Mobilizing Intersectoral Action to Promote Health: 
*The Case of ActNowBC in British Columbia, Canada*

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Mobilizing Intersectoral Action to Promote Health

The Case of ActNowBC
in British Columbia, Canada

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Preface

The level of health enjoyed by a population depends on many factors outside the reach of the health sector itself. For instance, the inequitable distribution of health across population groups is a function of social determinants such as educational access and attainment, income, and employment. [1] Risk factors such as unhealthy diets, smoking, physical inactivity, and the harmful use of alcohol, are themselves largely determined by factors such as price, marketing, availability of goods, and urban design, among other influences. The ability to cope with ill-health and the consequences of disease are affected by access to health care, insurance cover, and other social protection mechanisms.

Mandated by a range of high-level policy documents, intersectoral action has come to be seen by public health advocates as a key strategy for health improvement and health equity. The Ottawa Charter for Health Promotion [2] made “building healthy public policy” its first action area. The Bangkok Charter for Health Promotion in a Globalized World [3] committed to make “the promotion of health a core responsibility for all of government.” The World Health Report [4] of 2008 renewed the concept of primary health care and made healthy public policies across sectors one of its four proposed reforms. In the face of the overwhelming health burden of this century, the burden of non communicable diseases, the World Health Assembly has adopted an action plan [5] whose first objective is “to integrate prevention and control of such diseases into policies across all government departments.” Intersectoral action for health is an essential strategy for public health and a number of notable international efforts have been made to describe the concept and to extract the practical lessons for wider adoption. [6, 7]

Despite the clear case for intersectoral action, there is a sense among practitioners that the principle is not always translated into action. In the real world, it is held back by the competing interests of government ministries, by incentives for unisectoral action, and by a results-based management imperative that requires visible, attributable outcomes from specific investments and not from collective action (easier to attain in focused projects within direct control).

In this context, this study is particularly welcome and timely. ActNowBC is an interesting experiment, an example of a province asking itself: if we are investing millions in the organization of a mass event such the Winter Olympics, should there not be a discernible, positive, and lasting impact on our well-being? Given our understanding that health is determined by actions outside the health sector, can we set up an effective mechanism to foster collaboration for health across Ministries and with other stakeholders in the community? As noted by this study, the solution adopted, ActNowBC, is a “promising best practice”. It is an innovation in the field of mass events and could be held up as an example for other global and regional events such as a World Expo or World Cup Tournaments. The lessons of ActNowBC would also hold promise for many developing countries who themselves organize similar mass events with regularity (note, for example, the FIFA World Cup in South Africa and the Commonwealth Games in India being held in the same year as the Winter Olympics in Vancouver).

This effort to evaluate the performance of ActNowBC as an institutionalized form of intersectoral action is an invaluable contribution to the literature. The study frankly discusses many of the difficulties. Were the targets too behaviourally oriented? Were they so ambitious as to undermine the long-term viability of the initiative? Will ActNowBC survive over time, across political transitions, or beyond the 2010 Winter Olympics, the mass event that gave it birth?

This study does not shirk from addressing these questions, and the ultimate answers will only be available with later studies. But this case study is a clear illustration that intersectoral action is possible, and can be sustained over a number of years. It illustrates how different sectors can define a commonality of interest in health, how an accountable agenda for joint action is arrived at, and how a specific set of resources is invested in the collaboration. While the principle of intersectoral action for health is widely accepted, it is in such innovative, pragmatic approaches as ActNowBC that the ideal will become more real and, hopefully, more common.

Dr Fiona Adshead
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World Health Organization, Geneva
May 26, 2009
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Key Messages

In 2003, the Canadian province of British Columbia (BC) won the bid to host the 2010 Winter Olympic and Paralympic Games. The government of the day made the achievement a window of opportunity to establish a health promotion legacy for the people in the province. To this end, it launched ActNowBC in 2005, a bold intersectoral initiative that integrates the actions of the whole-of-government with those of civil society to achieve five health promotion targets by 2010, intending to make BC the healthiest jurisdiction to ever host the Games.

While it is too soon to predict if ActNowBC will deliver a health legacy beyond the 2010 Games, the added impetus of ActNowBC has created new health promotion programming and has propelled many existing activities to a stronger level of engagement. ActNowBC has also served to expand and enhance elements of an holistic strategy that aims to improve health equity in Aboriginal communities throughout the province.

To date, the initiative can be credited with changing the way the provincial government and all health promotion stakeholders are doing business in BC. In this regard, our case study contributes to the ActNowBC performance story, highlighting the importance of 1) using diverse strategies and mechanisms to foster collaboration in government and 2) developing strong partnerships with organizations within civil society.

Two factors appear to have been integral to the success of ActNowBC and are highlighted throughout this document:

High-level leadership: The BC Premier’s steady commitment to ActNowBC is key to why the initiative has remained high on the agendas of all Ministers, Deputies and Assistant Deputy Ministers since 2005. At the same time, senior civil servants have been resilient (or at least more cautious) in mobilizing awareness and operationalizing intersectoral coordination.

Balancing planning and action: The BC government has demonstrated an ability to “sail the ship while you build it”, moving ahead with a whole-of-government initiative even though not all the elements nor ideal conditions are in place. Similarly, civil society leaders have forged ahead with several programs, overcoming the challenges associated with simultaneously developing new partnerships among their respective organizations and with the ministries overseeing the implementation of ActNowBC.

We believe that the integrating mechanisms and strategies initiated and adopted so far as part of ActNowBC are “promising best practices” that can inform other jurisdictions in the development of similar horizontally and vertically integrated initiatives.
Executive Summary

In 2003, the Canadian province of British Columbia (BC) won the bid to host the 2010 Winter Olympics. The government of the day made the achievement a window of opportunity to establish a health promotion legacy for the people in BC, pledging to make the province the healthiest jurisdiction to ever host the Games. To this end, the government launched ActNowBC in 2005, a bold intersectoral health promotion initiative that integrates the actions of the whole-of-government with those of civil society. ActNowBC has five targets set for 2010:

1) Increase by 20% the proportion of the BC population (aged 12+ years) that is physically active or moderately active during leisure time from the 2003 prevalence of 58.1% to 69.7%.

2) Increase by 20% the proportion of the BC population (aged 12+ years) that eats the daily recommended level of fruits and vegetables from the 2003 prevalence of 40.1% to 48.1%.

3) Reduce by 10% the proportion of the BC population (aged 15+ years) that uses tobacco, from the 2003 prevalence of 16% to 14.4%.

4) Reduce by 20% the proportion of the BC population (aged 18+ years) that is currently classified as overweight or obese from the 2003 prevalence of 42.3% to 33.8%.

5) Increase by 50% the number of women counselled regarding alcohol use during pregnancy and have focused strategies for the prevention of fetal alcohol spectrum disorder (FASD) in all regional health authorities.

Between October 2007 and September 2008, we conducted 49 interviews in BC with key senior public servants, politicians, academics and NGO officials involved with ActNowBC. From their perspectives we examined the different elements of the ActNowBC “story”, and more specifically the factors and mechanisms that are facilitating 1) the whole-of-government contribution to ActNowBC and 2) the partnerships between the BC government and the civil society sector.

At the close of our study, ActNowBC has not yet matured to the point where definitive lessons can be drawn. Nevertheless, we believe that there is a transcendent approach in the performance story we have documented thus far – that the BC government has demonstrated an ability to “sail the ship while you build it”, moving ahead with a whole-of-government initiative even though not all the elements nor ideal conditions are in place. For example, the cross-ministerial accountability framework is only now emerging. And other ActNowBC actors, within and outside of government, are forging ahead while simultaneously balancing planning and action. We believe that the integrating mechanisms and strategies initiated and adopted thus far as part of the ActNowBC initiative are “promising best practices” that can inform other jurisdictions in the development of similar whole-of-government initiatives.

ActNowBC: Promising Practices and Key Challenges:
As this report was being written, a number of health promoting initiatives are said to have been aided by ActNowBC, directly or by virtue of its momentum. Already, targets three and five have been achieved. ActNowBC has also expanded and enhanced training and grant opportunities in a holistic healthy lifestyles strategy aiming to improve health equity within Aboriginal communities. In addition, BC has adopted stronger tobacco control legislation, restrictions in using industrially produced trans fat, new guidelines for healthy foods in vending machines in BC public buildings and school health guidelines related to vending machines and to physical activity levels.

We discovered that there were several factors that explain the outcomes and process-related achievements and contributions of ActNowBC that have been observed thus far. These factors fall into two broad categories: leadership, in different forms and at different levels; and the adoption of horizontal and vertical strategies and mechanisms to foster intersectoral action. The ActNowBC platform explicitly calls for all government sectors to work together—both at the horizontal (different ministries) and vertical (involvement of health authorities and municipalities) levels. It also encourages greater vertical coordination and collaboration between government and civil society organizations.

Leadership: The Premier’s steady commitment towards the principles of an integrated health promotion initiative is one of the key success factors behind the launch of ActNowBC, and the main reason why ActNowBC has been able to evolve and mature since its inception in 2005. His continuous support enhances the profile of ActNowBC and ensures that ActNowBC remains high on the agendas of all Ministers, Deputies and Assistant Deputy Ministers. The background work of senior civil
servants also clearly emerged as a critical success factor. They seized the opportunity to harness the momentum of the Winter Olympics to advance health promotion as a long-term investment and gain a province-wide health legacy with potential cross-sector benefits.

**Increasing collaborative action among government sectors with diverse strategies and mechanisms:**

This report highlights how the following mechanisms and strategies contribute to enhancing cross-sector collaboration:

- A compelling business case positioned chronic diseases as an economic drain on all Ministry budgets, not just that of the Ministry of Health.
- Some of ActNowBC targets are boldly ambitious and as such can only hope to be achieved through cross-sector coordinated and collaborative action.
- An incentive fund of $15 million supported pilot health promotion projects by ministries other than the Ministry of Health during the early days of ActNowBC.
- A new inter-departmental committee of Assistant Deputy Ministers distributes accountability for ActNowBC across ministries.
- Government level leadership was extended outside the health sector by having at one point a Minister of State for ActNowBC attached to the Ministry of Sports, Tourism and the Arts.

**The involvement of civil society organizations:** A coalition of nine civil society organizations – the British Columbia Healthy Living Alliance – received a $25.2 million one-time grant to implement and enhance community-based health promotion programs across the province oriented to the ActNowBC targets. 2010 Legacies Now, a not-for-profit society, also received a one-time grant of $4.8 million. The leaders involved have forged ahead with several programs, having overcome the challenges associated with simultaneously developing new partnerships among their respective organizations and with the ministries overseeing the implementation of ActNowBC.

**Challenges:** Rolling out such a multifaceted initiative, despite the best efforts of people committed to ActNowBC, is fraught with complex challenges and differences of opinion persist. While most respondents applauded the political decision to set ambitious targets to rally multisector action, some expressed concerns about the risks to sustainability of ActNowBC if targets are not met by 2010. Some respondents believe that there is an overemphasis on social marketing campaigns and not enough action on social determinants of health to secure a lasting legacy for BC. Others suggest that a stages approach is needed in that not all components of such a complex integrated strategy can be undertaken at once. Shifting governance structures may have slowed the stabilization of ActNowBC but with all departments embedding ActNowBC into their logic models and service plans, a high level accountability framework is anchoring ActNowBC.

**Conclusion:** In 2010, the BC government will report on whether the ActNowBC targets have been reached. In the meantime, this case study contributes to the performance story of ActNowBC, describing and discussing the effort of individuals and organizations connected to the implementation of the initiative. The quote below concisely summarizes the general tone within the government sector as it relates to ActNowBC, suggests that intersectoral action may be taking root and that ActNowBC may be changing the way that the government within the province does business:

“I give this government full points for setting targets and trying to get us all thinking about service plans [commitment to ActNowBC]. It really is a discipline that wasn’t particularly well-embedded in government prior to this administration…” (Gov)
Introduction

British Columbians are among the healthiest people in Canada. The population has the lowest standardized mortality rates due to chronic disease compared to people in the other provinces and territories in the country. [1] Nevertheless, British Columbia (BC) is not exempt from the increasing rates of preventable chronic disease prevailing in the rest of Canada and globally as populations age and live longer. [1]

According to the World Health Organization (WHO), a high proportion of heart disease, stroke, and type 2 diabetes and an estimated 40% of cancers could be avoided if common lifestyle risk factors like smoking, physical inactivity, unhealthy eating, obesity, and alcohol misuse were eliminated. [2] The required public health response to address risk factors, and to promote health in general, is characterized by multiple strategies operating in a coordinated manner, collaboratively and in partnership across health and non-health sectors. The literature provides a number of terms, some with overlapping meanings, that capture the essence of such an approach, such as integration, intersectoral action for health, whole-of-government, and joined-up government.

In this report, we present the intersectoral and integrated approach to health promotion launched in 2005 in BC, an initiative called ActNowBC. We chose ActNowBC for a case study because it is a unique health promotion initiative in several regards (see Table 1). First, the ActNowBC initiative strives to achieve health promotion targets, an uncommon feature of government-led initiatives. Second, ActNowBC is tightly linked to the Winter Olympics to be held in BC in 2010. When BC won the Olympic bid, the government pledged to make the province the healthiest jurisdiction ever to host the Games and declared 2010 as the highly symbolic target year for the health goals in ActNowBC. ActNowBC is the means by which the Olympic Games are to deliver a health promotion legacy to the people of BC. Third, ActNowBC uses an integrated approach that simultaneously targets multiple risk factors. Fourth, ActNowBC implements a whole-of-government approach and strengthens accountability for population health. Finally, the ActNowBC initiative is developing strong partnerships with a coalition of NGOs, a process that started with what is believed to be the largest transfer of funds ($25.2 million) in Canada from a provincial government to the NGO sector in the field of health promotion.

Table 1: Unique Features of ActNowBC in Canada

- The use of health promotion targets;
- The link to the 2010 Winter Olympics as an opportunity to advance population health objectives;
- The use of an integrated approach, simultaneously targeting multiple risk factors;
- Whole-of-government approach with mechanisms to strengthen accountability for population health; and
- Largest transfer of funds in Canada from a provincial government to the NGO sector in the field of health promotion.

This case study on ActNowBC was undertaken with the objective of better understanding the factors facilitating or constraining effective intersectoral action for health. In this report, we examine two aspects of ActNowBC in detail: 1) the factors and mechanisms facilitating contributions from all sectors of government to ActNowBC, and 2) the factors and mechanisms facilitating partnerships between the BC government and a coalition of civil society organizations to reach the ActNowBC targets.

This report is divided into four sections. The first section briefly outlines our case study methodology. In the second section, we define the concept of intersectoral action for health by highlighting its two key dimensions: 1) a vertical dimension referring to linkages between different levels of government or between different types of organizations, and 2) a horizontal dimension referring to the use, at one level of government, of a whole-of-government approach. We then focus on the horizontal dimension, which is the initial and core component of ActNowBC, by examining key issues associated with whole-of-government approaches through a scoping review of the literature. We present the case study findings in the third section, which contains four subsections. We start with a brief overview of ActNowBC and its history. We examine the whole-of-government component of ActNowBC and describe how this government-led initiative gradually established partnerships with a coalition of NGOs. This is followed by a brief overview of initial outcomes, with special attention given to equity considerations. Finally, we present the main sustainability challenges for ActNowBC from the perspective of the study participants. The fourth section discusses the case study findings in light of the international literature on intersectoral action for health and highlights lessons learned from developing and implementing ActNowBC to date.
Section 1

Case Study Methodology to Understand ActNowBC as a Natural Experiment

This is a qualitative case study. Case studies conduct a holistic analysis of a social phenomenon through understanding actions, events, contexts, and processes from multiple perspectives. [3-5] This case study on ActNowBC is both descriptive and explanatory. We describe the history, structures, and processes behind ActNowBC and analyse in depth the factors critical to its success evident thus far.

We view the ActNowBC initiative as a natural experiment. The BC government has developed an evaluation strategy for ActNowBC based on a before-and-after design with interim progress reports. This classic approach to evaluation, while essential, is often marred by concerns about the challenges of measuring outcomes and determining attribution. In measuring outcomes for ActNowBC, the challenge is to detect change in the prevalence of chronic disease risk factors at the provincial level over a relatively short period of time, that is, between 2003 and 2010. Even if the prevalence of risk factors changes, the challenge remains to attribute these outcomes to the ActNowBC initiative. New approaches in program evaluation, like outcome mapping and contribution analysis, have emphasized the necessity of building a “credible performance story” over time. [6] The first step is to demonstrate change in people and organizations targeted by the proposed intervention(s). In the case of ActNowBC, this translates into determining whether ActNowBC changes the way governmental agencies and NGOs, and people within these organizations, “do business.” This case study contributes to building the performance story for ActNowBC.

Data Collection
We obtained data for our report from two sources: 1) literature on intersectoral action for health and whole-of-government approaches; and 2) in-depth interviews with public servants, politicians, academics, and NGO officials.

Information was obtained from respondents using a semi-structured interview guide. While most interviews were conducted face-to-face, some were conducted by telephone. Interviews lasted on average approximately 60 minutes. All respondents signed informed consent forms before the interviews, indicating they understood why their participation in the study was requested. The Health Canada Ethics Board approved the study protocol in October 2007.

Selection of Respondents
We used a purposeful sampling strategy (“snowball sampling”) to identify respondents with the most information, expertise, and technical knowledge relevant to the case study. [7] We wanted to obtain a comprehensive description of ActNowBC and a diversity of opinions about its implementation, added value, and other features. The first round of interviews involved key leaders of the ActNowBC initiative, who subsequently suggested the names of other individuals we should approach. Those individuals who were recommended were interviewed, and they in turn identified other potential respondents. We conducted a total of 49 interviews with key respondents working in government (37), in academia (2), and in the NGO sector (10).

Data Analysis
All interviews were audio-recorded and transcribed. The transcripts were coded and analysed with NVivo software, version 7. [8] The coding tree was developed in steps. The analysis involved first using an open coding strategy to identify emerging themes and categories. [9] Themes and categories generated after performing line-by-line analysis of the first few transcripts were tested and further explored in subsequent interviews until saturation was reached. We used the immersion/crystallization approach [10] as the overall analytical strategy to identify themes and patterns emerging from the empirical data set.
Definitions and Scoping Review of the Literature

Definitions

The term **intersectoral action** has a broad meaning, and as a result, has different interpretations. For this study, we adopted the definition contained in a 2008 Senate Report on Population Health Policy in Canada. This definition distinguishes between the horizontal and vertical dimensions of intersectoral action:

“The horizontal dimension links different sectors such as education, health, the environment, etc. Within a single government, this can be referred to as an interdepartmental or whole-of-government approach. The vertical dimension links sectors at different levels; for example, the federal, provincial/territorial, regional, and local or municipal governments are linked both together and with groups, institutions, and organizations in the community.” (Senate Report, 2008) [11]

From that perspective, the concept of intersectoral action overarches the concept of **whole-of-government**. In our case study, we adopted the following definition of **whole-of-government**:

“…whole-of-government denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery.” [12]

Other terms have been used to capture the ideas contained in the above definition, for example, **joined-up government** and horizontal management.

Scoping Review of the Literature

Since the Alma-Ata Declaration of 1978 and the concept of Health for All, momentum has grown internationally for public health policies to work upstream and outside the health sector. [13] The 2005 Bangkok Charter for Health Promotion in a Globalized World recommended that “the promotion of health [be made] a core responsibility for all of government.” [14] The underlying principle, now firmly grounded in empirical evidence, is that economic and social development are strongly interconnected with health. WHO strategies for tackling chronic diseases have always advocated multifaceted approaches involving multiple sectors. [15, 16]

At the international level, a number of countries have begun experimenting with different forms of intersectoral action and whole-of-government approaches to address complex health and social issues. In the United Kingdom, for example, policy analysts credit the Blair government for introducing the concept of “joined-up government” in 1997. [17] Key advisors and ministers within the Labour Party became convinced that many of the most difficult social and health issues cut across departmental remits and required a joined-up solution. [18] However, intersectoral action and whole-of-government approaches take different forms, depending on how the issue is framed and what the desired outcome is. Increased coordination and efficiency are common and cross-cutting goals. Specific outcome goals are more varied, for example, improving health per se, acting on a specific risk factor or determinant of health, or targeting a specific subgroup of the population.

Nevertheless, the previous decade of experience in intersectoral action in general and in the use of joined-up approaches more specifically has not convinced all analysts that real and sustainable progress has been made. Empirical evidence is still limited on how to successfully implement and sustain such intersectoral and whole-of-government approaches.

The main purpose of this section is to identify the key themes and conditions for successfully adopting effective intersectoral action. We place special emphasis on whole-of-government approaches, which is the core (and initial) orientation of ActNowBC. This high-level mapping of intersectoral action themes and success factors provides readers with a lens through which to interpret the case study findings.

We report the results of our scoping exercise by focusing on three key interrelated themes: coordination, governance, and accountability.

---

1 These attempts in the health sector were partly mimicking those undertaken in other sectors as part of a wave of New Public Management (NPM) reforms.
Coordination

Coordination\(^2\) is the “umbrella” theme associated with whole-of-government approaches. Better coordination is the main desired consequence of whole-of-government initiatives and is seen as an essential condition for achieving a common goal or set of goals. All whole-of-government initiatives strive for more inter-ministerial coordination. However, several studies on whole-of-government approaches conclude that a gap between talk and action often occurs because of significant barriers to coordination. [19] Discussions about barriers to coordination inevitably lead to the theme of governance. Figure 1 presents three categories of coordination mechanisms directly related to the theme of governance that we will use in the next section.

**Figure 1: Three categories of coordination mechanisms**

(Behind) The Handshake:
- Mutual adjustment
- Common values and norms
- Organizational culture

Invisible Hand:
- Financial incentives
- Resources
- Supporting structures

Visible Hand:
- Leadership
- Authority
- Rules
- Directives

Adapted from a manuscript of the Mansholt Graduate School of Social Sciences. [20]

Governance

The concept of governance refers to:

“…the procedures associated with the decision making, performance and control of organizations, with providing structures to give overall direction to the organization and to satisfy expectations of accountability to those outside of it.” (Hodges et al., 1996: 7) [21]

Governance can also refer to a set of structures designed to support coordination or to define how coordination should occur. The categories of coordination mechanisms presented in Figure 1 will be used to outline some of the whole-of-government conditions for success.

(Behind) The Handshake: Developing a Backdrop to Action

Fundamental changes in organizational cultures are necessary to facilitate whole-of-government approaches in planning and executing programs and policies. Organizational culture can be defined as a “fairly stable set of taken-for-granted assumptions, shared beliefs, meanings, and values that form a kind of backdrop to action.” (Smircich, 1985: 58) [22] A report published by the Canadian Centre for Management Development (2001) focusing on horizontal management highlighted that coordination is easier when organizational members share the same values, norms, fact base, goals, and understanding of the key issues. [23] Another Canadian report on horizontal management concluded that shared mental models and vocabularies help give an initiative a working culture, a prerequisite to developing trust. [24] Without this backdrop, the use of coordination mechanisms is unlikely to lead to success. Informal structures may be needed in order to stimulate a shift in culture and the development of shared frameworks and mindsets. For example, a report about Policy Action Teams in the United Kingdom in the 1990s, in which the teams comprised of government officials from a range of departments, outside experts, and residents, concluded that these teams worked best with overt team-building activities (such as site visits and away days) and meetings held in an informal environment and style.

Whole-of-government initiatives should also have a clear purpose to ensure that partners align their vision and policy objectives. Unrealistic objectives can be a barrier to cross-ministerial work. [15, 25, 26] Organizational and individual expectations have to be taken into account during the design and implementation phase of a whole-of-government initiative.

The Visible Hand: Leadership and Authority

Strong leadership is a condition for successful intersectoral action. For example, Backvis and Juillet, in a key report on horizontal management among federal departments and agencies in Canada, concluded that the most important determinant of success was the presence of specific individuals acting as catalysts and champions at finding innovative solutions and resources. Conversely, the perception of a lack of coherent and consistent leadership from central agencies (e.g. Privy Council Office, Treasury
Board Secretariat) was a cause of frustration among respondents.

Defining the concept of “leadership” remains difficult since different forms of leadership present at different levels may be needed for successful coordination. In general terms, leadership may be viewed as creating a way for people to contribute to making something extraordinary happen. [27] In the field of public health, “leaders” are referred to as people with:

“…skills like the ability to see the big picture, to think and plan strategically, to share a vision with others, and to marshal constituencies and coalitions for action”. (Roper, 1994: 16)[28]

Leadership is often presented as a success factor that must be present from the beginning of a whole-of-government initiative. However, some studies have emphasized the necessity of developing strong leaders and building organizational capacity over time. [29] The role of formal versus informal leaders has been highlighted by several studies. Informal leaders can play an important role in facilitating change. [30] The role of formal leaders (appointed or elected) has also been documented in whole-of-government approaches. For example, in 1998, the United Kingdom government created the position of Cabinet Enforcer to strengthen joint working within government. The Cabinet Enforcer’s main responsibility was to coordinate the work of government and avoid fragmentation and omissions between ministries. [31] While it appeared that the Cabinet Enforcer had unlimited access to the Prime Minister, some analysts suggested that the position did not have significant power and authority. [31, 32] Two cabinet members served as Cabinet Enforcers in the United Kingdom between 1998 and 2001, after which the position was abolished.

One lesson from the United Kingdom’s experience and other studies is that enforcement through a statutory duty to collaborate may be necessary for the success of whole-of-government approaches. [29] At the very least, lines of authority should be clearly delineated [20] with enough formal details on what departments are expected to do, particularly regarding substance and expected outcomes.

**The Invisible Hand: Resources, Financial Incentives, and Supporting Structures**

Inadequate funding and a failure to realize that departments may have only a limited capacity to overcome interdepartmental differences (e.g. underestimating the cost of working horizontally) can act as significant barriers to cross-ministerial work. [24] However, while money can improve capability, too much money too early in the process can also prevent people from innovating. [23] Strategic timing of funding is important. Timely funding can help motivate departments and ensure that results are consistent with the objectives of the initiative.

Whole-of-government initiatives may also benefit from a management culture that relies less on command and control, and more on financial incentives, continual monitoring, and ongoing consultation and engagement. [24] Reward and recognition are strong incentives for cooperation and coordination and new supporting structures are sometimes needed to facilitate ongoing consultation engagement and to maintain the momentum toward intersectoral work.

**Accountability**

Accountability is a component of governance that refers broadly to the responsibility and ability of one group to explain its actions to another. [33, 34] Behind this fairly simple definition lies a complex and ever-expanding concept. [35] Accountability has an external component, in that the account is given to some other person or body outside the one being held accountable. Straightforward examples include accountability relationships between citizens and elected officials, or between elected officials and civil servants. From the external perspective, accountability relates to authority and control. As stated by Mulgan, “The core sense of accountability is clearly grounded in the general purpose of making agents and subordinates act in accordance with the wishes of their superiors. Subordinates are called to account and, if necessary, penalized as means of bringing them under control.” (Mulgan, 2000: 558) [35]

In addition, accountability has an internal component (also called inward or personal accountability). From the internal perspective, accountability refers to the personal exercise of judgment and adherence to internalized standards, regardless of external scrutiny or sanction, actual or potential. The concept of organizational culture becomes highly significant, based on the assumption that
the desired outcome can be achieved without the use of explicit sanctions or control measures.

The literature on whole-of-government approaches and accountability is focused on external accountability. Having a clear accountability framework is deemed important to ensure the success of whole-of-government initiatives. However, in intersectoral work, clarifying the lines of accountability can be a significant challenge. Cross-cutting work involves more complex accountability arrangements, often related to overlapping accountabilities [36], in part because whole-of-government reporting typically exists on a level above individual agency reporting. In joined-up initiatives, various forms of reporting to Parliament exist, each one with different benefits and challenges. [37] For example, in the case of Ministers reporting to Parliament, accountability and its required reporting can exist in one or more of the following forms.

- When each entity answers for its own part, one-to-one relationships exist, which are simpler, but result in fragmented reporting.
- When an active participant takes the lead role, the potential for integrated reporting exists, but the role of the other minister(s) is sidelined.
- When a non-participating minister takes on a coordinating role, the potential for impartiality exists; the coordinating minister is answerable for results without having direct responsibility for the services or resources.
- When ministers answer collectively, the potential for integrated reporting exists, but there is no apparent basis for traditional individual ministerial accountability.
- When the prime minister or premier takes responsibility, the emphasis shifts to whole-of-government accountability.

According to Wilkins, the trend towards accountability for results over the past 25 years has in effect introduced the sharing of responsibility, while leaving in place traditional concepts of accountability. [37] It is still desirable to see a Premier or Prime Minister taking responsibility, but it might not be sufficient.

While the concept of shared accountability has been growing in popularity over the past two decades, surprisingly little evidence exists about what works and what does not. A report published during the golden years (1997-2002) of the joined-up government phase in the United Kingdom concluded that departments were given very little guidance on implementing accountability arrangements for joined initiatives. [36] In addition, there is an evidence gap regarding the “accountability for results” movement, with some describing it as a “cat’s cradle of overlapping, competing, and unclear lines of accountability.” (Perry 6 et al., 1999: 43) [38]

Performance Measurement

Performance measurement may help make accountability possible. Ongoing performance measurement and periodic evaluations are key tools when implementing joined initiatives. Performance management systems may generate information that can be used as incentives to stimulate intersectoral work and to maintain momentum. Performance measurement can take different forms, each with different implications regarding accountability. It can refer only to processes and actions that address priorities (monitoring function and process indicators), or it can measure impact through targets. As reported earlier, traditional outcome evaluations are challenging in some fields, such as public health, since the benefits of intersectoral action may require several years to materialize. [39]

The evaluation challenge is even more daunting in joined initiatives. Typically, joined initiatives are more complex and may require longer planning and implementation phases. In the United Kingdom, one of the greatest challenges faced by managers with health-related intersectoral initiatives was that the government demanded very early evidence of impact. As a consequence, the intersectoral partnerships placed an early emphasis on recording outputs for individual projects rather than taking the time to consider how best to structure their activities to realize longer term outcomes. [40] A special project in the United Kingdom investigated how performance measurement influenced intersectoral work. The Measurement and Performance Project was developed to understand and improve the use of targets and performance measures in multi-agency working. Several case studies investigated whether performance measures act as barriers or incentives to multi-agency work to deliver public services. A cross-case analysis found that 1) performance targets act as incentives to partnership working when they support shared aims and objectives; 2) greater coherence is needed between national, regional, and local organizations when
agreeing to high level targets; and 3) targets must be set against baselines using robust information. [41]

Conclusion
Some lessons learned from whole-of-government approaches are that one size does not fit all [42] and that using a whole-of-government approach may not be appropriate in all circumstances or for all public sector activities. At least two crucial questions remain: What governance and coordination mechanisms work best for effective intersectoral action and cross-ministerial work, and in what context? What are the essential components of an effective accountability framework for whole-of-government initiatives? Providing credible answers to these questions requires more interdisciplinary research on governance and accountability. In that regard, a report from the Alliance for Health Policy and Systems Research notes that research on governance and accountability has been neglected so far, and only limited knowledge is available to inform policy and practice. [34] The ActNowBC initiative provides us with an opportunity to contribute evidence to answer these questions for whole-of-government initiatives in the field of public health.
Section 3

The Case of ActNowBC

Background

As in other Canadian provinces and territories, chronic diseases are the single greatest obstacle to sustainability of BC’s health care system. [2] In 2007, more than 1.3 million people in BC were reported to have one or more chronic conditions, while over 90,000 people experienced four or more chronic conditions. [43] Representing approximately 34% of the BC population, these individuals consume approximately 80% of the combined budgets of the Medical Service Plan, PharmaCare, and acute care. [43] Furthermore, with the growing aging population and costly advances in medicine, pressures on the health care system are anticipated to increase. In the mid-1990s, the total budget of the Ministry of Health was approximately $6 billion while in 2008-2009, the budget rose to over $13 billion. [44] Much of these health care costs are linked to preventable conditions. [2]

Even with BC being among the healthiest provinces in Canada (e.g. for health-adjusted life expectancy), government policy makers felt an understandable sense of urgency when confronted by the budgetary implications of the rising prevalence of key chronic diseases. This is the entry point to the story of ActNowBC.

Setting the Stage for ActNowBC

ActNowBC was officially launched in March 2005. In this section, we retrace the events and explore the conditions that led to its creation, starting with the first key milestone, the announcement in 2003 of the Winter Olympics.

ActNowBC Milestones

<table>
<thead>
<tr>
<th>Event</th>
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<tbody>
<tr>
<td>Reviewing whole-of-government approaches in other countries</td>
<td>2001/2002</td>
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<td>Desire to present / develop a new health promotion strategy by a new provincial government</td>
<td>2002 / 2003</td>
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<tr>
<td>Announcement to host the 2010 Olympic and Paralympic Winter Games</td>
<td>July 3, 2003</td>
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<tr>
<td>Healthy BC 2010 initiative submitted to the Cabinet and led by the Ministry of Health</td>
<td>May to October 2004</td>
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<tr>
<td>Government set out Five Great Goals for BC’s Golden Decade</td>
<td>February 2005</td>
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<tr>
<td>Name change from Healthy BC 2010 to ActNowBC</td>
<td>March 2005</td>
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<td>ActNowBC launched by the Provincial Government</td>
<td>March 2005</td>
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<td>Incentive fund of $15 Million over 3 years for ADM Committee, $25.2 Million to the BCHLA and 4.8 Million to the 2010 Legacies Now.</td>
<td>2005</td>
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<tr>
<td>Nomination of a Minister of State for ActNowBC, under the Ministry of Tourism, Sport and Arts</td>
<td>August 15, 2006</td>
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<tr>
<td>All Ministries’ service plans reflect how ActNowBC goals and objectives are being met</td>
<td>2007 / 2008</td>
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<tr>
<td>ActNowBC transferred to the Ministry of Healthy Living and Sport</td>
<td>June 23, 2008</td>
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The need for a comprehensive chronic disease prevention strategy has long been recognized within the BC Ministry of Health. [45] However, bridging that need to public policy has been challenging, given the immediate needs and public profile associated with the delivery of health care services. According to the interviewees, the announcement in July 2003 that Vancouver would host the Winter Olympic and Paralympic Games of 2010 opened a clear window of opportunity to move population health promotion onto the political agenda. Public health officials were able to align their messages with those of 2010 Legacies Now¹, a non profit organization created by government to assist in preparing the Olympic bid. The

¹ 2010 Legacies Now is dedicated to strengthening arts, literacy, sport and recreation, physical activity and volunteerism in communities throughout BC leading up to and beyond the 2010 Olympic and Paralympic Winter Games. [51]
Olympics’ booking promised not only economic benefits, infrastructures, and facilities that would last well beyond the Olympics, but also a healthier population:

“...our whole [chronic disease prevention] strategy when we first started to articulate it in 2003, was we needed something that was long enough in the future ...that we could actually start seeing some differences and we concluded that why not as a legacy of the Olympics-to have a healthier population.” (Gov)

In 2003 to 2004, a chronic disease prevention strategy, called Healthy BC 2010, was developed. Public health officials took advantage of the Olympic platform to make the strategy more attractive to top bureaucrats and politicians. But the background work started in 2001 when the BC government established a Select Standing Committee on Health with the mandate to examine how to ensure that government expenditures on health care were sustainable. The Committee clearly understood the need for upstream action:

“...we could prevent up to 60 to 70% of all cancers... up to 90% of all heart disease, up to 60% of all strokes, up to 90% of all cases of chronic lung disease, up to 90% of all diabetes - all the things that are filling up our hospitals, and our doctors’ offices and our graveyards... I am deeply concerned that the entire focus of the general public, the current government and the health care system as a whole is to pull drowning people out of the river. I implore you to ensure we devote adequate time and resources to making sure people don’t fall into the river in the first place.” Dr. Andrew Larder, Medical Officer, East Kootenay Region [46]

With this kind of thinking taking hold, two key messages were put forward to justify the Healthy BC 2010 approach:

• If chronic disease rates were not curbed, Ministry of Health spending for health care would absorb increasingly larger percentages of the total government budget; and

• Effective prevention of chronic diseases required moving away from disease-specific approaches.

In 2003, public health officials promoting Healthy BC 2010 made several extensive presentations to the Select Standing Committee. Particularly compelling was the presentation of the first message above in what is sometimes referred to as the “killer slide” (see Annex 1). It showed that, without any new actions to promote health and prevent disease (i.e. maintaining the status quo), by 2017, the BC Ministry of Health would require 71.3% of the total budget of the government, increased from 41.6% in 2005-2006. The budget projection was based on three assumptions:

1. The Ministry of Health budget would continue to grow at an annual rate of approximately 8%, a rate well above the average gross domestic product (GDP) annual growth rate of 3%;

2. The budget of the second largest ministry, the Ministry of Education, would keep pace with the average GDP annual growth rate, thus steadily accounting for approximately 27% of all government spending; and

3. Taxation levels would remain constant.

From that point on, it was difficult to see chronic disease as solely an issue to be dealt with by the Ministry of Health:

“...if health spending stays like it is and the majority of our spending goes to chronic illness, that’s another really key point, and education we flat line it, the rest of government runs out of money in 2017, that’s everything. Every other ministry of government ceases to operate or we, as tax payers, crank a bunch of money into the system.” (Gov)

“...it became an economic story, not a health story, and that was what really captured the imagination, there was a “killer slide” – which was built by the ministry of finance on behalf of the ministry of health, which would project for the next decade the costs (should the costs continue) and the gross economic indicators continue the way they are, then basically BC will be bankrupt by the year 2017. And that captured the imagination of government and all the ministries as well and that was the turning point.” (Gov)

The other key message in marketing Healthy BC 2010 was that the burden of illness in the province is primarily linked to chronic diseases, and that effective disease prevention required moving away from a disease-specific approach. This proved to be a difficult selling point to both the government and civil society sector, as each had traditionally operated on a “one-disease-at-a-time” basis.
However, the first hurdle to this shift was cleared when the BC Healthy Living Alliance (BCHLA) was formed in February 2003. The BCHLA represents a group of organizations that came together to improve collaborative actions in promoting physical activity, healthy eating, and living smoke-free⁴. Instead of focusing on disease-specific strategies, the BCHLA targeted the risk factors common to major chronic conditions.

While Healthy BC 2010 was being promoted, the BCHLA was also preparing a plan, called “The Winning Legacy”, that advocated for multilevel interventions (e.g. community-based, regulatory and economic) to curb the chronic disease epidemic. The Winning Legacy proposal⁵ was circulated to each ministry with recommendations that fell within each ministry’s portfolio. From that, the BCHLA realized that they should partner their efforts and change the interface between government and nongovernmental organizations, especially if they were going to be successful in working toward societal change and going beyond the one-disease-at-a-time approach.

With its own presentations to the Standing Committee, the BCHLA ended up reinforcing the message that public health officials were sending:

“…if we, in government, are saying something that is completely contrary to what is happening with the NGOs, you get one of two things happening in government. One is they make the wrong decision to one party or another or they end up in this stale mate and they don’t make any decision… but by having the NGO community say the same thing that government advisors are saying, you begin to think that maybe it’s not a bad idea even if it is a change in the way of doing business. So Healthy BC 2010, that was the platform.” (Gov)

After presentations from government officials and the BCHLA representatives about chronic disease prevention in the province, the Standing Committee published a report in 2004 and recommended that Healthy BC 2010 be pursued. [46] More specifically, they recommended focusing on tobacco and alcohol, healthy living, and physical activity. They also recommended doubling the provincial public health budget from 3% to 6%.

The Deputy Minister of Health asked public health officials to then go to every ministry of government to make the case for Healthy BC 2010. One of the key messages was that the province needed a “whole-of-government” approach, that is, that the Ministry of Health alone would not be able to address the determinants of health responsible for the chronic disease epidemic. Again, the compelling business case successfully influenced the audience:

“…The Ministry of Health has this rising health care cost [everybody should] help the ministry solve the problem because… while the Ministry of Health is usually charged with solving the problem it doesn’t have all the levers…the other big message out of Healthy BC 2010 was: don’t put the responsibility for chronic disease prevention onto the Ministry of Health, we can provide data, we can provide skills, we can provide technical support but every ministry of government needs to give some thought to the kind of policies that they impose from a healthy public policy lens… We are trying to get government as a whole to take a look at the policies that they do in order to foster healthy communities and healthy public policy and the Ministry of Health can’t do that, only they can do that. We can provide support and help but we can’t do it for them.” (Gov)

The drive to obtain support for Healthy BC 2010 also included presentations at the “First Ministers’ Meeting” in September 2004. The Ministers “just couldn’t see putting more and more money into the health care system.” (Gov)

While there were questions about the effectiveness of population health and chronic disease prevention strategies, the then Deputy Minister of Health made a strong case for investing in upstream interventions. The discussion and idea papers produced by the Ministry of Health for the other First Ministers were considered by Government and in 2004 the concept of ActNowBC was “born”. Respondents perceived the Cabinet’s approval to be a positive sign for the future of the population health field within government:

“Up to this point, population health really had not been given the attention, so now that cabinet submission and the story that had been told brought

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⁵ For more information about the Winning Legacy, please follow this link: http://www.bchealthyliving.ca/node/388
After the Cabinet endorsed the strategy, the main task of public health officials, between October 2004 and March 2005, was to refine it and define performance health goals. The name change, from Healthy BC 2010 to ActNowBC, was somewhat controversial. Some public servants within the Ministry of Health worried that “ActNowBC” would be associated with a “blame the victim” approach while others saw it as referring only to physical activity:

“It’s not so obvious that it has anything to do with tobacco control, it’s not obvious that it has something to do with healthy eating, healthy body weights, so ActNowBC to me connotes more of a physical activity program like ParticipAction…” (Gov)

Controversy notwithstanding, the intentions of ActNowBC were reinforced. During the February 2005 Speech from the Throne, five months before the provincial election, the BC government of the day identified “Five Great Goals” for BC for the decade ahead:

1. To make BC the best educated, most literate jurisdiction on the continent.
2. To lead the way in North America in healthy living and physical fitness.
3. To build the best system of support in Canada for persons with disabilities and special needs, children at risk, and seniors.
4. To lead the world in sustainable environmental management, with the best air and water quality, and the best fisheries management, bar none.
5. To create more jobs per capita than anywhere else in Canada.

The second Great Goal reflected the message conveyed by the business case – that investing in prevention was necessary due to the fact that “pressures on our health care system are rapidly outstripping our economy’s ability to generate new revenues needed to pay for growing service demands.” [47] ActNowBC became the delivery piece for achieving the second Great Goal. There was even a reference to ActNowBC in the Throne Speech as a “new health and fitness promotion program to help focus new energy and new resources on preventative health care.” [48]

On March 23, 2005, ActNowBC was officially launched, and the broad goals of ActNowBC were made public:

- To make British Columbia the healthiest jurisdiction to host the Olympic and Paralympic Winter Games.
- To improve the health of British Columbians by encouraging them to be more active, eat healthy foods, live tobacco-free, and make healthy choices during pregnancy.
- To build community capacity to create healthier, more sustainable, and economically viable communities.
- To reduce demand on the health care system.

The five ActNowBC targets by 2010 are:

1. Physical Activity – To increase by 20% the proportion of the BC population (aged 12+ years) that is physically active or moderately active during leisure time, from the 2003 prevalence of 58.1% to 69.7%.
2. Healthy Eating – To increase by 20% the proportion of the BC population (aged 12+ years) that eats the daily recommended level of fruits and vegetables, from the 2003 prevalence of 40.1% to 48.1%.
3. Tobacco Use – To reduce by 10% the proportion of the BC population (aged 15+ years) that uses tobacco, from the 2003 prevalence of 16% to 14.4%.
4. Overweight/Obesity – To reduce by 20% the proportion of the BC population (aged 18+ years) that is currently classified as overweight or obese, from the 2003 prevalence of 42.3% to 33.8%.
5. Healthy Choices in Pregnancy – a) To increase by 50% the number of women counselled regarding alcohol use during pregnancy; and b) To have focused strategies for fetal alcohol spectrum disorder (FASD) prevention in all health authority areas.

To achieve these targets, the ActNowBC initiative relies on intersectoral action through both vertical and horizontal dimensions. Annex 2 has a summary of all
ActNowBC-related programs and activities currently underway in British Columbia.

In conclusion, ActNowBC now means different things to different people. The general public recognizes ActNowBC as a healthy living social marketing campaign. There are ActNowBC websites and books offering tips about healthy living, as well as an ActNowBC Road to Health Community Tour, featuring a 9,000-square-foot travelling pavilion composed of interactive exhibits and informative displays.

However, to people within government, ActNowBC still refers to a whole-of-government approach to promote health:

“ActNowBC is not just an umbrella for how the government interacts with the public, but it is about how it interacts internally in and of itself...so it is holistic in terms of a government approach.” (Gov)

The whole-of-government approach is the topic of the horizontal dimension of ActNowBC. The focus is on the processes involved in designing and implementing a whole-of-government approach. A discussion about initial outcomes, including about ActNowBC’s contribution to the development of new healthy public policies (or the refinement of existing ones) is presented on initial outcomes associated with the ActNowBC initiative.

**ActNowBC: The Horizontal Dimension**

In this section, we examine the factors, structures, and mechanisms that influenced the implementation of ActNowBC within the BC government. We begin by providing an overview of how leadership and governance structures were used to give the ActNowBC initiative an intersectoral vision and direction. The perceived advantages and disadvantages of governance changes since the launch of ActNowBC are also discussed.

We examine more specifically four other mechanisms and strategies used to further secure partners from different ministries and to keep these partners engaged and committed:

1. Setting goals and targets that implicated more than the Ministry of Health.
2. Creating a $15 million incentive fund in the Ministry of Health to which all ministries could submit proposals for pilot projects showing a link with the ActNowBC goals.
3. Establishing an interdepartmental committee with an Assistant Deputy Minister from every ministry.
4. Developing an accountability framework.

**Leadership and Governance: Giving a Direction to ActNowBC**

Between March 2005 and June 2008, the ActNowBC initiative benefited from stable high-level political leadership. However, it also experienced a series of transitions in governance structures in government. Two interrelated considerations were central to all aspects of leadership and governance: ensuring the participation of the maximum number of individuals within government, and raising the profile of ActNowBC both within and outside government.

**High-Level Political and Public Service Leadership**

Consensus was strong among the respondents that political leadership played a vital role in the announcement of ActNowBC. The Premier set the tone immediately, by announcing the initiative in a Throne Speech, which is the highest level of communication within the province. This showed that the ActNowBC initiative was a high priority across government. When an initiative is promoted by the Premier and by the Cabinet, then you “have that political drive, you start to be able to move forward and commit to things that were not always possible before.” (Gov)

“The key to ActNowBC is the political will. You need a government that will set targets and goals for the whole-of-government and then hold itself accountable. The goals that they set need to be real goals and targets, they can’t be the lowest common denominator because nothing ever changes so you’ve got to set high enough goals and then you’ve got to
measure yourself against them and report publically. Government [typically] just don’t do that.” (Gov)

Political support contributed to establishing even more ambitious goals than what public health officials had originally envisioned:

“…over time the ‘one of’ disappeared and it became ‘the healthiest’ jurisdiction [to ever host the Olympics]…which is fine, I mean that’s what politicians do.” (Gov)

The importance of political will was also acknowledged by respondents from the civil society sector. During the planning phase of ActNowBC, the lines of communication were open between the Premier’s office and the BCHLA:

“…we cannot force anything but the Premier sure can… It’s coming from the highest place, otherwise none of this would have happened. The BCHLA, when we were peddling our Winning Legacy6, we had ready access to the Premier. He liked that work.” (NGO)

Political leaders thus expressed their support for health promotion and chronic disease prevention, not only within government, but also openly in the public sphere through Throne speeches and through interaction with the civil society sector.

The fact that the ActNowBC platform is viewed as largely apolitical is another success factor. As a result, spending associated with the ActNowBC initiative has essentially not been questioned by the opposition members in the Legislative Assembly. They commonly attended, across political parties, ActNowBC community events. Several senior public servants supported ActNowBC by demonstrating exemplary leadership in cross-ministerial work:

“What’s critical to success, absolutely critical is your senior leaders- if you don’t have your deputies and your ADMs on board, that’s it- it cannot work… everybody knows that in a bureaucratic system, in many ways, it is top down and so if your top people don’t practice collaboration and across sector integration, then it doesn’t happen. You know, it’s your leaders that have to hold your staff accountable.” (Gov)

Political and public service leadership was a key factor in the success of early implementation of the ActNowBC initiative. Because ActNowBC was supported by key leaders in the Cabinet and within government, it has been relatively easy to increase staff and find resources to build ActNowBC within government.

**ActNowBC under a shared leadership and governance model**

Despite its short history, the ActNowBC initiative has already experienced different forms of governance and stewardship models. We discuss these transitions below.

**Broadening the Leadership Base: ActNowBC under the Ministry of Tourism, Sport and the Arts (MTSA)**

ActNowBC remained within the Ministry of Health from March 2005 to August 2006. The Ministry of Health provided the expertise and leadership needed to successfully launch the initiative. However, there were at least three concerns about keeping ActNowBC within the Ministry of Health. First, that it would continue to be seen as a “health” project rather than as a cross-governmental initiative. Second, perceptions existed that the Minister of Health was already burdened with a large portfolio and the Ministry of Health was oriented so strongly toward acute care that chronic disease prevention strategies would not be emphasized sufficiently to optimally support the ActNowBC initiative. Third, many government stakeholders believe that it would be beneficial for ActNowBC to become better known to the public.

The desire, from a political perspective, to establish ActNowBC as a well-known brand was the determining factor behind the decision to have ActNowBC under the co-leadership of the Ministry of Health and the Ministry of Tourism, Sport and the Arts:

“…they didn’t want it to simply look like a government structure.” (Gov)

“…you’ve got a government that is doing the right thing and nobody knows about it. You are not going to get the long term political support if the good thing that government does doesn’t get acknowledged.” (Gov)

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6 The Winning Legacy proposed a plan for improving the health of British Columbians by 2010. The BCHLA plan emphasized the need for a combination of regulatory, economic and community-based interventions to tackle the chronic disease challenge in British Columbia.
Transferring some of the leadership and responsibilities for ActNowBC from the Ministry of Health to the Ministry of Tourism, Sport and the Arts addressed all of the points above. It was especially relevant to the public relations argument, since the Ministry of Tourism, Sport and the Arts likely has the strongest connections to media and produces the most advertising of any ministry in government. The Ministry of Tourism, Sport and the Arts also does all promotion around the Olympics. Under that new governance model, public health officials connected with ActNowBC since the beginning remained involved and supported the Ministry of Tourism, Sports and the Arts in terms of technical expertise. For example, an Assistant Deputy Minister from the Ministry of Health changed from chairman to sharing the position as co-chairman with an Assistant Deputy Minister from Ministry of Tourism, Sport and the Arts, to guide the work of an ActNowBC Interdepartmental Assistant Deputy Ministers Committee. The Ministry of Tourism, Sport and the Arts was expected to assume mainly a coordinating role for both the horizontal and vertical dimensions:

“…what MTSA are simply trying to do is coordinate and stimulate the activity of our other Ministries and coordinate the work of the non-governmental side.”

(Gov)

A Minister of State for ActNowBC

The shift to a shared governance model went beyond a transfer of coordination responsibilities from one ministry to another. The Premier also created a Minister of State position for ActNowBC. On August 15, 2006, the Minister of State was sworn in to office under the Ministry of Tourism, Sports and the Arts. This appointment was presented as a way to strengthen the government’s focus on the promotion of physical fitness and healthy living.

From 2007 to 2008, under the Balanced Budget and Ministerial Accountability Act, the Minister of State was responsible for ensuring that all government business works in harmony to support healthy British Columbians. More specifically, the Minister of State was to:

- Provide strategic facilitation and cross-government coordination.
- Encourage the investment of seed money across government to galvanize action.
- Ensure expert advice and support in developing ActNowBC initiatives and policy.

The vast majority of respondents were in favour of the decision to create the Minister of State position for ActNowBC, with some describing it as a “fabulous idea” (Gov) because it created “a full-time job making people accountable.” (Gov) However, there was no consensus among the respondents about whether attaching the Minister of State position to the Ministry of Tourism, Sport and the Arts was the best decision. Among respondents who agreed that the position needed to be outside of the Ministry of Health, many believed it should have been attached to the Premier’s office.

Perceived Advantages and Disadvantages of the Transition

Overall, no consensus existed among respondents on whether the change in governance (moving toward a shared governance model and creating the position of Minister of State) had a positive or negative impact on the ActNowBC platform: “you can argue for the transition both ways.” (Gov) For some respondents, the transition to a model involving the Ministry of Tourism, Sport and the Arts reinforced the idea that the ActNowBC initiative was not just a response to a health problem to be solved; it also gave the Minister of State the responsibility of holding everyone else accountable for advancing the ActNowBC platform:

“It did not matter where ActNowBC resided, as long as the principal of ActNowBC – was that it was a platform that all government ministries could see their real role and responsibilities.” (Gov)

“Because ActNowBC has such a broad reach, the Minister was able to go into Cabinet and he was able to go and twist the arms of the other ministries and say ‘you guys aren’t doing what you should be doing, this is the Premier’s and the government’s initiative, not Ministry X initiative.’” (Gov)

There was a clear consensus that the new governance structure provided ActNowBC with a higher profile than it would otherwise have had as one initiative within a very large Ministry of Health. Some respondents also made it clear that the person appointed as the Minister of State for ActNowBC within the Ministry of Tourism, Sport and the Arts showed tremendous leadership in promoting ActNowBC both within and outside government:

“The Public Affairs Bureau has indicated that the public awareness has grown dramatically in the last 18 months.” (Gov)
Some respondents, however, called the decision “a huge strategic error” (Gov). Many were concerned that ActNowBC under the Ministry of Tourism, Sport and the Arts would focus too much on “sports” through a social marketing campaign:

“…we were worried that it would become a kind of ParticipAction on steroids just for the social marketing campaign. A social marketing campaign is a component but it is not the real important piece that you need.” (Gov)

“It came out as sort of RAH! RAH! sports, marketing, tourism, elitism, behaviour changing, pick yourself up by your bootstraps kind of attitude…” (Gov)

In conclusion, the change in governance was perceived by most respondents as a trade-off. It gave ActNowBC more visibility outside of government, but it led, according to several respondents, to an overemphasis on social marketing as “the” strategy to meet the ActNowBC goals.

ActNowBC under the Ministry of Healthy Living and Sports

The last chapter of the ActNowBC story, as of November 2008, started on June 23, 2008 when the BC Government announced the creation of the Ministry of Healthy Living and Sports. This new Ministry takes over public health functions and will now oversee the entire ActNowBC initiative. The Minister of State position for ActNowBC was abolished. While the respondents interviewed after the announcement were optimistic that ActNowBC would remain a strong initiative under this new Ministry, the idea of trade-off was again brought up:

“The disadvantage is that we have a Minister now who is responsible not only for ActNowBC, but many other things where as previously it was a Minister of State for ActNowBC, so there are always trade-offs in these kinds of things. I’m hoping that the portfolio of the new minister is not so large that the concept behind the intersectoral approach is somehow lost in the day-to-day urgency of all those crisis-oriented things that tend to happen within a ministry of this nature that are not necessarily solely ActNowBC.” (Gov)

However, it was also perceived as a transition that could provide a focus on the social determinants of health given the portfolio of the new Ministry. The new Ministry’s portfolio hopes to improve programs and develop initiatives that center on training and skill development and that provide new supportive opportunities for children, seniors, women, and those who are the most vulnerable. The press release stated that “this new cabinet hopes to continue its efforts to enhance partnerships and programs that build strong communities throughout British Columbia; through support in housing / homelessness; economic development; transportation / infrastructure; and multiculturalism.” [49]

New Coordination and Accountability Mechanisms

A number of mechanisms and strategies were implemented between 2005 and 2008 to ensure that ActNowBC would effectively increase coordination and cooperation across government for attaining the ActNowBC goals. These mechanisms and strategies are described below.

Setting ActNowBC Goals and Targets

Target setting first involved examining data from the Canadian Community Health Survey to find the baseline (i.e. current status) for each of the ActNowBC pillars. Afterward, the ActNowBC targets were refined expeditiously by a small number of high-level decision-makers in government. One of the perceived advantages of not entering into a complex target setting exercise was timeliness:

“Without them setting or reaching for those targets, we would probably still be arguing about them today.” (Gov)

All respondents lauded the decision to include goals and targets in ActNowBC as integral to the initiative:

“…these are pretty precise and without the goals and the targets, ActNowBC means nothing.” (Gov)

The targets are recognized as “stretch” targets and seen as a way of pushing people in government to do more: “If you simply just go along with what you could easily achieve, then you are not really driving.” (Gov) From that perspective, some respondents stated that not successfully reaching all of the targets should not be seen as a failure:

“They are beacons. They symbolize where we want to be. I think we will be very pleased if by 2010 there are indications that we are headed in the right direction.” (Gov)
“…If we don’t reach them, then we have not failed - we hope to measure some change.” (Gov)

“I would feel devastated if we hadn’t influenced the trend. I think that in some cases, we will reach the targets but even if we don’t. I don’t really care, I want to see a change the trajectories of the risk factor data and if we have done nothing else that’s critically important.” (Gov)

But for some respondents, that ActNowBC ended up with “political” targets was perceived as a disadvantage. There were concerns that demonstrating success would be difficult, a situation that could undermine political support for ActNowBC in the long term:

“…good for them but man there is a difference between political targets and realistic targets. Both have merit, I understand there is value in both of them but when you try to actually attain a political target, that’s really difficult…” (Gov)

“…you have to think about setting up something that is attainable because if you don’t attain it, then you undermine everything that you are trying to do… We could have been much more modest.” (Gov)

“I’m a bit concerned when we fail to achieve those targets, the response may be, well that didn’t work, let’s do something else as opposed to understanding that a) the targets were unrealistic and b) those kind of profound social changes take a generation. I mean the lesson from tobacco is exactly that.” (Gov)

Consensus existed among respondents that the obesity target would be the most difficult to reach, while the target related to healthy choices in pregnancy would be the easiest. In fact, the official target for healthy choices in pregnancy (the only process target for ActNowBC) has already been met, and public health officials are now broadening the scope of the program by focusing not only on alcohol intake but also on smoking cessation, healthy eating, and healthy living in general.

Incentive Funds

In 2005, the Ministry of Health created an incentive fund to jump-start cross-ministerial work around the ActNowBC platform and goals. Through this mechanism, the Ministry of Health was to spend $15 million over three years to support pilot projects proposed by other ministries:

“We committed that funding…to help change the behaviour and thinking of senior government officials [from other ministries] and I think it did.” (Gov)

An eligible pilot project had to meet a number of criteria, including contributing to improving health and/or tackling a policy issue through a wellness lens; consisting of “new” business; involving cost-sharing (money or in-kind contribution); and being sustainable. At the beginning, most projects were approved, but the process became more competitive with time: “lots and lots of applications coming in, we had to strengthen the criteria in terms of what we could accept.” (Gov) The incentive fund supported 30 projects from 10 ministries between 2005 and 2008. According to government officials managing the fund, this segment of the ActNowBC initiative generated some projects that demonstrated real innovation.

For example, the incentive fund supported a project submitted by the Ministry of Community Services. That Ministry originally funded an oral health outreach program in a dental clinic in downtown east side Vancouver, one of the poorest urban neighbourhoods in Canada. Through the incentive funds, the program started offering a larger basket of services:

“If you have a toothache, that’s a pretty good motivator to go to the clinic. They had a guaranteed source of very marginalized people that were coming to the clinic and their thinking was that if they got the clinic and they got the clients, could they not use that as an opportunity to do some education around healthy eating and the need for physical activity to try to take the ActNowBC thing and wrap it around an existing program.” (Gov)

However, in 2007, the decision was made to not allocate new money to fund projects in this way. Respondents were split in their opinions about this decision. Some respondents felt that the smaller ministries simply couldn’t support these programs financially by themselves:

“If the funding does not continue, most projects will end, because budgets are tight.” (Gov)

“Not renewing the incentive fund - bad idea. I mean the other ministries look at Health as the ministry that ate the government and ate their budgets so here’s the Ministry of Health looking at an incentive fund that was less than a rounding error in its budget and yet made a real difference to them.” (Gov)
The incentive fund was intended for a three year period, never as “permanent dollars”. “Every program that has merit needs to be able to sustain itself.” (Gov) Respondents from the Ministry of Health were “on the fence” (Gov) regarding this issue. On one hand, the mechanism proved to be popular and stimulated the implementation of innovative projects. On the other hand, some of the other ministries were not necessarily taking measures to ensure sustainability of the projects proposed and some respondents believed that the Ministry of Health was still too much in control. It proved difficult to create situations where the initial financial boost from the Ministry of Health led to other ministries needing less support to continue innovative projects:

“…you want Health to put money in but you don’t want Health to take over so if Health starts to put in a big whack of money, then it needs to do so in a way that says, ‘it’s a contribution, it doesn’t come with strings attached’… otherwise it becomes a little empire-building exercise. That’s not what we want to do or how we see it so it’s that kind of delicate little dance between contributing but not taking over.” (Gov)

Several respondents expressed the idea that the incentive fund should be replaced by an “innovation” fund. The incentive fund was a success in the sense that “it got people engaged, but now we need incentives to try something new”. (Gov)

Assistant Deputy Ministers’ Interdepartmental Committee

The Cabinet and Treasury Board gave the Ministry of Health the responsibility of ensuring that ActNowBC would grow as a cross-government initiative. An Interdepartmental Committee was established, with 19 Assistant Deputy Ministers and representatives from the BC Public Service Agency, Intergovernmental Relations Secretariat, and Public Affairs Bureau. The ActNowBC ADM Committee is ultimately accountable to the Premier of the Province. The Committee mandate is to ensure that all ministries understand, support and contribute to the achievement of ActNowBC targets. [50]

The Committee was chaired initially by the Assistant Deputy Minister from the Ministry of Health. In 2006, the Assistant Deputy Minister from the Ministry of Tourism, Sport and the Arts became the co-chair, in recognition for its lead role in the initiative. The Committee was responsible for cross-ministerial issues and for making recommendations about potential public health-oriented policy actions. During the first year, the Committee tried to meet every month. By all accounts, the Committee had a slow start:

“I have got to be honest with you, the committee meetings got off to a slow start. They had to be convinced. They had to really work and it goes back to the work that actually started out here probably 15 years ago on the broader determinants of health. Getting them to understand what that was all about was not an easy task.” (Gov)

During the first year, the Committee meetings largely amounted to “Population Health 101” meetings. The content of these meetings was appreciated, but time constraints became an issue, and many Assistant Deputy Ministers delegated a director to attend the meetings in their place. Discussions during that first year also focused on how each ministry could contribute to the ActNowBC goals. Developing an ActNowBC logic model for each ministry and integrating ActNowBC measures into each ministry’s service plan started during the first year. While there was a fair level of support for this approach, it was a barrier to the participation of some Assistant Deputy Ministers: “do ADMs want to sit around and look at logic models for the whole day?” (Gov) There was a sense among some respondents that Assistant Deputy Ministers should not be involved with the tiny details, that instead they should be focusing on the high level information they needed to champion the ActNowBC message within their ministry. In that regard, proposals were made to establish intersectoral expert advisory subcommittees that could involve representatives from the NGO sector. However, the governance for ActNowBC was changed to also include the Ministry of Tourism, Sport and the Arts before these subcommittees could be established.

There was a consensus among respondents that the change in governance had a major impact on the functioning of the Committee. For one respondent, the change had a positive impact:

“One of the reasons why I think it was a slow start, and this isn’t a reflection on the individual, but until there was a Minister of State appointed, there certainly was a view that this was just a health project.” (Gov)

However, the governance change was not viewed positively by the majority of respondents involved with the Assistant Deputy Ministers Interdepartmental Committee. During
the 16 to 18 months after the transition, the Committee “lost its focus” (Gov) and “its momentum” (Gov), and the meetings were only taking place at intervals of three to four months. Some respondents suggested that only the Ministry of Health had the necessary expertise to lead the Assistant Deputy Ministers Interdepartmental Committee:

“Everything was going really quite well until they moved it out of the Ministry of Health…as far as I can tell, the ActNowBC ADM Committee has been basically non-functional for the last year or 18 months. The Committee existed before the change in leadership, which meant that Health was on the agenda in every ministry. That meant that it was in every service plan and that all happened before the change in governance. I do think that the Minister of State was a good idea, but it should have stayed within Health… I mean the lesson to be learned for me is that you don’t take something that is a very sophisticated health promotion approach and turn it over to people who don’t understand what health promotion is…and there is really not a lot of capacity and resources to deliver through MTSA.” (Gov)

“I would say that the internal government piece has slipped since the lead changed from health to tourism.” (Gov)

“There were some significant shifts…up to the transition, the ADM Committee was central to the strategy, it was developed to have somewhat of a decision-making point, so issues were taken to them…but with the move to the MTSA, with a new Minister of State, that was not required anymore from the Committee, so the ADM Committee was repositioned as an Advisory Committee to the internal workings of the ministry.” (Gov)

About a year and a half into its mandate, the Committee returned to high level issues. For example, the Minister of State requested that the Committee identify what British Columbia could do in the next 25 years to become the healthiest jurisdiction in the world. This exercise led to a voluminous compilation of policy ideas and options. A triage process, partly based on cost-effectiveness criteria, led to prioritization of 56 of these policy ideas. This was still an internal process, and with the change in governance to the new Ministry of Healthy Living and Sports, it is unclear what will happen to these 56 policy ideas. The Assistant Deputy Ministers Interdepartmental Committee is still trying to focus on cross-ministerial issues. The issue of procurement is currently an area of interest, one that would involve the private sector:

“…if we set a standard for a healthy workplace, we could require that anybody that sells a product or a service to the government has to meet that standard … I think that you might start by creating the ActNowBC awards for companies small, medium and large that deal with government and that adhere to these values. You then introduce it into the RFP (request for proposals) so that it says consideration will be given to companies that have healthy workplaces…” (Gov)

In terms of process, emphasis has been placed on the need for the Assistant Deputy Ministers to attend the meetings, instead of sending delegates and substitutes: “you either show or you don’t show.” (Gov)

In conclusion, while there is a consensus that creating the Assistant Deputy Ministers Interdepartmental Committee was a worthwhile step there are still disagreements about how the Committee should operate.

**Developing an Accountability Framework**

High-level political leadership and new governance structures played important roles in fostering intersectoral cooperation. However, developing an accountability framework was seen by most respondents as both the most important and the most difficult component of ActNowBC as a whole-of-government approach.

Three fundamental questions guided development of the accountability framework:

1) Who should be held accountable (at what level)?

2) What should individuals and organizations be held accountable for?

3) How (i.e. through which mechanisms) can accountability be put into practice?

These three questions are clearly interrelated; for example, the choice of a specific accountability mechanism has implications for who is held accountable and what they are accountable for. Accountability is being established both internally and externally.

Externally, accountability for ActNowBC involves the highest level of authority – the Premier. Indeed, the
fact that the Great Goals and the ActNowBC goals have been widely publicized indicates that substantial communication is occurring with the Cabinet. In January 2008, the BC government released its first ActNowBC progress report. The report presented a sample of the initiatives from each of the targeted areas and a description of the progress toward achieving the ActNowBC objectives. Internally, specific mechanisms have been implemented to strengthen accountability for population health through the ActNowBC goals. We review two of these mechanisms below.

**Logic Models - First Piece of an Accountability Framework**

The logic models are one piece in a larger accountability framework. A general logic model was developed for the whole initiative (See Annex 3). Afterwards, two logic models were developed for each ministry. The first logic model focuses on what each ministry can do internally for their own employees (e.g. providing healthy food in vending machines), while the second one specifies what each ministry needs to do for the general population (e.g. ensuring that healthy foods are provided in schools). The Assistant Deputy Ministers Interdepartmental Committee was involved in developing these logic models. In addition, an official from the Ministry of Health visited each ministry to help define activities and programs that could directly contribute to achieving the ActNowBC goals. During a full-day session involving 20 Assistant Deputy Ministers, the discussions focused on what each ministry could do regarding the four ActNowBC pillars. Limits had to be established as to what was acceptable. For example:

“*It’s a stretch to say that the Ministry of Transportation program to build roads is helping to efficiently deliver [healthy] products to communities around BC. That is not an ActNowBC project, just to build roads. We have crossed those ones out and said, that is not something that is part of your ActNowBC commitments.*” (Gov)

Continuing with the example of the Ministry of Transportation, the external logic model included the following short-term expected changes:

1. A “cycling access lens” is used when planning highway improvements.
2. Cycling infrastructure across the province is maintained and improved.

3. A well-maintained provincial multimodal transportation network is provided for moving people and goods.
4. Trail systems linking to major transportation routes are increased.
5. Access for communities to local trail systems is increased.

Most, but not all, respondents valued the ActNowBC logic models, mainly because they are a familiar tool in government:

> “It’s so simple, yet so complicated…but they are useful and I’m a big fan of them because they are a common language so every ministry knows what they mean.” (Gov)

The logic models were seen as another way to engage the various ministries and plant the philosophy of cross-ministerial work “*within their psyche*”. (Gov) However, the logic models were also seen as the foundation for developing an accountability framework:

> “I think the missing piece is accountability. I think if we can somehow find a way to hold the ministries more accountable for their contribution… I think the logic models stage is probably the first precursor to that…they have identified, through their core business the kind of things they can contribute. The next step would be to identify certain deliverables and then hold them accountable and I think that we will eventually get there.” (Gov)

As of October 2008, the development of the accountability framework is still underway. We describe below the steps taken since March 2005.

**Using Service Plans**

BC ministries are required, for transparency and accountability, to develop annual rolling 3-year service plans outlining priorities, performance measures, and targets. Deputy Ministers Committees review the priorities, and the Government Caucus Committee reviews full plans. Progress is reported annually.

Respondents perceived that requiring ActNowBC activities in the service plan of each ministry was one of the main mechanisms by which cross-ministry contributions to ActNowBC were mobilized. The high-level review and approval processes for service plans including ActNowBC initiatives were seen as more
effective in supporting whole-of-government approaches than health impact assessment\(^7\), a method that some felt has not made a positive difference in the past to guide decision-making within the BC government:

“It’s…better having the accountability in the service plans and having the logic models than not having it there at all. I mean there was an experience here…with health impact assessments and it didn’t work and the reason it didn’t work is that it became just a check-off…but putting it in the service plan is a little different because a service plan is signed by the deputy and by the minister and they are accountable for delivering what’s in it…the minister is on the hook for making sure that it is done and the deputy’s performance pay is geared to having that done, so I think it’s a very powerful tool.” (Gov)

Several stages are involved in ensuring that ActNowBC is properly positioned in the ministerial service plans. The Assistant Deputy Ministers Interdepartmental Committee is responsible for reviewing the ActNowBC components in the service plans. The Minister of State for ActNowBC, during his term, was also involved with the different ministries. The service plans are then reviewed by a Government Caucus Committee. Finally, the Agenda Development Committee performs a formal review of all service plans. The Agenda Development Committee is a committee of the Cabinet comprising four cabinet ministers, two private members, and the Premier (who serves as chairman). The minutes of Agenda Development Committee meetings are reviewed by the Cabinet, which provides the final review and approval. One challenge noted by some respondents was that the ActNowBC component in a typical service plan was usually just a paragraph in a very long document. However, efforts were made to ensure that priorities, like ActNowBC, were clearly identified:

“…the service plans, we have changed them this year, they are much more abbreviated. Last year they were 30-40-50 pages… I think the bureaucracy really wound up and made it so enlarged and we didn’t control that and so it probably become less than meaningful so we are trying to crystallize it to focus around some more specific goals and processes that are measurable and that people may take some interest in seeing and doing.” (Gov)

In line with the Ministry of Transportation example used in the section on logic models, Table 2 presents the section of the service plan that refers to ActNowBC.

Table 2: Excerpt from the Service Plan (2007) of the Ministry of Transportation

<table>
<thead>
<tr>
<th>Service Plan of the Ministry of Transportation – The ActNowBC component</th>
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</thead>
<tbody>
<tr>
<td><strong>In support of this initiative, the Ministry of Transportation is:</strong></td>
</tr>
<tr>
<td>• Promoting physical activity by facilitating cycling, trails, and access to recreation. The Ministry has dedicated $60 million to cycling infrastructure for the Gateway Program in the lower Mainland, $10 million of which will be matching funds used to engage local government in linking into the cycle network. In addition, the Ministry provides up to $2 million annually through its Cycling Infrastructure Partnership Program, which is a 50/50 cost share program aimed at assisting local governments to enhance the attractiveness of cycling as a commuting option through the construction of bike networks throughout the Province.</td>
</tr>
<tr>
<td>• Working with the Ministry of Community Services, the Ministry of Transportation administers the LocalMotion program, which provides $40 million over 4 years for investment in capital projects including bike paths, walkways, greenways, and improved accessibility for people with disabilities. This program gives local governments extra resources to improve air quality and safety, reduce energy consumption, and encourage all British Columbians to get out and be more active in their communities.</td>
</tr>
<tr>
<td>• Facilitating access to nutritious foods, health care, recreational opportunities, and other social and economic activities through the provision of safe and supported transportation links.</td>
</tr>
</tbody>
</table>

It is impossible to say with certainty that these investments would not have been made without the presence of ActNowBC. Still, there was a consensus among respondents that having a clear reference to an ActNowBC component in the service plans (based on the logic models) emphasized the importance of all ministries contributing to the ActNowBC goals. The consequences of not delivering on ActNowBC seem to rest at the individual level. For example, Ministers and Deputy Ministers have “hold backs” on performance pay if no progress is shown towards components of these service plans. The challenge remains to define the appropriate process and outcome measures, since officials do not want to be blamed for things over which they have little or no control. From that perspective, it is unclear

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\(^7\) Health Impact Assessment (HIA) has been defined by the World Health Organization (http://www.who.int/hia/en/) as a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. Consequently, HIA provides decision-makers with information about how any policy, program or project may affect the health of people.
if a ministry should include something in their service plan that requires another ministry to fulfill an obligation, unless clear agreement and commitment exist between the ministries involved.

A Work in Progress
The next step in refining an accountability framework involves finding ways to influence all ministries to have a “healthy-living lens” when proposing something to the Cabinet or Treasury Board. Several respondents mentioned that developing an accountability framework is still a work in progress, although some of the reporting and monitoring functions are covered through the review of service plans. The next challenge also involves how to define success since performance assessment helps make accountability possible. For some respondents, there is a need to identify outcomes that are measurable:

“To me the logical next step of the logic models is to add outcomes that you can measure. So don’t change the core business of the Ministry of Mines but continue to work with them and create through their logic models, even if it’s just a couple of activities, that you can actually measure and say, yes we have done it and then hold the ADM representative on the ADM Committee accountable for that.” (Gov)

However, according to several respondents, it remains challenging to avoid a “check-box” mentality regarding accountability.

Summary Points - ActNowBC as a Whole-of-Government Initiative
• High-level political and public service leadership was a critical factor in success by providing a continuous impetus for establishing ActNowBC as a whole-of-government initiative.
• ActNowBC could not stay a purely internal initiative since the political support for ActNowBC is partly conditional on its visibility in the public sphere.
• Two internal “pull” mechanisms, the incentive fund and the Assistant Deputy Minister Interdepartmental Committee, contributed to understanding the issues and challenges with intersectoral action for chronic disease prevention and increased communication and cooperation across ministries.

• The development of logic models and integration of ActNowBC into service plans are the two main accountability mechanisms used so far to ensure that each ministry contributes to ActNowBC.
• Developing a comprehensive accountability framework remains one of the most significant implementation challenges of ActNowBC.
• The horizontal dimension of ActNowBC delivered increased investments in programs or infrastructures that promote or facilitate healthy living. ActNowBC is also seen as having contributed to the development or refinement of a number of healthy living-related policies and legislation. However, respondents were not prepared to always frame the influence of ActNowBC on policies using a “cause and effect” paradigm.

ActNowBC – The Vertical Dimension
We describe in this section the mechanisms delivering vertical integration to the ActNowBC initiative: ongoing collaboration with the BCHLA, the involvement of Health Authorities and BC municipalities, and the creation of the ActNowBC Leadership Council.

A Partnership with the BC Healthy Living Alliance
After the launch of ActNowBC, there was a consensus among Ministry of Health officials that the support and contribution of individuals and organizations outside of government was needed to achieve the ActNowBC goals:

“…even if you have a whole-of-government approach, if you don’t get civil society to support it, you are dead in the water…” (Gov)

The BC Healthy Living Alliance (BCHLA) was formed in February 2003, before ActNowBC. Numerous NGOs had a history of collaboration, particularly around the issue of tobacco. They had experienced how partnerships and, in turn, the services that each provide, are often more effective and taken more seriously if they integrated their efforts for the longer term, understanding that social behaviours take time to change.
In March 2005, BCHLA submitted to the BC government *The Winning Legacy – A Plan for Improving the Health of British Columbians*, which included evidence-based rationales for legislation and 27 recommendations that paralleled ActNowBC. In March 2006, the province invested $30 million in the non-governmental sector, with $4.8 million to 2010 Legacies Now and $25.2 million to the BCHLA.

“It’s the largest grant that I have ever been associated with in public health and it changed the relationship overnight between government and the non-government sector.” (Gov)

The BCHLA reaches deeply into the civil society community. It comprises nine NGO representatives, who are voting members, and ten non-voting members including health authorities and representatives from the Ministry of Healthy Living and Sport, ActNowBC and 2010 Legacies Now. There is also a Network of 22 other organizations who share a common interest in the work of BCHLA and who are invited to participate in some of BCHLA’s activities. The Alliance represents the interests of its members when the province is making decisions. Collectively, BCHLA members represent over 40,000 volunteers, 4,300 health and recreation professionals, and 184 local governments across BC. [51]

Member organizations of the Alliance have identified goals to reduce the burden of chronic disease in BC, including to:

- Advocate for and support health-promoting policies, environments, programs and services;
- Enhance collaboration among government, nongovernmental, and private sector organizations; and
- Increase capacity of communities to create and sustain health-promoting policies, environments, programs, and services. [52]

**Early Opportunities and Challenges**

**Getting Started**

The funding created an opportunity for the Alliance and the government to partner; however, it also presented some challenges. First the government needed to find a secure mechanism to deliver such a large grant. The BCHLA is not a legal entity and could not receive it directly. At the request of the BCHLA, one of the alliance members with the required status and size, the BC Recreation and Parks Organization, agreed to house the grant and be accountable for it.

Next, even though BCHLA member organizations were addressing similar or identical risk factors, it nevertheless took time for them to agree on how to work together and how to build trust among all partners.

“At first, if all of the members had their way, they would have just split the money up and just taken it into their NGO, but…we had to look at this as a huge opportunity and if we don’t get it right, the government will never take a risk like this again because it’s a big risk. Everyone heard that but it took time. We spent hours helping everyone understand what this meant and what they could do and create some processes that they felt comfortable with.” (NGO)

“… Much to our surprise, we got money…that actually gave us a challenge that we were not prepared for, and I guess some fairly predictable negative competitive behaviours began to surface in the group. For some of the organizations, $25 million is more than they have ever seen in multiple years in their organization.” (NGO)

BCHLA members required 18 months to plan how they would divide the money, and they have now articulated plans for each of their strategies. As a consequence, the necessary meetings “cost us incredible resources, time and energy and the meetings have taken us away from some of our other projects.” (NGO)

“We ended up with this $25.2 million grant, which in many ways has been hugely problematic as the Alliance is an advocacy group designed to come together for advocacy. But what happened after we received the grant was this group of very different organizations with hugely different capacities, hugely different histories, and different mandates needed to somehow come together to create a way in which we could spend this money…” (NGO)

One of the critical first steps, and challenges, was to agree on a branding strategy:

“Working as an Alliance, branding is something that has to be really thought through and articulated and agreed upon because it could be very divisive because

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* 2010 Legacies Now is a not-for-profit society and a non-voting member of the BCHLA.
it is a sensitive thing...so we developed a profiling matrix and really achieved consensus as to who is branded where, how often and in what context and had everybody sign off on that and that really served us well.” (NGO)

A Near-Complete Alignment Between Targets and Priority Areas

After publication of The Winning Legacy [52], representatives from both the Ministry of Health and the NGOs recognized that an alignment should be established between ActNowBC and the BCHLA. There were similarities between the government and the BCHLA approaches around the risk factor targets even if BCHLA members have developed more ambitious targets,9 and formulated them differently:

“We think that it’s fantastic that the government set targets... The physical activity targets are exactly aligned. The healthy weights and healthy eating are much further apart but in the same direction... I think that the focus of discussion is more fruitful if we figure out how we are going to get there, whether or not it should be 5%, 20% or 50% because it is the trending that is important.” (NGO)

“...we didn’t like the way in which the government had constructed their targets, of like, you know, 20% increase or 20% reduction... It gets complicated for the average person to understand whereas 7 out of 10, or 9 out of 10 that is quite straightforward.” (NGO)

The BCHLA developed three strategies directly aligned with the ActNowBC pillars on physical activity, healthy eating, and tobacco reduction. They added a cross-cutting strategy around community-capacity building to ensure that progress could be sustained. Overall, 15 initiatives in those strategies have been funded and are now being implemented; they will be evaluated with the assistance of an arms length organization, the Michael Smith Foundation10. These 15 initiatives are presented in Annex 4. While consensus existed about the merit of each initiative, some respondents, both within and outside of government, expressed concern over the potential to make an impact, given the fact the money was dispersed over several initiatives:

“I mean it’s 25 million dollars but that’s not a hell of a lot of money when you are trying to do something of this magnitude... I think we diluted our initiative by spreading our money so broadly over so many initiatives but I think it was the necessity of ensuring that each of those NGOs sitting around the table saw some of the money come their way. I think they are worthwhile, these strategies, and I can support them. I hope we will be able to show concrete outcome results because from where I’m sitting this is absolutely critical.” (Gov)

In order to make a significant difference in the long term, the BCHLA respondents feel that acting on the social determinants of health is vital:

“If you look at the mission of the Alliance, it’s looking at taking action in those traditional risk factor pillars but also looking at the contributing factors to those specific chronic diseases and so we have been discussing over the past year acknowledging that we are not even going to reach the risk factors targets if we don’t do something on the broader kind of scope.” (NGO)

Several BCHLA member organizations discussed the possibility of using regional targets to better address health disparities in British Columbia. Some targets are “really not a big deal” (NGO) in some regions but much more difficult to reach in others. Ultimately, the BCHLA did not use regional targets but did target more vulnerable populations in their initiatives:

“...in very many circumstances they are the most difficult to reach populations and the most deeply entrenched in their chronic disease developing behaviours... So we established a big challenge for ourselves.” (NGO)

BC Government and the BCHLA: How Close Is Too Close?

The partnership between the BC government and the BCHLA has passed through different phases and was definitely affected by the transitions in governance structures. Respondents from the BCHLA described the
attitude of the government toward the Alliance as ranging from very supportive to “highly critical and policeman-like.” (NGO) Some respondents discussed the importance of staying independent:

“It’s a bit naïve actually that if they think they can pull the Alliance closer to government it will be good for government. It isn’t. We need to be at arm’s length … If the population perceives us to be the hand maidsens of government, then we will have lost on all fronts. The government will have lost all of their organizations and the Alliance will have lost…that trust that our donors and the population have with us and we measure it regularly and we guard it with our lives.” (NGO)

Remaining at arm’s length is also crucial in order to engage in policy advocacy. This is an important issue for the nine voting member organizations, since the Alliance was created for this very purpose. The one-time grant enabled the BCHLA to extend its reach, but it also consumed time and energy, leaving little of either for advocacy:

“The Alliance is just regrouping actually in terms of rebuilding its advocacy agenda. We have obviously been consumed with strategies around the 25 million and how we were going to best use it.” (NGO)

Being part of the Alliance also compromised to a certain extent the ability of each member organization to advocate for its own priorities:

“It used to be, and still is to some extent now but for a while if I asked for a meeting with the Minister of Health, I got it … Shortly after our grant, we wanted to see the Minister on another issue having nothing to do with the Alliance and we were told ‘well, we just had a meeting with the Alliance so we don’t need to see you’. Very very bad because while lots of the risk factors do overlap and are the same, there are many issues which are ours alone.” (NGO)

A Promising Partnership
Despite the challenges facing BCHLA in taking full advantage of the grant, representatives of both the government and the Alliance offered positive feedback about the past, present, and future of this partnership:

“…there is a whole bunch of learning in terms of how to work together and be accountable and it took a lot of time and energy and effort and we have, I think, done an absolutely terrific job of doing that… I think we can certainly give ourselves a huge kudos for sorting through all those issues, for being absolutely rigorous in our scientific review, in our accountability, in our transparency, in our desire to be fair and work ethically with each other. It was all very admirable and laudable.” (NGO)

“I think that the coalition that came together is a unique model and the coalition that came together I think is very functional, it’s much more functional that I ever thought it would be and I’m very happy to say that. I think they have done a remarkable job in their process and they have become very good partners.” (Gov)

“…our hope is that this isn’t just a one-time thing and that we can create annualized funding so that the Healthy Living Alliance can continue to do the work that it is doing.” (Gov)

Involving different layers of government
ActNowBC also involves partnerships with the provincial Health Authorities and with municipalities across BC.

The partnerships between the ActNowBC decision-makers at the provincial level and the Health Authorities are most evident, and in a way mandatory, in the case of targets #3 (Tobacco Use Reduction) and #5 (Healthy Choices in Pregnancy):

“…we were asked to put together, each one of the Health Authorities, a regional action plan around Fetal Alcohol Spectrum Disorder…we were also required to look at strategic plans for tobacco reduction so that kind of got rolled into ActNow as well. Under that banner, Health Authorities were required to have a strategic plan for tobacco reduction that would help them to meet the provincial targets by 2010. So in that sense, I think some of the common public health issues of the day were able to kind of be gathered under one sort of umbrella, under one banner if you will and I think it got the attention of the province through a single initiative.” (Gov)

Interviewees from the Health Authorities mentioned that it was easy to adhere to the principles of ActNowBC but that more consultations would have been appreciated:

“I think certainly there were not a lot of field or local Health Authority consultations on ActNowBC, I mean that just came. The ministry and the province,
that’s what they want to do. It sounds like a good idea, nobody is opposed to it other than I think looking at some of the issues and looking at how they are coming out. We were not even consulted in terms of the ActNow goals and objectives…” (Gov)

But the Health Authorities also contributed to ActNowBC through ongoing collaborations with the BCHLA. The BCHLA includes representatives from the Health Authorities as non-voting members of the Coordinating Committee which is responsible for all policy matters and stewardship of the initiatives undertaken by the BCHLA:

“I want them to work and if they are successful and they get 50 million dollars the next time and Health Authorities don’t get anything, that’s fine by me, it’s the idea that’s the important thing, not whose got the money and who can do it. So if they can do it, that’s great and they have been very certain to include their partner Health Authorities in that. They have been very aware of the fact that there are things that Health Authorities are involved in, they are key to the partnership, they have got a lot of relationships around the province so they recognize that the Health Authorities are key partners and have included us all along the way so that is not any sort of a problem, it has actually worked very well.” (Gov)

The same can be said about the Union of BC Municipalities (UBCM). They have received direct support from the BC Ministry of Health in 2005 through a $5 million contribution to the UBCM’s Community Health Promotion Fund (CHPF). It was created to support health promotion programs and activities in communities through a focus on healthy living and chronic disease prevention. The CHPF supports the goals of ActNowBC. To date, more than 150 pilot projects have been completed or approved to support community and individual health promotion across BC. As the original program contribution was fully expended with the 2009 call for applications, the Community Health Promotion Fund is now fully committed. Several communities in BC are also working closely with the not-for-profit organization 2010 Legacies Now. The UBCM is also a voting member of the BCHLA.

ActNowBC Leadership Council
In 2007, the BC government created the ActNowBC Leadership Council11. The Council comprises 12 public opinion leaders from different sectors (Aboriginal leaders, sports personalities, health care professionals, business leaders, etc). This high-profile committee is expected to raise the profile of ActNowBC and, consequently, to raise awareness about healthy living issues in the general population. “We want them to be advocates for what we are doing, we want them to let us into their delivery channels.” (Gov) The establishment of this Council also reflects the desire of politicians to connect with the public as much as possible when dealing with high profile issues:

“The Premier is very prone to create committees and councils to deal with big issues like technology and climate change or, in this case, wellness and public health and I think that it has been an effective way to rally and communicate with the public at large.” (Gov)

As of October 2008, the Council has met only four times. While it is too early to assess the impact of the Council on the ActNowBC initiative, caution was expressed by some respondents about ensuring that the messages remain the same over time. For example, because of the Olympics in 2010, some respondents were concerned that the emphasis would be placed on physical activity from an “elite” or “competitive” lens.

“I think it is very dangerous and misleading to assume that professional athletes have much to say about this subject [healthy living] because they live in such a specialized world that if we devote our budgets and energies to promoting highly competitive sports activities, I think we are misdirecting the program.” (Gov)

Summary Points – Vertical Dimension
• A history of collaboration among the members of the BCHLA served them well when the ActNowBC grant was announced. Nevertheless, reaching consensus on what to do as an alliance and how to operate collectively required a significant amount of time.

• Member organizations felt challenged in retaining their independent identities while working as part of the alliance under the ActNowBC banner.

• The size of the grant created a risk of NGOs losing their arm’s length position relative to the government and thereby compromising their advocacy roles. Their advocacy for action on social determinants and for work with vulnerable populations was delayed because of the healthy living focus of ActNowBC.

• Provincial Health Authorities and municipalities across the province are also contributing to ActNowBC either through direct support from the province or through their participation to the BCHLA as non-voting members.

Initial Outcomes – Progress towards targets and contribution to policy development

The commitment to monitor and evaluate ActNowBC both in terms of “processes” (this case study) and “outcomes” (meeting goals and targets), contributes to ensuring the sustainability of the initiative. Indeed, the publication in January 2008 of the first progress report for ActNowBC “Measuring Our Success” gives an indication of the government’s intention to sustain support for the initiative.[54] The then Minister of State for ActNowBC wrote that the initiative will not stop with the Olympic and Paralympic Winter Games; rather, that promotion of healthy living and health is to be a permanent part of the BC living experience. Referring to success in reducing tobacco smoking rates (see table 3) in the province, the result of long standing commitments by multiple stakeholders, the progress report states that sustained action over a number of years remains the vision behind ActNowBC. In the following month, the government’s strategic plan for 2008-2009 through 2010-2011 reiterated the link between healthy living and a sustainable health care system. [55]

Table 3: First progress report (January 2008) on ActNowBC—the Target on Tobacco Use

The first progress report comprises a similar figure as the one above for the other four targets. While some figures showed progress toward the targets (targets related to healthy choices in pregnancy, tobacco use and consumption of fruits and vegetables), others are showing worrying trends (targets related to physical activity and obesity). The authors remained careful in their conclusions regarding the influence, or lack of influence, of ActNowBC. They point out that data from 2003 and 2005 was collected before many ActNowBC initiatives were in place or were still in a pilot or prototype phase. Therefore it may be premature to draw conclusions as to trends and it may be more appropriate to consider these two data points as baseline information rather than an indication of program effect or lack thereof.

At the time of writing this report, BC also has new healthy public policies, legislation and regulations. While respondents were not prepared to always frame the influence of ActNowBC on new policies using a “cause and effect” paradigm, it is undeniable that ActNowBC has created momentum and strengthened the impetus around certain issues, especially those identified in its targets. At the same time, initiatives independent of ActNowBC, some well advanced before the launch of the initiative, have contributed to achieving its targets. The new legislation in place since 2005 is listed below.

Tobacco control

Amendments to the Tobacco Control Act passed in 2007 strengthened tobacco control laws in BC and contributed to the achievement of one of the ActNowBC targets. The amendments included:
• ban of all tobacco use in public and private kindergarten to Grade 12 schools in BC (with an exception for the traditional ceremonial use of tobacco by Aboriginals).
• ban of the display and promotion of tobacco in stores where youth have access.
• ban of smoking in all indoor public/workplaces, and within a 3m radius of most entrances and windows to those public/work places.

In addition, the Motor Vehicle Act, amended in 2008, bans smoking in motor vehicles when those under 16 years of age are present.

**BC Public Health Act**

A new Public Health Act for BC has potential to contribute to ActNowBC goals in a number of ways. First, it enables government to regulate against “health impediments” – conditions, things, or activities that contribute to chronic disease, disability, or injury. A case in point is the current proposal for trans fat regulation to restrict the use of industrially produced trans fat in prepared foods in provincial food service establishments. The regulation has been approved in February 2009, the first regulation approved under the new Act.

Directly affecting ActNowBC are new public health reporting requirements. The Act extends the requirements to beyond communicable diseases. The Medical Health Officer and the Provincial Health Officer will need to report “in an independent manner” on public health issues, on achievements of government health targets which can include ActNowBC, and to make recommendations where needed.

The Act also allows the Minister of Health, in order to promote and protect health and well-being, to require a public body to make, in respect of a specific issue or geographic area, a public health plan. The Minister must also monitor the health of the population, make recommendations regarding public health, and evaluate and advise the government on actions of government that may affect public health. With this lever, the Minister can comment on the actions of other ministries that affect ActNowBC objectives.

**School health**

BC has new guidelines for food and beverage sales in schools. Junk food is steadily being replaced with healthy foods and beverages in school vending machines, cafeterias, stores, and in school fundraisers. Schools are also required to provide 30 minutes of daily physical activity up to Grade 9; students in Grades 10 to 12 will perform an average of 150 minutes a week of physical activity as part of their graduation requirements.

**Workplace health**

As part of the provincial strategy to reduce health care costs by improving individual health, healthier food choices will replace “junk food” in vending machines in all public buildings across the province.

**Equity Considerations**

The ActNowBC initiative does not contain targets for specific population groups. However, some of the BCHLA projects, and some of the ActNowBC government-led initiatives have targeted vulnerable population groups. In many cases, ActNowBC made a contribution to existing initiatives.

Key among ActNowBC contributions to existing initiatives is the case of the “Honour Your Health Challenge” (HYHC) – a lifestyles strategy aiming to improve equity in health in Aboriginal communities. When ActNowBC was announced, HYHC, which had originally focused on tobacco cessation, had already been reoriented to a holistic health strategy including healthy eating, more physical activity and stress reduction as well as tobacco misuse. Resources from ActNowBC have expanded and enhanced the training, funding and networking opportunities in the HYHC available to Aboriginal communities.

The Aboriginal ActNowBC initiative was also set up after the official launch of ActNowBC in March of 2005. Aboriginal ActNowBC is specifically focused on Aboriginal peoples in BC, home to the second largest Aboriginal population in Canada. The BC government provided funds ($6 million) to the National Collaborating Centre for Aboriginal Health (NCCAH) to implement Aboriginal ActNowBC. The NCCAH is funded by the Public Health Agency of Canada and has a mandate to support Aboriginal communities across Canada in realizing their health goals.

The first ActNowBC progress report (January 2008) shows data from the Canadian Community Health Survey (CCHS) indicating that the BC Northern Health Authority – the Health Authority with the highest proportion of Aboriginal people – had trends moving away from the 2010 targets 1 to 4 (smoking, fruits and
vegetables, physical activity, and overweight and obesity) between 2003 and 2005 before the implementation of ActNowBC. The next ActNowBC progress report, to be published before the end of 2009, may be able to indicate, depending on the CCSV sample size in each Health Authority, if progress has been made in vulnerable geographical areas.

**ActNowBC – Risks and Assets to Sustainability**

Almost immediately after the launch of ActNowBC, the time-limited nature of two key circumstances – the link to the Olympics, and to one Premier and Government – led to speculation as to whether the initiative was sustainable, and if so, for how long. Respondents viewed some features of ActNowBC as risks to sustainability and other features, as assets.

**Risks**

There is risk in setting targets for initiatives that have short time lines when outcomes are expected only in the longer term. Respondents understood that it will take generations for the healthier living promoted by ActNowBC “to be part of everybody’s skin.” (Gov) They saw the politically ambitious nature of the ActNowBC targets as a vulnerability, anticipating that a number of targets will not be met, thus leaving the initiative open to criticism. At the same time, there was a sense that dealing with the targets is a matter of managing expectations:

“I think there will be some scrambling around if you don’t meet those aggressive targets. I don’t know what it will mean to sustainability. I hope that what we will have shown is that we are on the way and I think if we can do that, that would be a huge success, if just to flat line [the trend] instead of move the trend [downward].” (Gov)

“It’s going to be awfully difficult to achieve the 2010 targets by 2010. Our hope is that there is enough visibility, enough motivation to sustain the underlying components of this initiative regardless of whatever sort of political winds start to change because they will inevitably change. So what we are hoping for is that there is enough out there so that it has got some sustainability.” (Gov)

Another risk to ActNowBC is a possible change of government. Most respondents stated that it was too soon to know whether the ActNowBC platform could survive such a change were it to occur in the near future, as the whole-of-government approach had not yet been “institutionalized” within the government. If another political party forms the new government, there is no certainty that ActNowBC will remain a priority to the extent that it has for the current government. Despite some uncertainty regarding its role, a key horizontal mechanism, the Assistant Deputy Minister Interdepartmental Committee, was seen as an important component of maintaining the whole-of-government approach, but it depends on the commitment of a particular cadre of individuals currently at the Assistant Deputy Minister level.

Similarly, the priority level of ActNowBC could decrease once the 2010 Olympics are over, despite the intention that ActNowBC deliver a lasting legacy to the people of BC.

“Sustainability is…a seed that needs to be planted. It’s one thing to put this full court press towards the targets for 2010 but the real risk is that as soon as that 2010 comes, the momentum will be lost, new government comes into play, new flavours, new priorities and then we’ll just fade back into the woodwork… I think people are on board for the right reasons and I think critical to success will be developing a sustainability strategy to keep the momentum going and keep the incentives there and keep the kind of primary imperative coming from government to say that we still have to do this and as we said for the 2010 targets, they are not just for 2010, they are targets that will take time so I think that will be the piece that needs to be communicated and it will have to be a comprehensive strategy.” (Gov)

A number of respondents perceived a superficiality in ActNowBC and considered this a risk to its sustainability. ActNowBC is not addressing the social determinants of health through policy instruments, and as such, may not be sufficiently rooted to withstand inevitable political changes.

“…for a number of those targets, you won’t achieve them without addressing some of the inequities issue because the big changes are not going to come from the higher socio-economic groups because they are already making those changes. I mean the smoking issue, for example, is a low income issue and that’s where the hard core of smoking still is.” (Gov)
“If the government was really serious about it, they would be working in a brave renaissance kind of way to implement health policy that would impact people’s health. That’s their role, not doing these kinds of glitzy superficial things that aren’t going to make a bit of difference in people’s lives.” (NGO)

To ensure its long-term sustainability, the ActNowBC initiative will need the participation and support of public health experts and activists working on issues related to health disparities and the social determinants of health.

**Assets**

Risks notwithstanding, respondents spoke of aspects inherent to ActNowBC that they predict and hope will sustain it. They point to the strength of the original research, arguments, and rationale, for example, behind the message in the “killer slide”. They see the concern for the sustainability of the health care system as a non-partisan issue and a citizens’ initiative, not just a government one. Similarly, the involvement of ActNowBC with schools is felt to have a broad base of support from other stakeholders in the education sector, seen by some respondents as giving the initiative sufficient resilience to outlast a change in government and the Olympic thrust. Opposition party members supported ActNowBC from the outset, it being difficult for anyone to disagree that people should be more active and fit. Rebranding ActNowBC could be sufficient as a means for a new government to adopt the initiative.

“I hope that the initiatives within ActNowBC are so based on research, public policy and evidence and outcomes that whatever parties are in power they will say, this is the right thing to do because of that and that’s why I think the model…that it is evidence-based and researched allows hopefully for transitions between governments because at some point, there is going to be a change in government.” (Gov)

“That [sustainability] really depends on us….on how successful we are in managing transitions. I think that [ActNowBC] is well established and its well rooted in evidence and research and well founded; and its got a strong momentum, so I think any government coming in to stop it would have to deliberately do so and I don’t think that that would be politically correct and also it continues to be…part of the healthy continuum of service to mitigate some of the [health care](1) costs. And also to reduce the incidence of chronic disease in the province, so its incorporated as a component in the delivery system as much as the number of acute deaths…so it is there, so to remove that it would have to be a deliberate action.” (Gov)

Senior bureaucrats are strongly committed to ActNowBC. As noted in the previous section on the emerging accountability framework, there is consensus among respondents that the logic models and service plan development are rooting the cross-departmental way of working to achieve the ActNowBC targets. Senior public officials also acknowledge that engaging communities and building their capacity through, for example, the work of the BCHLA are achievements that will hold for the longer term.

“Even with the best of intentions, political priorities change whether there is a change in government or not and so those of us who believe that the stars were lined up around ActNowBC right now understand that we need to take full advantage of that and drive it down into the system, whether that is the education system or the health system or whatever, far enough so that ownership will reside with the people on the ground who are actually doing the work because that’s how it is going to be sustainable.” (Gov)

Even if the funding does not continue, respondents felt intersectoral action need not end because collaboration and partnerships do not have to be driven solely by money.

“The money did go out to the NGOs and they are doing their thing, but the true intersectoral action would have to be between all of the 20 ministries in government working with the private sector and with the NGOs, so I think there is room for a lot more intersectoral collaboration.” (Gov)
Section 4

Discussion

In this section, we examine to what extent the factors and mechanisms that characterize intersectoral action stimulated by ActNowBC are similar or dissimilar to those identified in other studies on intersectoral action for health. For the horizontal dimension, we revisit the issues of governance and accountability, and how they affect sustainability. For the vertical dimension, we draw comparisons with other partnership models involving governments and NGOs. And we briefly discuss how ActNowBC compares with health promotion initiatives associated with other Olympic and Paralympic Games, although empirically-based studies of these types of initiatives are rare.

ActNowBC as a whole-of-government initiative

Since the launch of ActNowBC in March 2005, much effort has been devoted to animate and inspire BC politicians and civil servants to share the responsibility for this cross-cutting initiative and to take action accordingly. Below, we dissect that process and some of the structural features of ActNowBC in light of the current literature on horizontal management.

Shared Leadership and Governance

There is ample evidence in the literature indicating that bureaucratic accommodation usually follows political accommodation. [56] This study has highlighted the importance of high-level political leadership – by the BC Premier - during the implementation phase of ActNowBC as a whole-of-government initiative. This particular source of leadership has also been highlighted as a critical success factor for ActNowBC in a recent publication. [50]

In this study, we also presented evidence about other forms of leadership. Indeed, leadership refers not only to individuals and their skills and abilities to orient people and organizations in a certain direction; it can also be viewed as a “collective process”. For example, the literature on shared or rotating leadership offers some additional points for discussion. It can facilitate Intersectoral Action for Health (IAH), with the health sector not always needing to be in control, but it can also have pitfalls. [57]

Some key questions associated with a shared leadership model are: When is leadership most appropriately shared and how is shared leadership best developed? According to Pearce (2004), shared leadership is especially relevant for tasks that are highly complex and interdependent and that require a great deal of creativity. [58] From the perspective of the respondents, implementing an intersectoral approach requires tasks with all three of these characteristics.

Since its inception, ActNowBC has experienced different leadership models. A shared leadership model was in place between August 2006 and June 2008, during which time the Ministry of Health and the Ministry of Tourism, Sport and the Arts both had roles and responsibilities in promoting and managing ActNowBC. During that period, ActNowBC benefited from the presence of a Minister of State who with the Cabinet, used different incentives to encourage acceptance of joined-up work, this being shared leadership and responsibility across ministries for ActNowBC. The incentives/disincentives were mainly transactional (e.g. hold backs from Deputy Ministers for not meeting certain requirements or achieving certain targets linked to the logic models and service plans) and some transformational (e.g. symbolic emphasis on commitment to a shared vision, emotional engagement, and desire to engage in breakthrough achievements).

The key to successful shared leadership is to have, at all times, clear understanding about who is responsible for what and sufficient time for a “stabilization” phase after a change in leadership. With ActNowBC, numerous changes in leadership and governance models in a relatively short period of time gave rise to difficulties. The empirical data confirm that enthusiasm for ActNowBC, within and outside of government, has fluctuated since 2005. Currently, ActNowBC is back to a more traditional vertical governance and leadership structure under the new Ministry of Healthy Living and Sports. The question remains whether or not a stabilization phase will begin.

The leadership of senior civil servants was also a critical success factor behind the launch of ActNowBC. Public health bureaucrats took the opportunity presented by an Olympic bid to frame health promotion as an Olympic Games legacy for the province. Once the bid was won, their influence cannot be underestimated as they were ready and able to position what was to be gained through ActNowBC in terms of political visibility, the potential savings to the provincial budget as well as the benefits to population health. On the strength of their
arguments, the Premier came on board when the bid was won and internal and public Cabinet support was from then on consistently transmitted and paved the way for the breadth of intersectoral collaboration at the heart of ActNowBC.

Civil servants with what Perry et al call a “pinball” career played an important role in ActNowBC. They have a skill set particularly effective for intersectoral action, being intentionally and systematically involved with multiple ministries. During the implementation phase of ActNowBC, one civil servant with a dual appointment to the Ministry of Health and the Ministry of Tourism, Sport and the Arts, went from ministry to ministry providing assistance in defining outputs and outcomes in the logic models that corresponded to the targets and goals of ActNowBC.

This case study contributes evidence that a broad leadership base is essential to the success of whole-of-government initiatives. The senior civil servants involved in the launch and implementation of ActNowBC have shown the capacity to do what some sociologists call “a skilled bricolage”, i.e. to use ingeniously whatever resources are at hand. They showed leadership in making the most out of the opportunity provided by the 2010 Olympic and Paralympic Games in Vancouver:

“… The leader’s function is… fixing things on the spots through a creative vision of what is available and what might be done with it.” (Thayers, 1988, p. 239) [60]

Targets and Accountability

Setting and monitoring health targets is one way in which government provides leadership, guidance, and strategic direction to the health sector or to whole-of-government initiatives in pursuit of healthier populations. While the pragmatic SMART conditions for targets are well known (Specific, Measurable, Achievable, Realistic and Time-constrained), setting evidence-based public health targets is a complex enterprise that requires expertise from all public health disciplines. Even the literature is divided over the extent to which health targets can be “evidence-based.” For some public health specialists, targets are a mixture of “dreams, science and political reality.” (McCarthy, 1999, 364:1664) [63]

The ActNowBC targets are specific, measurable, and time-bound. However, respondents disagreed about whether some targets were realistic and achievable.

Recognizing that setting health targets is always a highly political affair with associated risk, some public health specialists advise not to put time and resources into technical target formulating, but instead to define visible indicators to trends that are political by nature. [62] One could question whether targets should be the basis for accountability to the public and for cross-ministerial performance. Nevertheless, the respondents seemed on the whole to have accepted the targets, albeit as very ambitious, understanding that they are intended to encourage innovative thinking and to challenge each government sector to accomplish more for health promotion, while at the same time demonstrating to the public the government’s good intentions to achieve a health legacy. In research after 2010, it will be important to explore the consequences, if applicable, of not achieving one or more targets.

Specific to internal accountability for reaching the targets, some but not all literature on whole-of-government approaches suggests that having a clear accountability framework as early as possible is an important factor for success. [37, 64] It is especially critical that all stakeholders have a clear understanding of their roles and responsibilities; otherwise, accountability is weakened, and achieving organizational objectives is threatened. [65]

The ActNowBC accountability framework was not clarified quickly – it took several years for the framework to emerge. While some may see this as less than ideal, Perry et al. (1999), reporting on holistic government in the United Kingdom, concluded that coordination and integration could be extinguished quickly by establishing rigid systems of measurement and accountability early on. Perry stated that:

“(...) better by far is to encourage continual strategic conversation about outcome measures, targets, systems of monitoring and accountability. Public managers should be encouraged to develop their own outcome measures. This can sometimes be hard for politicians who may suspect that such self-regulation merely lets officers off the hook. But as we have learned, machismo in setting rigid forms of accountability too early turns out to be the enemy of effective holistic working.” (Perry et al., 1999: 44-45)

Apart from timing, defining clear accountability frameworks is difficult when devising whole-of-government strategies, since cooperation across sectoral lines inevitably blurs the traditional boundaries of budget allocation, dispersal, accounting, authority, and responsibility. Wilkins noted that the literature has
no models about how to deal effectively with overlapping accountabilities. Some literature suggests that, instead of accountability mechanisms focusing on inputs and outputs, the emphasis should be on reporting against broader performance indicators designed to measure progress toward targets and outcomes. [68]

Within this frame, we believe that ActNowBC is a hybrid model. With the logic models, each ministry is defining inputs and outputs, while at the same time responsibility is nurtured for achieving the broad ActNowBC goals, involving continuing communications with, for example, the Cabinet and the Assistant Deputy Ministers Interdepartmental Committee.

It remains to be seen how the current accountability mechanisms and strategies for ActNowBC – the stretch targets, logic models, service plans, and how they were developed – will contribute to the sustainability of the initiative.

**ActNowBC and the engagement of nongovernmental organizations**

There is a growing body of literature about the significant roles that NGOs can play in supporting intersectoral action for health. [15, 29] But while their role is well documented there is less evidence about the partnership models between government authorities and NGOs that are effective in the field of health promotion for the longer term. The selection of a funding model remains a key issue.

Several international experts suggest the ongoing use of earmarked taxes on tobacco or alcohol to support health promotion efforts. This way, funding for health promotion is not directly competing with other claims, such as high profile acute care services, on the health budget in the budget bidding processes. [69] The International Network of Health Promotion Foundations also advocates the use of Acts of Parliament to secure sustainable funds for health promotion initiatives. [69]

In BC, health promotion has now been separated from acute care by virtue of the creation of a Ministry of Healthy Living and Sports with a health promotion mandate apart from the Ministry of Health Services. The extent to which this mechanism secures funding for health promotion, compared to a taxing scheme, remains to be seen. In the case of ActNowBC, the BCHLA has played and continues to play an important role in the areas of advocacy for health promotion policy and the delivery of community-based programs. But the relationship between the BC government and the BCHLA can be referred to as an opportunistic partnership in that the $25.2 million grant to the BCHLA was one-time. However, the BCHLA is now advocating the creation of a permanent Health Promotion Fund to target disadvantaged British Columbians, suggesting an annual injection to the Fund of $10 million from the BC Government. [12] A Coalition for Health Promotion that is part of the International Network of Health Promotion Foundation, but that is not directly related to ActNowBC, is also advocating the creation of an arm-length health promotion foundation that would facilitate and support community-based health promotion initiatives in the province. They envision that funding could come from two sources: 1) $1.00 per person per year (from the tax base), the equivalent of $4.3 million in 2007 or 2) a one-time permanent endowment of $25 million from the BC government. [70]

There is no indication, at the moment, that the BC government is moving towards establishing a permanent funding transfer from the government to the NGO sector. However, the documented achievements of ActNowBC with the NGO sector may well become a critical factor in shaping the future of NGO-led public health and health promotion initiatives in the province.

**ActNowBC as a Health Legacy initiative**

The idea of using the Olympic and Paralympic games to leave a “health legacy” is not new. For example, the 2004 Athens Olympic and Paralympic Games saw several health promotion initiatives implemented. There was an emphasis on providing “smoke-free” games and many initiatives consisted of disseminating brochures with health promotion messages. The total cost of the health promotion programs of the Athens Games was estimated at 943,000 Euros; a relatively small fraction (0.08%) of the overall cost of the games. [71] There is similar talk of sustainable health legacies surrounding the 2012 Olympic Games in London, with an apparent emphasis on mass participation in sports, exercise and physical activity. [72]
Since the inception of ActNowBC, similar to Athens and what is expected with London, there is significant investment in social marketing campaigns targeting individual behaviours. Unlike Athens, ActNowBC has seen engagement of health and non-health portfolios at the government level and community-based programs have seen improvements in for example the built environment (e.g. cycling path, etc.) and school food programs. There are also promises that a wider range of policy instruments and interventions could be implemented [73], with a renewed emphasis, for example, on the social determinants of health.

The World Health Organization has an interest for the concept of “health legacy” not only in the context of Olympic and Paralympic Games but for all major mass national and international events. For example, discussions are ongoing about creating a health legacy for the Shanghai 2010 World Exposition.
Conclusion

In our case study we have explored the whole-of-government approach to health promotion unique to ActNowBC, an initiative intended as the health legacy of the 2010 Vancouver Olympic and Paralympic Winter Games. Because our information is based on interviews conducted between October 2007 and September 2008, our report presents a work in progress.

Intersectoral approaches, their processes and mechanisms, are shaped by the contexts from which they emerge. Accepting this, the lessons learnt from an initiative like ActNowBC, what works and what does not, may not be completely transferable. However, our research revealed several factors that explain the achievements of ActNowBC thus far – both those attributed to the initiative and those to which it has contributed.

Leadership that seizes the opportunities to act

While leadership is an obvious and generic success factor for intersectoral initiatives, it is often less clear exactly what aspect of leadership is most noteworthy. With ActNowBC, we found leadership among politicians and senior civil servants by virtue of their ability to seize the opportunities at hand. This is a relevant leadership trait in contexts with shifting and competing priorities and where decision-makers need to react quickly with available resources rather than wait for ideal circumstances. The Premier’s steady commitment towards the principles of an integrated health promotion initiative is one of the key success factors behind the launch of ActNowBC, and the main reason why ActNowBC has been able to evolve and mature since 2005. His continuous support guarantees that ActNowBC is to remain high on the agendas of all Ministers, Deputies and Assistant Deputy Ministers. Senior civil servants involved in ActNowBC also manifested leadership in a number of ways:

• Taking advantage of the unrelenting concerns about rising health care costs to effectively advance a business case for health promotion and disease prevention with potential benefits to more than the health sector.

• Given the significant financial investments for the Games directed at specific communities, framing the health legacy from ActNowBC as a province-wide gain giving it political traction.

• Securing a one-time $25.2 million grant to a coalition of NGOs – the BCHLA – by promoting the similarities and complementarity between the government’s platform for chronic disease prevention and the pillars of the BCHLA strategy.

• Taking advantage of the financial momentum for the Games to secure $15 million for an incentive fund designed to “pull in” other Ministries.

There was also the ability to “sail the ship while you build it”, i.e. taking action without all elements in place. For example, waiting to have completed a comprehensive accountability framework for such an initiative would have delayed action significantly. In other words, ActNowBC decision makers have strived to find the right balance between planning and action.

Diverse horizontal and vertical strategies and mechanisms

Another key message from this case study is that a combination of strategies and mechanisms can increase momentum, in this case for health promotion, can distribute the accountability for an initiative and can contribute to its sustainability. With ActNowBC the combination includes:

• High-level political commitment:

The Premier’s commitment was the impetus for establishing ActNowBC as a whole-of-government initiative and continues to secure it as such.

• Publicly stated ActNowBC goals and targets:

While controversial and politically risky, the ActNowBC goals and stretch targets have acted as a lever to promote intersectoral work and at the same time have distributed accountability across health and non-health sectors all while keeping the initiative high on the political agenda. The targets have also given public visibility to ActNowBC as a health promotion brand of the current provincial government.

• Breaking down the silos in government – the horizontal dimension:

Barriers such as the lack of knowledge about chronic diseases and their societal impact and turf protection by government ministries have been tackled through:

• Internal “pull” strategies and mechanisms:

• The incentive fund and the ADM Interdepartmental committee drew
in non-health sectors to a shared understanding of the intersectorality of risk factors and challenges associated with chronic disease prevention and created better communication and cooperation across ministries.

- The logic models and the integration of ActNowBC into high-level service plans are accountability mechanisms to ensure that each ministry contributes to ActNowBC.

- Civil servants with skills for intersectoral work facilitated communication across ministries in the early phases of ActNowBC, particularly during the development of the logic models.

- Engaging civil society organizations and different layers of government – the vertical dimension

The $25.2 million grant to the BCHLA, challenges notwithstanding, represents a significant infusion to a variety of community-based grass roots projects, complementing the actions involving different layers of government.

What is next for ActNowBC?

At the point at which our study concludes, the ActNowBC initiative faces sustainability and evaluation challenges. There was a provincial election in May 2009. It is too soon to tell whether ActNowBC has been long enough in a “stabilization” phase to survive the changes that may come if a new party is elected to lead the government. It is also too soon to evaluate ActNowBC against all the stretch targets.

Some of the mechanisms used to increase and secure intersectoral action, like the incentive fund and the grant to a coalition of NGOs, may not recur. It remains to be seen if the whole-of-government way of promoting health and the coordination and collaboration seeded by the grant to the BCHLA have taken root sufficiently to continue without subsidy.

The literature provides no gold standard or definitive guidance as to how to structure and implement intersectoral action to achieve health promotion goals. And ActNowBC has not yet matured to the point where lessons can be drawn with potential for uptake by other jurisdictions. Nevertheless, we feel a transcendent approach has emerged from the performance story we have documented thus far – that the BC government has demonstrated an ability to “sail the ship while you build it”, moving ahead even though not all the elements nor ideal conditions are in place, for example, the accountability framework is only now emerging. And other ActNowBC actors, within and outside of government, are continually navigating changes and risk, striving to find the right balance between planning and action. We feel that the attitudes of key players and the cross-government intersectoral strategies and mechanisms they have accepted so far are examples of “promising practices”.

As we write this report, ActNowBC targets three (tobacco use) and five (healthy choices in pregnancy) have been achieved. The added impetus of ActNowBC propelled existing initiatives relevant to these two targets to a stronger level of engagement. ActNowBC has also contributed to expanding and enhancing training and grant opportunities in a holistic healthy lifestyles strategy aiming to improve equity in health in Aboriginal communities. In addition, a number of health promoting policy changes are said to have been aided by ActNowBC, directly or by virtue of its momentum. Among them, stronger tobacco control legislation, restrictions in using industrially produced trans fat, new guidelines for healthy foods in vending machines in BC public buildings and school health guidelines also related to vending machines and to physical activity levels.

Challenges notwithstanding, many respondents applaud ActNowBC as a bold, broad reaching and innovative undertaking. For others, still needed is government application of stronger policy instruments with impacts on determinants for ActNowBC to secure a lasting health legacy for the people of BC.

The quote below illustrates the type of initial changes needed for the intersectoral action to take root.

“… I give this government full points for setting targets and trying to get us all thinking about things like service plans [for intersectoral action]. It really is a discipline that wasn’t particularly well-embedded in government prior to this administration…”

(Respondent- Government)
Acknowledgements

The authors wish to acknowledge the contributions of the following individuals for the useful advice and suggestions that they continuously provided during the course of this project: Mary Collins, Nancy Dubois, Gauden Galea, Andrew Hazlewood, Wayne Mitic and Claude Rocan. We are also deeply grateful to our respondents who took time from their full and busy lives to contribute to this work. This project was undertaken by the World Health Organization Collaborating Centre on Chronic Non Communicable Disease Policy, with funding provided by the Public Health Agency of Canada.
The business case for ActNowBC was made most compelling by one “killer slide” below. It showed that without any new actions to promote health and prevent disease (i.e. maintaining the status quo), by 2017, the BC Ministry of Health would require 71.3% of the total budget of the government, increased from 41.6% in 2005-2006. The budget projection was based on three assumptions:

1. The Ministry of Health budget would continue to grow at a rate of approximately 8% annually, a rate well above the average gross domestic product (GDP) annual growth rate of 3%.

2. The budget of the second largest ministry, the Ministry of Education, would keep pace with the average GDP annual growth rate, thus steadily accounting for approximately 27% of all government spending.

3. Taxation levels would be constant.
Below are a sample of the initiatives from each of the pillars, along with the progress status in achieving the ActNow BC objectives.

<table>
<thead>
<tr>
<th>Pillars</th>
<th>Initiatives</th>
<th>Partners</th>
<th>Success Factors</th>
</tr>
</thead>
</table>
| Physical Activity | Active Communities                              | The BC Recreation and Parks Association is implementing the initiative, in partnership with ActNowBC and 2010 Legacies Now. | As of June 30, 2007:  
  • there are 137 registered “Active Communities”;  
  • 581 Active Communities Tool Kits have been distributed and 398 Active Workplace Workbooks have been downloaded. |
| Physical Activity | Action Schools! BC                              | Students, staff, families and community practitioners can contribute to and take advantage of the school-based action plans. | Between January 2004 and May 2007, over 300,000 students attended the 1,308 schools registered in Action Schools! BC school. |
| Healthy Eating | BC School Fruit and Vegetable Snack Program (SFVSP) | The program partners with the Ministries of Health, Education and Agriculture and Lands and is delivered through the BC Agriculture in the Classroom Foundation. | November 2006 evaluation found that:  
  • children who were at risk (eating less than five fruits/vegetables per day) increased their consumption servings by two;  
  • 65% of children reported making positive changes including: eating more fruits/vegetables and feeling healthier.  
As of September 2007, 162 schools were enrolled. |
<p>| Healthy Eating | Dial-A-Dietitian                                | Cooperation and collaboration with dietitians, nutrition and health agencies and the BC Ministry of Health. | From April 2005 to March 2006, approximately 20,000 calls were answered by Dial-A-Dietitian staff. |</p>
<table>
<thead>
<tr>
<th>Pillars</th>
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<th>Partners</th>
<th>Success Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating</td>
<td><strong>Health Check™ BC Dining Pilot Program</strong></td>
<td>The program partners with the Canadian Heart and Stoke Foundation, the BC Ministry of Agriculture and Land and the BC Ministry of Health and is being pilot-tested in selected White Spot Restaurants in BC.</td>
<td>2007 survey results, of five White Spot Restaurants suggest that: • 81% of participants look for healthy food choices when ordering food; • 61% said they would be more likely to order an item if the logo was beside it on the menu.</td>
</tr>
<tr>
<td>Tobacco Control</td>
<td><strong>QuitNow</strong></td>
<td>The services are managed by the BC Lung Association, in partnership with the Ministry of Health.</td>
<td>In 2006 alone, 5,364 persons who smoke registered with QuitNow.ca, which was up from 2005 (3,498). QuitNow by phone is available in 130 languages and with a Telecommunications device for the Deaf.</td>
</tr>
<tr>
<td>Tobacco Control</td>
<td><strong>Municipal Smoking Bylaws</strong></td>
<td>Provincial Government.</td>
<td>BC will finally have consistent legislation that applies equally across the province to protect all workers and the public from hazards of second-hand smoke.</td>
</tr>
<tr>
<td>Tobacco Control</td>
<td><strong>Honour Your Health Challenge</strong></td>
<td>A skill-building training event in October 2006 included 214 front-line workers, 30 non-Aboriginal provincial/NGO representatives and 40 resource people.</td>
<td>From January 2007 to March 2007, a total of 160 communities participated in Honour Our Health activities (i.e. walk groups, traditional dance programs, etc.).</td>
</tr>
<tr>
<td>Healthy Choices in Pregnancy</td>
<td><strong>Health Authority FASD Prevention Plans</strong></td>
<td>Developed by the five Regional Health Authorities and the plans include working with relevant community partners.</td>
<td>These programs increased community nutritionist services and food voucher funding to support vulnerable pregnant women.</td>
</tr>
<tr>
<td>Healthy Choices in Pregnancy</td>
<td><strong>Service Provider Awareness and Education</strong></td>
<td>Provincial Health Authority Services of BC has partnered with the health authorities, Ministry of Children and Family Development, Public Health Agency of Canada, BC Association of Pregnancy Outreach Programs, and the BC Centre of Excellence for Women’s Health.</td>
<td>As of April 2007, 1,600 service providers including physicians, midwives, public health nurses, Pregnancy Outreach Program staff and mental health and addictions staff have received training.</td>
</tr>
</tbody>
</table>
ActNowBC Logic Model

Factors related to improve health and quality of life

To address these factors, actions are taken that are comprehensive in terms of activities, reach, and approach (Who, What, Where, and How)

As a result of these actions, programs, policies, and practices are delivered or implemented as expected

When programs are delivered as planned, then short-term outcomes will be achieved

Changes in the individual, system, and environmental conditions lead to mid-term outcomes

When intermediate outcomes are sustained, these long-term outcomes are expected

Pillars

What are ActNowBC activities and how are they approached?

What might be expected in the short-term? 2005-2010

Mid-term outcomes 2005-2015

What might ultimately be expected to change 2015 +

**Awareness, Promotion and Knowledge Exchange**

**Principles**

- Comprehensive
- Multisector
- Participatory
- Awareness raising
- Accountable

**Reach**

- Approach
  - General population
  - Targeted population

- Settings
  - Schools
  - Work
  - Home
  - Community

**Legislation & Policies**

**Education, Training Capacity Building**

**Participation & Involvement Through Programs & Services**

**Context and External Factors**

**Individual**

- Increased awareness and knowledge of the benefits of physical activity, healthy eating, healthy choices in pregnancy, and living tobacco-free

- Decreased use of alcohol in pregnancy, and tobacco use

- Increased consumption of vegetables and fruits

- Decrease in obesity rates

- Increased levels of physical activity

- Social norms include healthy living

- Increase, enhance, and sustain social and physical infrastructure that supports healthy choices, e.g., cycle paths, sidewalks, networks, and coalitions

**System**

- Increased awareness, understanding, and commitment among all sectors, and its role in influencing population health

- Increased intersectoral collaboration and planning

**Environment**

- Availability and accessibility to program, services, and infrastructure that supports a healthy lifestyle

- Improved health and life expectancy

- Lower preventable health care and social service costs

- Decrease in preventable chronic diseases

- Decrease in morbidity, mortality, and disabilities

- Sustainable health promotion and prevention system

- Sustainable social and physical changes in the conditions that support healthy living

**Quantitative e.g.**

- Number of programs implemented
- Number of policies developed
- Number of communities involved
- Percentage of people reached
- Number of training opportunities

**Qualitative e.g.**

- Levels of satisfaction
- Learning experiences
- Participatory processes
- Case studies
- Successful experiences

**Resources:** Fiscal * Material * Human * Partnering

**Monitoring and Evaluating**
## BCHLA Initiatives

<table>
<thead>
<tr>
<th>Category</th>
<th>Initiative</th>
<th>Description of Intended Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Healthy Eating</strong></td>
<td>Support for School Guidelines</td>
<td>Led by Dietitians of Canada, Support for School Guidelines initiative works to support the happier and faster implementation of the provincial government’s Guidelines for Food and Beverage Sales in BC Schools. Supports include brandnamefoodlist.ca</td>
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<tr>
<td></td>
<td>Healthy Food and Beverage Sales – Branded Stay Active – Eat Healthy</td>
<td>The Healthy Food &amp; Beverage Sales in Recreation Facilities and Local Government Buildings has now completed its branding process and is launching its new website, “Stay Active, Eat Healthy” full of tools and resources for communities to implement healthy eating policies and guidelines co-led by BC Recreation and Parks Association and Union of BC Municipalities.</td>
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<tr>
<td></td>
<td>Farm to School Salad Bar</td>
<td>The program brings fresh, locally-grown produce directly to BC kids, as children consume 30% of their daily calories at school. Led by the Public Health Association of BC this initiative has been piloted in sixteen schools in the North and Interior, where access to such foods can be limited and thus, it builds relationships between schools and local farms.</td>
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<td></td>
<td>Food Skills for Families</td>
<td>Led by Canadian Diabetes Association, Pacific Region the Food Skills for Families Initiatives assists BC’s most vulnerable families to learn to select and prepare healthy food. It builds on the strengths of two existing programs – Cooking Fun for Families and Cook for Your Life!</td>
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<td></td>
<td>Sip Smart! BC</td>
<td>It strives to help BC kids to kick the liquid-sugar habit. The BC Pediatric Society and the Heart and Stroke Foundation, BC &amp; Yukon are launching an elementary school education program, including innovative resources materials.</td>
</tr>
<tr>
<td><strong>6. Physical Activity</strong></td>
<td>Walk BC</td>
<td>Promoting and encouraging people to walk regularly, as it is the easiest, cheapest and quickest way to exercise. As a result, the BC Recreation and Parks Association and the Heart and Stroke Foundation, BC &amp; Yukon are working with communities to implement local walking program (group and individual programs). In addition, the BCHLA is partnering with communities and provincial organizations such as the BC Medical Association so that health professionals can suggest local walking programs.</td>
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<tr>
<td></td>
<td>Everybody Active</td>
<td>Supports access to activities, by encouraging communities to adopt policies and programs that remove barriers to participation. The initiative aims to increase physical activity and the access to quality leisure programs among individuals who are economically disadvantaged. Co-led by the BC Recreation and Parks Association and the Heart and Stroke Foundation, BC &amp; Yukon.</td>
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<td></td>
<td>Community-Based Awareness</td>
<td>Through this initiative, the BC Recreation and Parks Association and the Heart and Stroke Foundation are giving communities the tools to promote and encourage the benefits of physical activity.</td>
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<td></td>
<td>Built Environment and Active Transportation</td>
<td>It strives to build communities to bridge the gaps in physical activity. Unfortunately, rural and smaller communities are often limited in their ability to provide pedestrian and cycling-friendly neighborhoods. This initiative is led by the BC Recreation and Parks Association and the Union of BC Municipalities.</td>
</tr>
<tr>
<td><strong>10. Tobacco</strong></td>
<td>Tobacco-Free Workplaces</td>
<td>The program targets young adults at the workplace. The Canadian Cancer Society, BC and Yukon Division is working with unions, employers, and industry health and safety associations to establish environments that support tobacco-free employees.</td>
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<tr>
<td>Category</td>
<td>Initiative</td>
<td>Description of Intended Outcomes</td>
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<tr>
<td>11.</td>
<td>Tobacco-Free Post Secondary Initiative</td>
<td>This program delivers the message to where people learn (i.e. tobacco-free campuses). It includes protection from tobacco marketing, endorsing tobacco-free policies, developing cessation resources and educating students and faculty on tobacco as a health and safety issue in the workplace. This program is led by the BC Lung Association.</td>
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<tr>
<td>12.</td>
<td>Smoke-Free Housing in Multi-Unit Dwellings</td>
<td>Works with housing providers to create more smoke-free living spaces. The Heart and Stroke Foundation, BC &amp; Yukon has implemented a smoke-free housing pilot project to provide technical support to interested housing providers, is providing educational forums across BC and a comprehensive website.</td>
</tr>
<tr>
<td>13.</td>
<td>Targeted Education Campaign</td>
<td>This initiative has the goal of informing young adults about the risks of tobacco use and is led by the Heart and Stroke Foundation, BC &amp; Yukon. Quitters Unite was the student concept launched into a full campaign in fall 2008.</td>
</tr>
<tr>
<td>14.</td>
<td>Community Detailing Initiative</td>
<td>This initiative aims to engage businesses and community organizations where young adults spend their time (i.e. recreation centres, restaurants, etc.) to promote cessation resources. It is branded with the Quitters Unite messaging and led by the BC Lung Association.</td>
</tr>
<tr>
<td>15.</td>
<td>Community Capacity Building</td>
<td>Led by the Canadian Cancer Society, BC and Yukon Division, the Community Capacity Building strategy aims to improve regional and community capacity to achieve community health; support and align healthy eating, physical activity and tobacco reduction initiatives within regional and community networks; facilitate communications on BCHLA initiatives within regions; and expand community opportunities for BCHLA initiatives under the three pillars. A particular focus is on vulnerable populations and Aboriginal communities.</td>
</tr>
</tbody>
</table>
Reference List


51. BC Healthy Living Alliance: Working together to promote wellness and prevent chronic disease [http://www.bchealthyliving.ca/]


