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KITS POINT consulting ... making a difference in health care

BC Healthy Living Alliance

working together to promote wellness and prevent chronic disease

HEALTHY LIVING: TARGETS FOR 2010

January 21, 2005

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Introduction

In spring 2004 the B.C. Healthy Living Alliance took on the task of developing provincial advocacy targets for the reduction of 4 major risk factors by the year 2010. This is consistent with the mandate of the Alliance, namely "To improve the health of British Columbians through leadership that enhances collaborative action to promote physical activity, healthy eating and living smoke-free."

BCHLA Goal

To reduce the burden of chronic disease in British Columbia by:

- enhancing collaboration among government, non-government and private sector organizations,
- advocating for health promoting policies, environments, programs and services, and
- increasing the capacity of communities to create and sustain health promoting policies, environments, programs and services.

BCHLA Targets for 2010

- 9 out of 10 British Columbians will not smoke
- 7 out of 10 British Columbians will be eating at least 5 fruits and vegetables a day.
- 7 out of 10 British Columbians will be physically active
- 7 out of 10 British Columbians will be at a healthy weight.

Principles

The Alliance and its activities are guided by a commitment to:

- a population health approach, recognizing that many factors influence health, including: income, social status, education, social support networks, employment and working conditions, physical environments, personal health practices, biology and genetic endowment, health services, and healthy child development;
- fostering vertical and horizontal integration across risk factors, the prevention-management continuum and jurisdictions;
- building upon existing programs and experiences, where possible;
- basing decisions and actions on the best available evidence;
- respecting the unique strengths, experience and expertise of all organizations and individuals that participate in the Alliance;
- participation of member organizations and individuals, recognizing that each will contribute various resources to the Alliance, depending on their capacity to do so.

BCHLA Risk Factor Target Setting Process

The goal of this project was to develop consensus on provincial targets for the 4 risk factors for 2010 – targets that take into account the variation in risk behaviour in communities across the province.

The targets were set through a 6 month process where the Alliance with the support of a consulting team[1]:

[1] Patricia Ryan, Kits Point Consulting, and Hans Krueger, H. Krueger & Associates Inc.

- reviewed the literature to demonstrate clearly the link between the four risk factors and chronic disease
- chose indicators for which targets would be set that would allow it to assess how BC was doing in comparison to others, and to track progress over time;
- collected and presented information on risk behaviour in B.C. at the provincial, health authority and health service delivery area level
- compared B.C. to other provinces and other jurisdictions in terms of risk behaviour
- involved regional health authority representatives and members of regional healthy living alliance in a consultation process aimed at increasing awareness around regional specific risk behaviour and appropriate targets
- held a consensus workshop with the Coordinating Committee of the Alliance and the regional representatives to finalize the targets.

A number of documents were developed to support this process. This included a reference document and power point presentations which presented data on risk factors and their link to chronic disease; along with risk behavior at the provincial, health authority, and Health Service Delivery Area. These are available on the Canadian Cancer Society, B.C. & Yukon Division web site.

Regional Consultation

During the regional consultation process 11 meetings/workshops, involving more than 200 participants, were held across the province. The groups discussed the risk factors in their health region, their link with chronic disease, and potential targets for their region. (see Appendix 3 for more discussion of the process and groups)

Most participants felt that the targets should be set high, as they would be used for advocacy purposes, and therefore, should be ambitious. The groups also proposed that the targets be set as positive goals – for instance - increase healthy activity rather than reduce number of people who are inactive.

Although the focus of the regional workshops was to set targets, the groups regularly touched on key strategies to help reach these targets. It was agreed that linkages to public policy and addressing the broader determinants of health and their potential impacts would be key. There were also a number of suggestions about setting targets for specific at risk populations. Four groups expressed concern about the lack of any obvious link to the determinants of health &/or the process and did not set targets. The specific comments and suggestions of the groups, including strategies, will be used by the Alliance as it moves forward.

The summary notes from these sessions with detailed comments on the process and the proposed targets were used to inform the discussion and final target setting a consensus workshop with the Coordinating Committee of the Alliance and the regional representatives.

The regional representatives who were present at the consensus workshop reported that the process had provided an excellent opportunity to bring this broad stakeholder group together to engage in serious dialogue about how to work together

to advance this agenda. Most groups wanted to know what the next step was and how they would be involved.

BCHLA TARGETS FOR 2010

These targets are presented below along with charts showing where the BCHLA target fits in relation to various benchmarks. The BCHLA targets are aggressive – purposefully – but in most cases fall within the range proposed through the consultation process. In response to the feedback received during the consultation the targets are phrased in a positive way.

NON SMOKING

Target: 9 out of 10 British Columbians[2] will not smoke by 2010.

This is an increase in the proportion of the population who are non smokers from the current 81% to 87%, an increase of 7%.

[2] Ages 12 and over.

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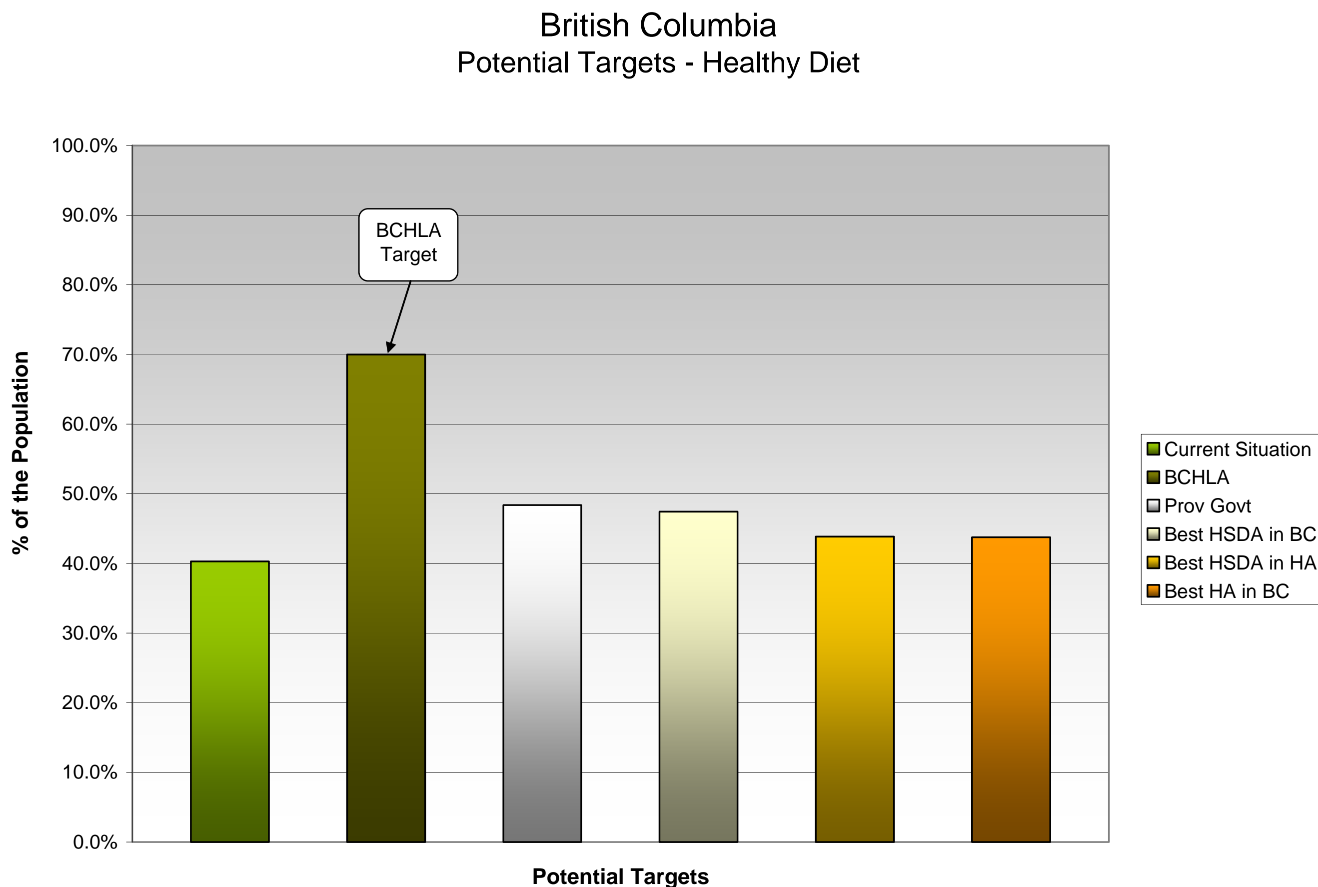
HEALTHY EATING

Target: 7 out of 10 British Columbians[3] will be eating at least 5 vegetables and fruits a day by 2010.

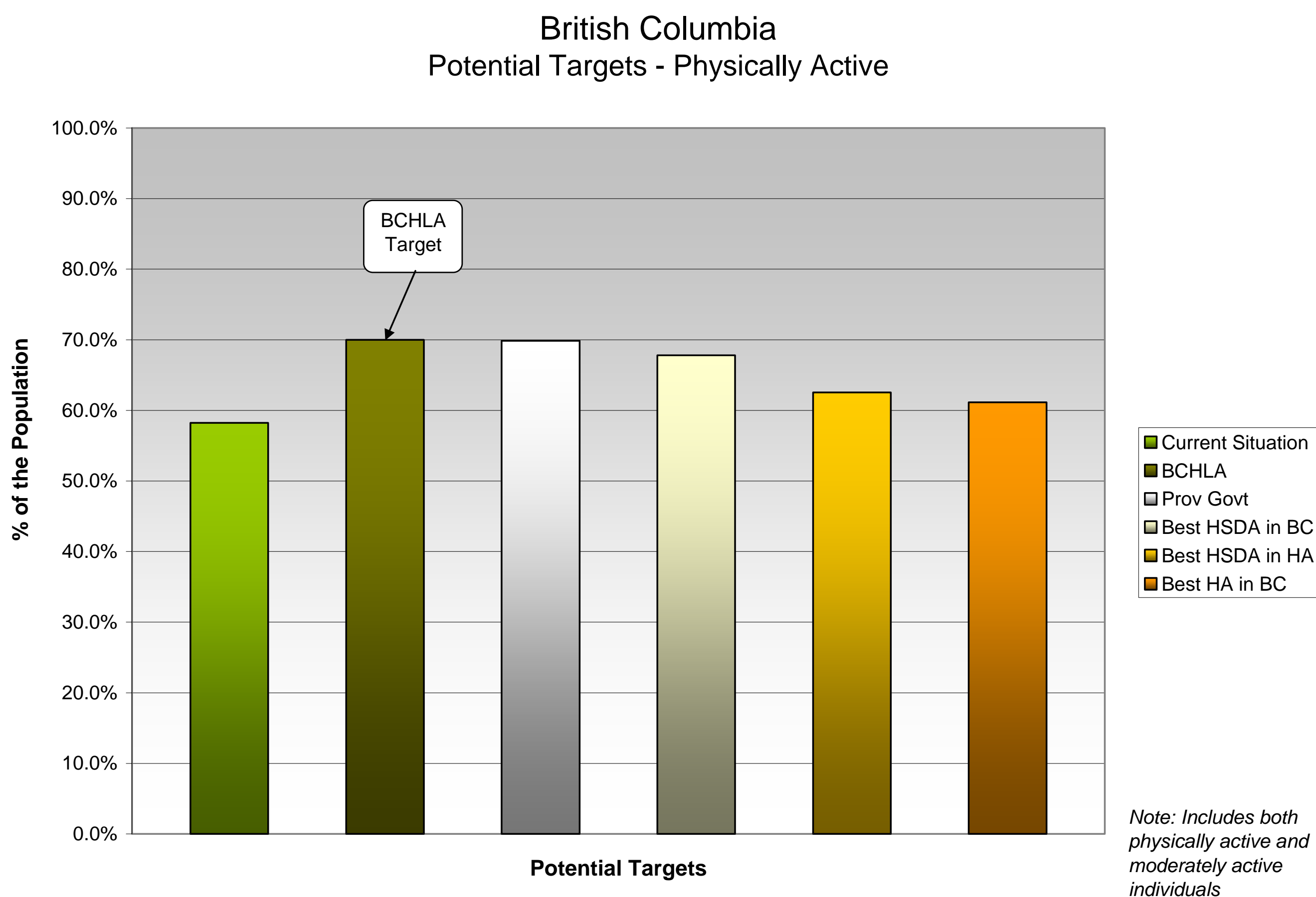


This is an increase in the proportion of the population who eat at least 5 servings of vegetables and fruits a day from 40% to 70%, an increase of 74%.

[3] Ages 12 and over.

HEALTHY ACTIVITY LEVEL

Target: 7 out of 10 British Columbians[4] will be physically active by 2010.

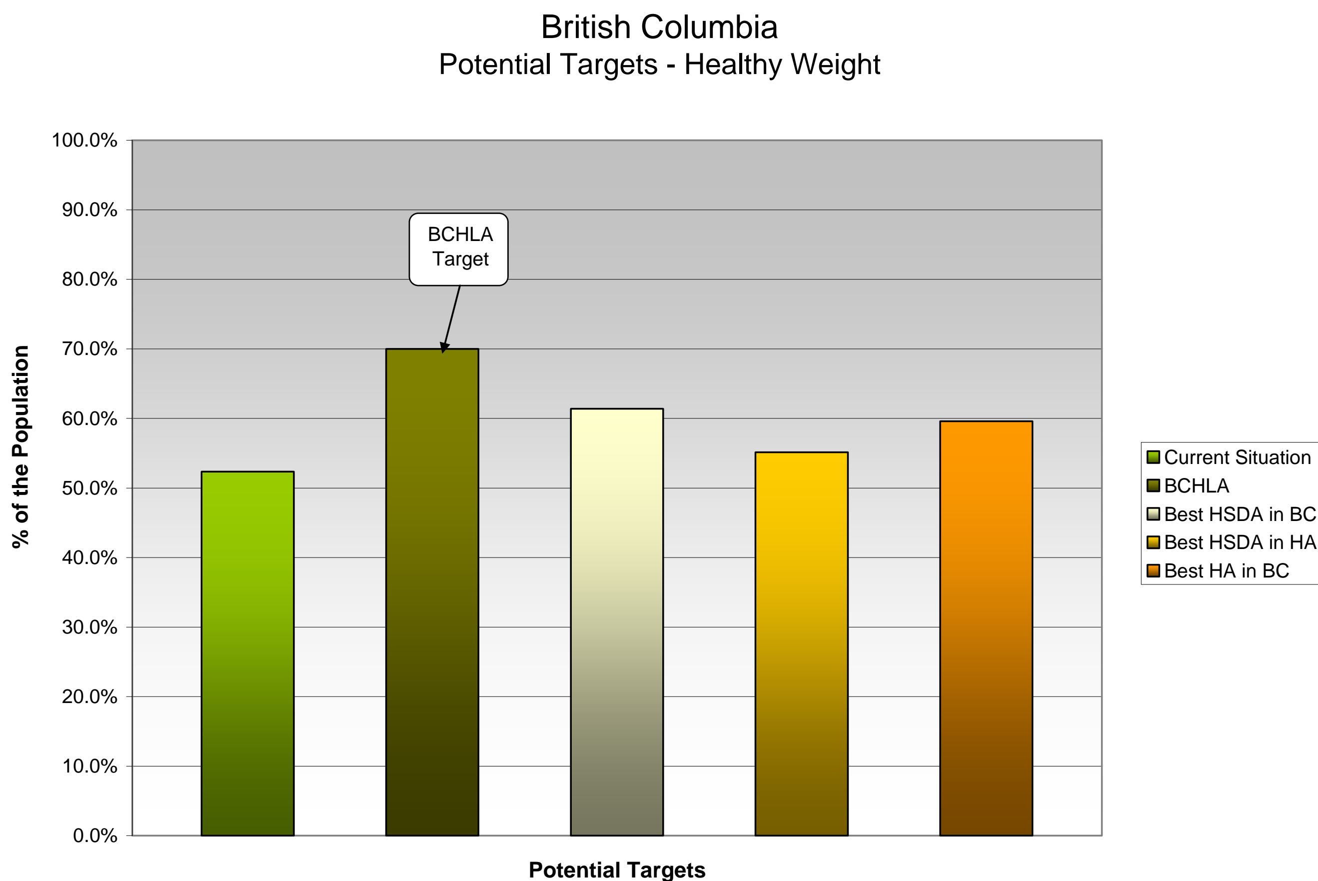


This is an increase in the proportion of the population who are physically active from 58% to 70%, an increase of 20%.

[4] Ages 12 and over.

HEALTHY WEIGHT

Target: 7 out of 10 British Columbians[5] will have a healthy weight by 2010.



This is an increase in the proportion of the population with a self-reported healthy body weight from 52% to 70%, an increase of 34%.

[5] Ages 20 to 64, excluding pregnant women.

THE ECONOMIC BENEFITS OF REACHING OUR TARGETS

Efforts to reduce risk factors are important to the long term sustainability of our health. In addition to the health consequences, there are high costs, both direct medical costs and productivity losses, associated with specific risk factors.

The potential economic impact of reducing specific risk factors was assessed based on information from three recently released documents which estimated the cost of obesity[6], physical inactivity[7] and smoking[8] in British Columbia. Using the information included in these documents an estimated annual additional cost for an individual with these risk factors was calculated. These costs include the direct costs to the health care system and indirect costs associated with productivity losses due to increased morbidity and mortality.

Estimated additional costs adjusted to 2003 dollars are as follows:

British Columbia
Estimated Annual Cost per Individual

	Physical Inactivity	Overweight	Smoking
Direct Costs	$ 150	$ 323	$ 876
Indirect Costs	$ 190	$ 383	$ 1,508
Total	$ 340	$ 706	$ 2,384

This information was then used to estimate the potential cost avoidance if the number of individuals with specific risk factors was reduced.

Several key assumptions were made in this preliminary analysis.

- Potential cost avoidance calculations are based on the estimated difference in costs (table above) between individuals with and without the risk factor.
- The assumption is that this difference would result in cost avoidance in the year that the risk factor was removed. In reality, removing the risk factor would only result in cost avoidance over time, with the estimated amount being the ***maximum potential annual cost avoidance;*** subsequent work on this project will establish more realistic cost avoidance estimates tied to achieving the targets.
- Each person would completely 'remove' the risk factor and maintain this state over time.

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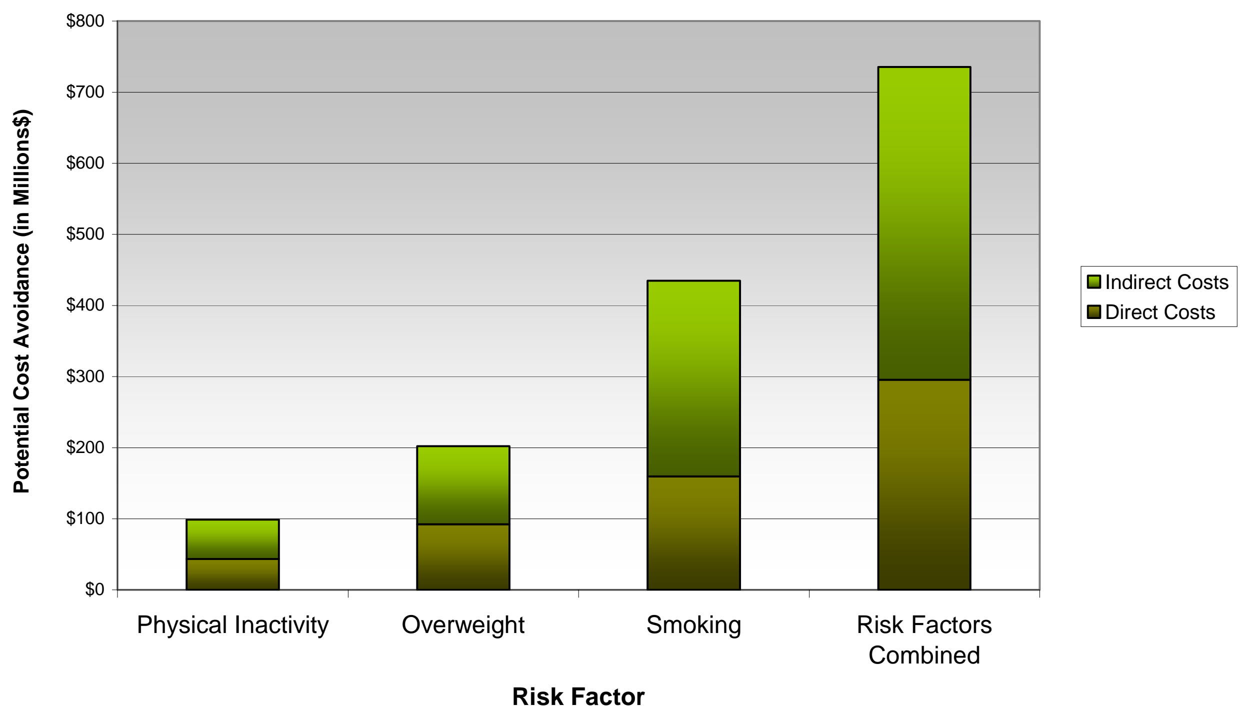
[6] Coleman R. *Cost of Obesity in British Columbia*, GPI Atlantic, January, 2001.
[7] Coleman R. and S. Walker. *The Cost of Physical Inactivity in British Columbia*, GPI Atlantic, March, 2004.
[8] Bridge J. and B. Turpin. *The Cost of Smoking in British Columbia and the Economics of Tobacco Control*, Health Canada, February, 2004.

The estimated cost avoidance identified on the following chart is thus ***maximum annual*** costs avoided for the province if the above assumptions were to be met. That is, if the BCHLA targets set out in this document were fully achieved and each of the individuals achieved a health state equal to individuals without the risk factor, then the maximum potential annual costs avoided could reach as high as $736 million, including $296 million in direct costs and $440 million in indirect costs.



NEXT STEPS

These targets once finalized by the Alliance will be used as a key element of the Alliance's advocacy strategy. A communication and engagement strategy will be developed to build a broad commitment to the targets set in this project.

In another related project sponsored by the CCS/BCCA, members of the Alliance, the literature is being reviewed to:

- identify effective interventions for each of the risk factors
- estimate the potential costs and benefits of implementing specific interventions designed to reduce several risk factors

This project builds on this target setting project.

Appendix 1
Terms of Reference

British Columbia Healthy Living Alliance

Vision

A healthy British Columbia

Mission

To improve the health of British Columbians through leadership that enhances collaborative action to promote physical activity, healthy eating and living smoke-free.

While the Alliance recognizes there is a wide range of chronic diseases, our primary focus, to begin with, is on the common risk factors (physical inactivity, poor dietary habits, tobacco use, obesity) and underlying determinants that contribute significantly to cancer, cardiovascular disease, chronic respiratory disease and diabetes.

Goal

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- respecting the unique strengths, experience and expertise of all organizations and individuals that participate in the Alliance;
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Membership and Structure

Appendix A, Membership and Structure, outlines the operational components of the Alliance (Coordinating Committee, Secretariat and Implementation Working Groups) and identifies the member organizations. The Coordinating Committee sets the strategic direction for the Alliance, e.g. action plans. The Secretariat conducts organizational and communication functions, as outlined in Operating Guidelines. The work of the Alliance is performed by Implementation Working Groups, as directed by the Coordinating Committee, where there are no other groups/organizations currently equipped to take on a task.

As outlined in Appendix B, the Alliance networks with the Chronic Disease Prevention Alliance of Canada, a broader group of stakeholder organizations with provincial scope, and regional/local alliances. These organizations may be involved in the work of the Alliance through participation on Implementation Working Groups.

APPENDIX 2.

RISK FACTOR TECHNICAL DEFINITIONS

Smoking

Proportion of the population (based on household population aged 12 and over, or 12 -19 for youth) who are current daily or occasional smokers.

Unhealthy Eating

Proportion of the population (based on household population aged 12 and over) who consume fruits and vegetables less than five times per day.

Physical Inactivity

Proportion of the population (based on household population aged 12 and over) reporting that they are physically inactive based on their responses to questions about the frequency, duration and intensity of their participation in leisure-time physical activity.

"Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over the past 3 months. For each leisure time physical activity engaged in by the respondent, an average daily energy expenditure is calculated by multiplying the number of times the activity was performed by the average duration of the activity by the energy cost (kilocalories per kilogram of body weight per hour) of the activity. The index is calculated as the sum of the average daily energy expenditures of all activities. Respondents are classified as follows: 3.0 kcal/kg/day or more = physically active; 1.5 - 2.9 kcal/kg/day = moderately active; less than 1.5 kcal per day = inactive."[9]

(See below for CCHS questions related to Physical Activity)

Obesity

Proportion of the population (based on household population aged 20-64 excluding pregnant women) with a calculated body mass index (BMI) of 25.0 or greater. BMI is calculated based on self-reported height and weight.

- Underweight = BMI less than 18.5
- Healthy Weight = BMI of 18.5 to 24.9
- Overweight = BMI of 25.0 to 29.9
- Obese = BMI of 30.0 or greater

[9] See http://www.statcan.ca/english/freepub/82-221-XIE/00604/defin2.htm

CCHS PHYSICAL ACTIVITIES Questions

Have you done any of the following in the past 3 months?
1 Walking for exercise
2 Gardening or yard work
3 Swimming
4 Bicycling
5 Popular or social dance
6 Home exercises
7 Ice hockey
8 Ice skating
9 In-line skating or rollerblading
10 Jogging or running
11 Golfing
12 Exercise class or aerobics
13 Downhill skiing or snowboarding
14 Bowling
15 Baseball or softball
16 Tennis
17 Weight-training
18 Fishing
19 Volleyball
20 Basketball
21 Any other
22 No physical activity

If “Any other” is chosen as a response, **What was this activity?**

INTERVIEWER: Enter one activity only.

In the past 3 months, did you do any other activity for leisure?
1 Yes
2 No
What was this activity?

INTERVIEWER: Enter one activity only.

In the past 3 months, how many times did you participate in %identified activity%?
|_|_|_| Times
(MIN: 1) (MAX: 99 for each activity except the following:
Walking: MAX = 270
Bicycling: MAX = 200
Other activities: MAX = 200)

About how much time did you spend on each occasion?
1 1 to 15 minutes
2 16 to 30 minutes
3 31 to 60 minutes
4 More than one hour

Appendix 3 – Regional Consultation Process

Interior Health Region

In October 2004, Interior Health held 2 Target Setting workshops for the BCHLA. The first workshop was held in Kamloops (TCS Healthy Life Network) on October 12th and the second in Kelowna (Okanagan Healthy Living Alliance) on October 25th.

Both areas had existing Chronic Disease Prevention Networks, therefore, invitations to participate in the workshop were sent to involved members. The TCS workshop in Kamloops consisted of participants from Health (Acute and Community), Parks and Recreation and the Kamloops Municipality. The Okanagan consultation in Kelowna consisted of participants from Health (Acute and Community), Parks and Recreation, OUC, BC Cancer Agency, Brain Injury Society, and Aboriginal Health Services. Noticeably absent in this process was the participation of the Kootenay Health Service Area. Efforts were made to hold a consultation workshop, however, chronic disease prevention networks had not been formally established within this area. On a positive note, a meeting of interested community partners did occur to discuss this project and the possible formation of an alliance.

Vancouver Coastal Health Region

A target setting workshop was held on November 9th with participation of 16 people involved in health promotion or community development from across the health region. This was facilitated by Kristen Farquharson, Chronic Disease Coordinator, VCH Primary Health Care Network. In addition, the materials were circulated to a number of other clinical and management staff for feedback

Vancouver Island

Four meetings in three locations across Vancouver Island were held to share information and set regional targets for reduction of risk factors for chronic disease. This work was supported and organized by Sylvia Robinson of VIHA and Dan Pagely of the BC Recreation and Parks Association.

A total of 44 people participated in the process. The background of the participants ranged from research and education, to health care and recreation. About half of the participants were staff of the universities and non profit organizations.

Northern Health Region

The targets for the north came about from 3 main sources.

1. Community meeting in Terrace, approximately 20 involved
2. Teleconference involving health care professionals involved in chronic disease prevention and management across NHA, approximately 30 were involved
3. HEAL committee

Judy Huska, Marvin Barg, and Alice Dome facilitated the process.

Fraser Health Region

The Fraser Health Authority sponsored a 6 hour workshop on behalf of the BCHLA to examine risk factors associated with chronic disease and to recommend targets for risk factor reduction. The workshop took place on November 10th, 2004. Approximately 40 people attended with a healthy cross section of representatives. Participants came from organizations and agencies affiliated with sport, parks, and recreation, education, aboriginal communities and health, including: Canadian Diabetes Association, Prevention Source BC, BC Lung Association, Action Schools and Canadian Mental Health Association. Staff roles of those present ranged from Medical Health officers to nutritionist; medical student to public health nurse; community action coordinator to recreation programmer. Laurie Gould and Wendy Bruins facilitated the process.