community-wide programs involving multiple settings and sectors and that mobilize and integrate community engagement and resources.
• Sports systems and programs that promote sport for all and encourage participation for life.

**Policy Direction:**
This HFBC Policy Framework directs health authorities to use a combination of strategies aimed at the individual, social-cultural, environmental and policy determinants of physical inactivity. This includes setting standards for physical activity; identifying synergies with other interventions; networking with other sectors so that healthy built environments and opportunities for physical activity can be developed; and developing resources that increase people’s awareness of, and tendency to choose active lifestyles in all settings.

All work in this area aligns with Goal 1 in BC’s Guiding Framework: *Healthy Living and Healthy Communities*, and the following performance measures* will help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of British Columbians who are physically active or moderately physically active in their leisure time.*</td>
<td>60%* (2009/10)</td>
<td>70%*</td>
</tr>
<tr>
<td>The percentage of BC students in grades 3, 4, 7, 10 and 12 who report that at school, they are learning how to stay healthy.</td>
<td>50% (2010/11)</td>
<td>90%</td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

*Data source changed to Canadian Community Health Survey.*
**Tobacco Control**

**Evidence/Rationale:**
Tobacco-related illness is the leading cause of preventable death in BC. Tobacco causes up to 6,000 deaths each year, including over 100 non-smokers who die from diseases caused by second-hand smoke. The estimated cost associated with tobacco use in 2012 was $2.03 billion ($670 million in direct health care costs).

Although smoking rates have fallen steadily over the last few decades, the total number of smokers is still a concern. For example, BC still has the fourth largest number of people who smoke with over 550,000 current smokers (Ontario, Quebec and Alberta have more smokers than BC). One of the highest users for tobacco products in the province continues to be those with mental illness and addiction issues.

The Guiding Framework includes an ambitious target to further lower tobacco use in BC to 10% by 2023. This reinforces the need for continued effort, and as such the Tobacco Control Strategy is being refreshed and refined in order to further reduce exposure and decrease the number of smokers in the province. This will be done in consultation with key stakeholders and will further inform the actions for tobacco control moving forward.

**Current State:**
The original Tobacco Control Strategy was launched in 2004 with a goal of reducing death, disease and disability caused by tobacco use, and to reduce its subsequent costs to the health care system. Since then, there have been many successes in reducing the use and impact of tobacco in BC.

The tobacco control program utilizes multiple tools of influence, including legislation, education, program and service delivery, and financial levers to meet the following objectives:

- Prevent initiation among youth and young adults.
- Promote quitting among youth and adults.
- Eliminate exposure to second-hand smoke.

While respecting space for First Nations traditional use of tobacco, the Tobacco Control Act has helped create barriers to access and disincentives for use, while the BC Smoking Cessation Program, QuitNow and other cessation supports have effectively supported many British Columbians to stop smoking.

**Policy Direction:**
Reductions in tobacco use over the past decade have reinforced the effectiveness of using multiple tools of influence across key settings in order to change behaviour. This HFBC Policy Framework directs health authorities to continue focusing on population wide prevention, protection and cessation initiatives and enhancing targeted cessation efforts to current users and known high-risk populations, while increasing awareness and prevention initiatives that help ensure people (particularly youth) don't start smoking.

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15 Canadian Community Health Survey 2011/12
All work in this area aligns with Goal 1 in BC’s Guiding Framework: *Healthy Living and Healthy Communities*, and the following performance measures* help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of British Columbians (age 15+) who smoke.</td>
<td>14% (2011)</td>
<td>10%</td>
</tr>
<tr>
<td>The percentage of BC students in grades 3, 4, 7, 10 and 12 who report</td>
<td>50% (2010/11)</td>
<td>90%</td>
</tr>
<tr>
<td>that at school, they are learning how to stay healthy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage of new mothers who report smoking during pregnancy.</td>
<td>8.6% (2010/11)</td>
<td>4%</td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

### Healthy Early Childhood Development

**Evidence/Rationale:**

Healthy early childhood development is a key determinant of health. The foundations for human development—physical, intellectual and emotional—are laid during pregnancy and into early childhood. Conditions in the prenatal period and experiences throughout the early years critically influence a range of health and social outcomes throughout a child’s life course. Research shows that many developmental disabilities and challenges in adult society have roots in pregnancy and early childhood, such as mental and physical health issues, obesity, difficulties with literacy and numeracy, lack of economic participation, poverty and criminality. For example, a woman’s pre-conception drinking determines her drinking during pregnancy, which can result in fetal alcohol spectrum disorder. Additionally, her pre-conception weight and weight gain during pregnancy are important prenatal determinants of childhood obesity. Children who are breastfed have a lower risk of obesity.

Children’s physical, social and emotional health, cognitive development, and speech/language development are all critically influenced by their fetal and early life environments. Young children require safe, secure, nurturing and responsive environments with opportunities to explore their world, play and communicate with others. Communities, health care providers, and all levels of government can support expectant women, new parents and other caregivers so they have the capacity to provide healthy early environments that are free from violence, abuse, neglect and poverty and that provide positive supports for healthy development and outcomes throughout the mother and child’s life course.

Economists assert that investment in early childhood is the most powerful investment a country can make, with returns over the life course many times the original investment. BC’s Healthy Start initiative and other key interventions such as screening programs and education/awareness resources support enhanced provincial consistency and equitable access/utilization of public health services, including public health screening and assessment, health promotion and education and intervention. They are based on best practice evidence and are foundational to supporting healthy fetal, infant and child development for citizens of BC.

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**Current State:**
Current maternal and early childhood development initiatives in BC strive to prevent vulnerability, enhance resiliency, and promote healthy lifelong behaviours among pregnant women, children and families. The Healthy Families BC Healthy Start Initiative was rolled out in 2011 with the establishment of perinatal, child and family public health service standards, and the BC Healthy Connections project to evaluate the Nurse-Family Partnership intervention. Through these initiatives, prenatal and postpartum public health services are offered to all women with a specific focus on vulnerable mothers and their families. The goal is to support women to have healthy pregnancies (including counselling on alcohol and tobacco use during pregnancy), and improve parenting knowledge and positive health outcomes for children. This is one example of proportionate universality in practice. Other core public health services include childhood screening, well-child assessments for growth and development and health promotion through evidence-based educational resources that support parents and caregivers.

**Policy Direction:**
Based on the above, this HFBC Policy Framework reinforces the need to build on the evidence-based foundation of interventions to deliver prenatal and postpartum public health services and provide key educational materials and resources for parents and caregivers. Exploring opportunities to further enhance maternal health, align with the Lifetime Prevention Schedule and support healthy development will be a key component moving forward.

All work in this area aligns with Goal 2 in BC’s Guiding Framework: *Maternal, Child and Family Health*, and the following performance measures* will guide and measure progress in this area.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate of low weight singleton births (per 1,000).</td>
<td>41.0 (2008–10)</td>
<td>36.0</td>
</tr>
<tr>
<td>The percentage of children who are not vulnerable on any Early Development Indicator Dimensions.</td>
<td>69% (2009/10 – 2010/11)</td>
<td>79%</td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

**PROMOTING POSITIVE MENTAL HEALTH**

**Evidence/Rationale:**
The impact of mental health problems in BC is significant. In 2008/09 the province spent about $1.3 billion on services to directly address mental health and substance use problems (a figure that only takes into account spending across three of the six main ministries involved in the delivery of mental health and substance use services).  

Mental health promotion aims to build an individual’s social, intellectual and emotional strengths and capacities; improve his/her ability to cope with and bounce back from adversity; and create community environments that support enhanced collective well-being. Mental health promotion considers the complex interplay of various risk and protective factors that influence positive mental health and well-being. Action to address these risk and protective factors can also support outcomes related to other health issues and behaviours, such as use of tobacco and other psychoactive substances (including alcohol), healthy eating, physical activity and injury prevention. By focusing on evidence-based interventions and best practice, positive mental health promotion can yield long-term positive outcomes and economic gains for individuals, families, communities and government.

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20 Ministry of Health Services, Ministry of Children and Family Development. *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in BC*. Victoria, BC. Ministry of Health Services; 2010, Nov.

21 Ibid
There is also emerging evidence that intervening with certain groups of people, often at key developmental stages or transition points in their lives, can effectively reduce the risk of future mental health and/or substance use problems. Although some types of vulnerability may be influenced by culture, family history or genetics, others (such as exposure to violence and trauma, or lack of social support) can be mitigated through strategic intervention. To this end, targeted prevention interventions attempt to reduce risk and enhance protective factors, mitigating vulnerability for many. It is also critical to ensure all First Nations and Aboriginal people in BC are supported in a manner that respects their customs, values, and beliefs to achieve and maintain mental wellness and positive, healthy living regardless of where they live.

**Current State:**

Promoting positive mental health is identified as a key strategy for improving the overall health and well-being of BC’s citizens, as well as offsetting the future burden of mental illness and substance use problems. The World Health Organization defines positive mental health “as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” Mental health promotion focuses on enabling and achieving positive mental health for the whole population while simultaneously recognizing the need to provide targeted support for individuals or groups that require it. Evidence from systematic reviews of mental health promotion and mental illness prevention initiatives shows long-lasting positive effects on multiple areas of functioning.

Mental health promotion actions seek to take advantage of opportunities to enhance development in early childhood and across the lifespan, and to shape healthy environments in key settings including homes, schools and workplaces. *Healthy Minds, Healthy People: a 10-Year Plan to Address Mental Health and Substance Use in BC* was released in November 2010, and details a cross-governmental, multi-sector and multi-system plan with a strong emphasis on efforts to promote positive mental health and well-being, and prevent mental illness and substance use problems across the lifespan. Thirty-three of the 63 actions presented within *Healthy Minds, Healthy People* are “upstream” in nature, and will continue to inform future work in this area.

**Policy Direction:**

Based on the above, health authorities will continue to support the 33 actions related to upstream health promotion and illness prevention as outlined in *Healthy Minds, Healthy People* to enhance collective resiliency and well-being. As part of this continuing support, the HFBC Policy Framework directs health authorities to expand the policy base for community-based initiatives that promote positive youth development and use multi-strategy approaches to address vulnerability across all settings.

Actions in this area also align with Goal 3 in BC’s Guiding Framework: Positive Mental Health and Prevention of Substance Harms, and the following performance measures* will help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of British Columbians who experience positive mental health.</td>
<td>71% (2009/10)</td>
<td>80%</td>
</tr>
<tr>
<td>The percentage of young BC children who are not vulnerable in terms of social development.</td>
<td>85.5% (2009/10 – 2010/11)</td>
<td>88.0%</td>
</tr>
<tr>
<td>The percentage of young BC children who are not vulnerable in terms of emotional development.</td>
<td>86.2% (2009/10 – 2010/11)</td>
<td>88.0%</td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

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A Culture of Moderation for Alcohol Use

Evidence/Rationale:
Alcohol remains the most widely-used psychoactive substance in Canada, and close to 80% of people in BC consumed alcohol in 2011. While many people enjoy alcohol in moderation, it is estimated that 20% of the drinking population who are the heaviest drinkers consume about 70% of the alcohol sold in Canada.23

Alcohol use has a serious impact on many individuals, families and communities in British Columbia, accounting for 18,725 alcohol-related deaths in BC between 2002 and 2011.24 Hospitalizations related to alcohol are on the rise and are expected to exceed tobacco-related hospitalizations in the next few years (Figure 9).

Figure 9.

Adapted from BC Hospitalization Cases Caused by Alcohol vs Tobacco Use (BC Centre for Disease Control and University of Victoria, 2013)

Alcohol is a factor in 60 types of diseases and injuries, and a component cause of 200 others.25 While alcohol is a legal commodity with economic and social benefits, it also has high potential to be harmful when used inappropriately.26 For example, while low levels of consumption have some benefits related to heart disease for middle-aged and older people, the risks for other chronic diseases such as cancer grow with increased consumption levels and with certain consumption patterns.

Furthermore, fetal alcohol spectrum disorder (FASD) is the leading preventable cause of developmental disability among Canadian children. A recent study of the economic burden of FASD in Canada indicated that the annual cost of FASD to Canada is estimated at $7.6 billion.27 In addition to health and economic costs, the personal and social costs are also significant. The total direct lifetime cost per child affected by FASD is estimated at $1.8 million28 for remedial medical, educational and social needs.

24 Centre for Addictions Research of British Columbia. Alcohol and Other Drug Monitoring Project.
28 Jonsson, E. 2012, Presentation Summary of Dr. Egon Jonsson to the Northwest FASD Partnership Ministers’ Meeting, Regina, Saskatchewan
Heavy drinking rates range from well below the national average in Fraser South, Fraser North and Richmond, to 20-30% higher than the national average in Northwest and East Kootenay HSDAs. The rate of heavy drinking is significantly higher among higher income males than among lower income males. As with smoking, the highest rates occur among men and women in their twenties. It is also higher in some populations, such as First Nations, who may be less likely to consume alcohol, but are more likely to drink heavily when they do consume it.

Lessons learned from our success in reducing tobacco use indicate that building a culture of moderation for alcohol consumption will require multiple tools of influence, action in all key settings, and a particular focus on preventing youth from engaging in risky alcohol use.

Current State:
The WHO Global Alcohol Strategy, to which Canada is signatory, unanimously adopted in 2010, directs ten areas for action to reduce alcohol-related problems and costs:

1. Leadership, awareness and commitment.
2. Health services’ response.
3. Community action.
4. Drinking and driving policies and countermeasures.
5. Availability of alcohol.
7. Pricing policies.
8. Reducing negative consequences of intoxication.
9. Reducing the impact of illicit alcohol.
10. Monitoring and surveillance.

While BC has made progress in a number of these areas, much work remains to address alcohol-related chronic diseases and injuries and the increasing prevalence of binge drinking, especially among young people. Promoting practices and policies that prevent under-age drinking, intoxication and other forms of risky drinking, increasing awareness about alcohol-related issues and influencing social norms about drinking behaviours, especially consumption within the Canadian Low-Risk Alcohol Drinking Guidelines, are important to promote a culture of moderation and help reduce costs associated with alcohol-related illness and injury.

A number of projects designed to track consumption and engage community leaders and service providers, parents, teachers and youth on collaborative action to address risky alcohol use are currently underway. Additionally, Healthy Minds, Healthy Campuses and Municipal Alcohol Policy have recently been introduced to support post-secondary institutions, local governments and First Nations in promoting health and preventing harms associated with alcohol through policy development, capacity-building and other activities that address risk and promote protective factors.

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29 Canadian Community Health Survey 2011/12
30 Ibid
31 Ibid
Policy Direction:
Building on existing evidence-based work, health authorities will look for opportunities to increase the focus on reducing alcohol-related harms and costs and addressing risky alcohol use in communities and on campuses. An important component will be influencing choices to build a culture of moderation for alcohol use and change consumption norms to reduce risky alcohol use and underage drinking.

All actions in this area align with Goal 3 in BC’s Guiding Framework: *Positive Mental Health and Prevention of Substance Harms*, and the following performance measures* will help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among BC students who use alcohol or cannabis, the percentage who first use before the age of 15.</td>
<td>Alcohol: 75%</td>
<td>Alcohol: 60%</td>
</tr>
<tr>
<td>Cannabis: 67% (2008)</td>
<td>Cannabis: 55%</td>
<td></td>
</tr>
<tr>
<td>The proportion of British Columbians (age 15+) who engage in hazardous drinking.*</td>
<td>25.6% (2008)*</td>
<td>21.7%*</td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.

*The baseline and target have been recalculated from those previously published in the Guiding Framework to reflect Healthy Minds, Healthy People: A 10 Year Plan to Address Mental Health and Substance Use in BC, which measures the percentage of British Columbians that consume alcohol (age 15+) who engage in hazardous drinking.

Injury Prevention

Evidence/Rationale:
Unintentional injuries have a devastating impact on the physical, psychological and economic health of people living in BC, taking a significant toll in terms of lives lost, lost economic productivity and costs to the health system. The leading causes of hospitalization from unintentional injuries in BC in 2010 were falls and transport-related incidents. Preventing injuries means assessing the risk, addressing the causes and/or minimizing the impact through the design and implementation of protective mechanisms.

Each day, approximately 1,200 people in British Columbia are unintentionally injured and of these, five die and 26 are permanently disabled as a result of preventable injuries. Injuries are the leading cause of death for British Columbians aged one to 44 years and the fifth leading cause across all age groups. The highest burden of unintentional injury related death is experienced by children aged 15 to 24 years, accounting for 85% of all childhood (<25 years) unintentional injury deaths. Injury-related hospitalization rates by age groups over the five-year period between 2006/07 and 2010/11 show a marked increase during the adolescent period and a significant increase after the age of 65 (Figure 10). In 2004 (the last year data is currently available for), injuries cost British Columbians $2.8 billion and 1,721 lives.

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33 Ibid.
34 BC Injury Research and Prevention Unit. 2006/07-2010/11
35 [http://www.injuryresearch.bc.ca/docs/3_20090818_085612EBI-National1.pdf](http://www.injuryresearch.bc.ca/docs/3_20090818_085612EBI-National1.pdf). p.43. 2004 (currently being updated)
Falls and fall-related injuries are responsible for significant disability, loss of independence, and reduced quality of life for seniors, and are often a marker for underlying and often untreated health problems. There is good evidence supporting the predictability and prevention of falls among seniors in various settings, and proving that prevention interventions can decrease falls and fall-related injuries.

As the population of seniors in BC continues to grow, the need for a reduction in avoidable health care spending will be paramount. The ability to prevent even a small percentage of falls and fall-related injuries experienced by BC seniors will have a significant impact on the lives of seniors, their families and the wider health care system resources.

**Current State:**
The goals for comprehensive injury prevention programs include:

- Building a culture of safety at work, home and play by increasing awareness of injury risks, implementing prevention education and taking priority actions, such as designing and developing safe environments, systems and products.
- Reducing the incidence of injuries among children and youth in BC through physical and social environmental modifications and increased awareness of safety-promoting behaviours.
- Reducing the incidence of falls, fall-related injuries and fall-related risk factors among seniors in BC through surveillance, enhanced community capacity, public information and evidence-based prevention measures.

As a great number of injuries occur in motor vehicles, on work sites and during play, partnerships across multiple sectors are required in order to create a culture of safety.

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36 Gillespie et al., 2009, 2010
37 CentreS for Disease Control and Prevention, 2010
**Policy Direction:**
The HFBC Policy Framework directs health authorities to continue to deliver programs and interventions that promote safe and active play and prevent falls and other avoidable injuries. It also requires that efforts are targeted to high-risk populations (such as seniors) and groups in key settings such as homes, schools, workplaces and residential care.

Health authorities will work with the Ministry, other stakeholders across government and community partners (e.g., the BC Injury Research and Prevention Unit) to increase awareness and promote protective factors for falls and injuries in BC.

All actions in this area align with Goal 5 in BC’s Guiding Framework: *Injury Prevention* and the following performance measures* will help support and monitor progress:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BASELINE</th>
<th>2023 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The age-standardized hospitalization rate for unintentional injuries</td>
<td>7.8 (2010/11)</td>
<td>6.2</td>
</tr>
<tr>
<td>(per 1,000).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The age-standardized mortality rate for unintentional injuries</td>
<td>20 (2010)</td>
<td>15</td>
</tr>
<tr>
<td>(per 100,000).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The age-standardized rate of fall-related hospitalizations for</td>
<td>30.8 (2009)</td>
<td>25</td>
</tr>
<tr>
<td>British Columbians age 75+ (per 1,000).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Phase two of developing this policy framework will be to identify incremental targets (e.g., three-year time frames) that will help identify progress and drive results towards the longer term goals. These measures will also be augmented by process measures/targets to support implementation as needed.
ACCOUNTABILITY

As part of the larger Health System Strategy, a performance management accountability framework will be built that includes clear roles and accountability mechanisms for health authorities. The Guiding Framework identifies a number of performance measures, which will be used to help measure progress and success against the focused intervention streams in the HFBC Policy Framework. Additional process or outcome measures may be set specifically for components of the HFBC Policy Framework as part of an Evaluation and Performance Framework (to be developed fall 2014).

DATA

The planning and evaluation of the HFBC Policy Framework will be supported by an effective program of surveillance, which will be guided by the Population and Public Health Surveillance Plan for BC. It is anticipated that quarterly and/or annual reporting will be a requirement for health authorities. An Evaluation and Performance Framework will be developed to help monitor progress and support course correction for interventions under the HFBC Policy Framework. This will be embedded in a larger accountability framework tied to the Guiding Framework in order to ensure all the goals and targets are achieved.

The consultation process for the Surveillance Plan identified a number of strengths that need to be reinforced and challenges to be addressed. New governance models that provide infrastructure while acknowledging and using existing assets within the system will need to be developed to support successful implementation.

The HFBC Policy Framework will also produce new challenges for surveillance. For example, a focus on community and school partnerships increases the need for data on topics such as risk and protective factors for relatively small geographical areas. The focus on risk and protective factors and social determinants requires new data sources that go beyond traditional health data. And the integration of concepts such as disease burden, cost-effectiveness and the life course requires the development of new skills and knowledge within the public health system. Next steps include finalization of the Surveillance Plan and work plan development for implementation, which will be linked to the HFBC Policy Framework evaluation and performance measurement process.

MARKETING AND COMMUNICATIONS

The implementation of the HFBC Policy Framework will be supported by a marketing and communications strategy, which will be developed with a provincial scope to ensure consistent messages and tools across all health authorities. This work will build on the existing foundation for HFBC, integrate current and new/expanded programs as required, and support greater brand alignment, public awareness and engagement efforts. This collaboration will allow for stronger networks that reflect local actions and insights, more culturally appropriate content for First Nations, improved navigation of resources and uptake in healthy lifestyles and behaviours by the public and a reduction in costs through shared research, planning and asset development.

PARTNERSHIPS & COLLABORATION

The public health system relies on collaborative partnerships in order to support service delivery in the province. Strong connections across all sectors and levels of government, within communities, schools and workplaces, with academia and from community-based and non-governmental organizations are vital in order to shape programs, improve access to services, influence policy, reduce inequities and ultimately improve individual and community well-being.

Many of the social, economic and environmental challenges faced by British Columbians affect, and are affected by, factors in multiple sectors (e.g., homelessness, poverty, environmental management, health, education, economic development, transportation, etc.). The more these factors interact with each other and cross over traditional structural and organizational lines of authority, the more potential they have to become large, complex issues that are increasingly difficult to address. A more collaborative approach is required in order to address these challenges, so we can better account for the interconnectedness that exists across social systems while also ensuring we are maximizing the benefits as they relate to all sectors and citizens.
When looking at the outcomes articulated in the HFBC Policy Framework, it is impossible not to consider how the other sectors, such as education, agriculture, transportation and housing, influence and connect to them. These linkages and impacts are underlying factors that influence how healthy or unhealthy individuals or populations are. Therefore, the success of the HFBC Policy Framework is contingent on the ongoing and strengthened collaboration with partners in other sectors. A whole-of-government approach that creates space to identify where the linkages exist and facilitates collaboration and joint planning across ministries and sectors will help ensure that all participants are able to achieve mutually beneficial outcomes. To support this work, the Assistant Deputy Minister Committee on Population Health Improvement tries to leverage activities across government in order to address the underlying factors that affect health, build healthier public policies and support job creation and economic growth in the province. Such initiatives as the HFBC Policy Framework, the Early Years Strategy, Housing Matters, Improving Access to Primary Care for First Nations, the work of the Road Safety Council, Active Transportation and Bike Laws, and the Domestic Violence Action Plan all link in support of these goals. This approach requires strong leadership to account for the interconnectedness that exists across social systems and institutionalize action across government and across society.

### Roles and Responsibilities

**Ministry of Health**

The Ministry of Health acts as the steward of BC’s health system by providing leadership and policy direction and setting province-wide goals, standards and expectations for health service delivery by health authorities.

The Ministry’s Population and Public Health Division (PPH) is the focal point within the provincial government for the provincially coordinated functions of the HFBC Policy Framework. It provides, as part of the ministry’s overall stewardship function, the strategic direction and tools to assist in planning, implementation, communication and overall accountability. PPH also supports the health authorities by collecting and using data and research to inform decision-making; implementing system-wide accountability and reporting; developing and delivering social marketing and communications materials; and determining appropriate funding models.

**Health Authorities**

The regional health authorities (RHA’s) are responsible for the health of their region’s populations. They deliver the appropriate suite of public health services required to meet their population’s needs and achieve the goals and targets outlined in the Guiding Framework. The health authorities govern, plan and coordinate services regionally and work to coordinate universal public health initiatives across the province as appropriate.

Over and above delivering its own services, the First Nations Health Authority works to ensure that general health and wellness services meet the unique needs of First Nations and Aboriginal peoples, and creates the space for taking different and often innovative approaches to addressing health needs and promoting wellness. This includes its approach to the incorporation of traditional practices and cultural competency of service providers. Through partnership accords with the ministry and health authorities, FNHA works collaboratively to integrate the health needs of First Nations into Ministry and health authorities’ planning and service delivery.

The Provincial Health Services Authority is responsible for providing select specialized and province-wide health care services across BC and will work with the five regional health authorities and the First Nations Health Authority to help meet population health needs at the local and provincial levels.

Health Authority Board Chairs and CEOs are responsible for implementing initiatives under the HFBC Policy Framework in accordance with Ministry policy directives in order to achieve targets outlined in the HFBC Evaluation and Performance Framework. Regional health authorities will need to work with the FNHA to ensure programs, services and initiatives under this HFBC Policy Framework are tailored to appropriately address First Nations and Aboriginal health needs.

Health authorities will also need to partner with the following groups, as necessary, for policy/program development and implementation:

**Local Governments**: Local governments (defined as municipalities and regional districts in the Public Health Act, Local Government Act and the Community Charter) play an important role in affecting health in their communities. A strong working relationship between regional health authorities and local governments is critical for both...
partners to deliver on their mandates and priorities. The HFBC Policy Framework will be implemented by health authorities through the collaborative mobilization of local governments across a range of activities including, but not limited to, the creation of health-promoting built environments and community environments.

**School districts** and schools are also important partners as we continue to build the Healthy Schools initiative through collaboration between this sector and health authorities. **Post-secondary institutions** also engage in healthy living initiatives to support their student populations’ physical and mental health and well-being. The **private sector**, both as employers who want to improve workplace health for their employees and as initiative partners, brings many opportunities for partnership to improve population health.

**Non-Governmental Organizations (NGOs):** Partnerships with NGOs are necessary to support and assist with the delivery of public health programs and/or use their influence to raise awareness of public health issues. These partnerships are instrumental in the development and delivery of programs and will continue to play a major role as the HFBC Policy Framework progresses. Health authorities will jointly plan with NGOs to elevate the profile of critical population health issues, improve reach and access of services, provide additional capacity and expertise, and improve opportunities for integration into the broader community.