A STUDY OF THE IMPLEMENTATION OF PROVINCIAL/TERRITORIAL HEALTH GOALS IN CANADA: FINAL REPORT TO NHRDP

NHRDP Project No. 6610-2345-004

Charles James Frankish
University of British Columbia
Institute of Health Promotion Research
LPC Building, Room 324
2206 East Mall
Vancouver BC V6T 1Z3

C. Dawne Milligan
University of British Columbia
Institute of Health Promotion Research
LPC Building, Room 324
2206 East Mall
Vancouver BC V6T 1Z3

Brenda Kwan
University of British Columbia
Institute of Health Promotion Research
5804 Fairview Avenue
Vancouver BC V6T 1Z3

Pamela A. Ratner
University of British Columbia
School of Nursing
Koerner Pavilion T223
Vancouver BC V6T 2B5

Deanna Williamson
University of Alberta
Department of Human Ecology
302 Human Ecology Building
Edmonton AB T6G 2N1

Lawrence W. Green
National Center for Chronic Disease Prevention and Health Promotion
4770 Buford Highway (CDC Mail Stop K-50)
Atlanta, GA 30341
United States

For Further Information Please Contact
the Investigator C. J. Frankish at:

Telephone: (604) 822-9205/Fax: (604) 822-9210
E-mail: frankish@interchange.ubc.ca

January 2001
Vancouver, British Columbia

Funded by **Health Canada** through the **National Health Research and Development Program (NHDRP)**
Telephone: (613) 954-8540
Fax: (613) 954-7363

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In the past ten years, every province and territory in Canada (except the Yukon) has developed a set of "health goals" or "health and social goals" related to enhancing the health of populations. These goals were initiated at the level of the provincial/territorial government. During the same period, authority and responsibility for substantial aspects of the health system have shifted to the regional level in most provinces/territories. The objectives of this study were to examine, in each province/territory and health region (190), the extent of implementation of the health goals, factors that enhance and limit their implementation, and the ways in which health goals are perceived to be influential. A number of data sources were used, including a review of literature on policy implementation and on health goals implementation, a review of provincial/territorial level documents, an interview with a senior health ministry official in each of the 12 provinces/territories, and a survey distributed to all 190 health regions (130 replied; response rate 68%).

The number of health goals per province/territory varies from 4 to 10. For the purpose of analysis, the 66 health goals across Canada were grouped into ten categories based on the topic focus for each goal. The most common types of goals relate to the "social and economic environment" and to "health services/system."

The extent of implementation of the health goals can be described in a variety of ways. The health goals were most commonly used as a conceptual tool (e.g., as a framework for planning) at both the ministerial/departmental and regional levels. Most regions had completed developing their regional goals and objectives, while regional indicators, targets, and strategies were still being developed. In addition, the health goals were influential in increasing the focus on, and an understanding of, the determinants of health. This occurred in the ministries/departments of the government, in the health sector, and at the regional level.

Several questions in the regional survey related to implementation of the *specific* goals. Compared with the other types of goals, health services/system goals have been much more highly acted upon in the relevant health regions (i.e., regions in provinces/territory that have this type of goal). More than one half of the responding regions reported no change in action over time for all types of goals. However, among those regions that reported a change in action, it was most often an increase in action. For each type of goal, the most commonly reported factor contributing to higher overall action was that a region was already and concomitantly working toward the same end as the goal. Most of the relevant regions believed that all five factors listed in the survey contributed to greater action on their health services/system goals. For most types of goals, ratings of higher compatibility with regional health mandates were associated with ratings of greater action.

The ministerial interviewees and regional survey respondents perceived a variety of factors to have influenced implementation. They identified positive influences, such as a stable government that was supportive of the health goals, the approval of the health goals by Cabinet (legitimizing), and knowledge of "population health" and the broad determinants of health. Several negative contextual influences were reported by the interviewees; these influences were similar to those identified by the survey respondents as being priorities that had competed most with the goals at both the provincial/territorial and the regional levels (i.e., health service delivery issues, funding issues, and restructuring/reorganization). The survey respondents generally did not believe that the goals were high priority at either the provincial/territorial or the regional level.

The nature/characteristics of the health goals were reported to be influential, but may act as a double-edged sword in relation to implementation. The breadth of focus of the goals assisted in gaining commitment or "buy-in." Their breadth also made the goals difficult to operationalize. In limited cases, the specificity and detail of the goals (i.e., inclusion of objectives, targets, etc.) can provide clarity, yet may be overwhelming.

Various players were reported by most interviewees to have positively influenced the *development* of health goals - the leadership and political support of politicians, government employees in high-level

positions, and the health councils (that were responsible for overseeing implementation in some jurisdictions). The disbanding of the health councils was perceived to have slowed *implementation* of the goals. At an organizational level, *changes* in structure, rather than the organizational structure itself, were reported to have negatively affected implementation.

The support available to the regions was also perceived to have influenced implementation. Most of the provincial/territorial level mechanisms to ensure regional use of the goals that were listed in the survey were reported to be nonexistent. For most of the mechanisms, however, a belief in its existence was associated with perceptions of it having an enhancing influence on a region's use of the goals. Most health regions reported that a limited degree of funding was allocated from the government to the regions for the specific purpose of addressing the goals. Funds in the regions were perceived as largely insufficient for addressing the goals. One-half of the regions reported having attempted to assess progress toward achieving health goals. Region-specific data ranged from being moderately to fairly available. A moderate proportion of the available data was viewed as reliable, timely and valid.

Positive correlations (based on statistical analyses) were found among all relevant factors in the survey and the "regional implementation score" (a measure intended to reflect the status of implementation in the health regions).

Various conclusions are made. Although the health services/system goals have received the most attention, the provincial/territorial health goals also focus on other non-medical determinants of health. There is evidence to suggest that some regions have acted on these other types of goals. While the context appears to have a large influence on implementation, other factors were found to be associated with enhanced implementation of the goals. This finding suggests that factors other than the context may be used to enhance implementation (e.g., allocation of funding, provincial/territorial mechanisms to ensure use, etc.). The most common use of health goals has been as a conceptual framework for planning. Goals serve more of a philosophical purpose than a practical or managerial purpose, the latter of which may be more conducive toward greater accountability, data collection and monitoring. This leads to the question of whether provinces/territories are fully committed to health goals through political support, persistence in using the goals, and allocation of funding. It is unclear whether any commitment extends to developing the capacity of the regions, territories and provinces to be accountable for, act on, and monitor progress on health goals.

These conclusions have several implications for key stakeholders. Health Canada has already shown leadership by promoting the idea that health is influenced by broad determinants, many of which are the foci of specific provincial/territorial health goals. However, the recent increase in federal funding for health renewal is being directed largely toward health system infrastructure and health service delivery, not toward the non-medical determinants of health. Health Canada may assist the provinces and territories in addressing the non-medical determinants of health through its national initiatives (i.e., population health approach, early childhood development, anti-poverty initiatives).

Similarly, if ministries/departments and government recognize the non-medical determinants as a policy and program priority, then it becomes important for them to provide clear direction and expectations about what they and the health regions can, or should, do to act on the full range of health goals. The health regions themselves may attempt to clarify their role in acting on the non-medical determinants of health, especially if their mission or mandate encompasses these determinants. In addition, the health regions may be supported by national and provincial/territorial initiatives (e.g., Canadian Institutes for Health Information) in their efforts to collect data or develop data systems to monitor progress on health goals. Generally, a high level of interest exists in promoting awareness of, and action on, broad determinants of health. Initiatives have already been created to fund research related to these determinants, and researchers, by applying to these funding sources, have shown their interest.

RÉSUMÉ

Au cours des dix dernières années, toutes les provinces et territoires du Canada (sauf le Yukon) ont développé une série "d'objectifs de santé" ou "d'objectifs sociaux et de santé" visant l'amélioration de la santé des populations. Ces objectifs ont été initiés au niveau des gouvernements provinciaux/territoriaux. Au cours de la même période, l'autorité et la responsabilité de certains aspects importants du système de santé ont été transférées aux palliers régionaux et ce dans la plupart des provinces/territoires. La présente étude visait à examiner, dans chaque province/territoire et région sanitaire (190), l'état d'implantation des objectifs de santé, les facteurs favorisant et limitant leur implantation et les perceptions face à leur influence. Plusieurs sources de données ont été utilisées incluant une revue de la littérature sur l'implantation de politiques et sur l'implantation des objectifs de santé, une revue des documents provinciaux/territoriaux, une entrevue avec un représentant senior des ministères de la Santé dans les 12 provinces et territoires et un questionnaire distribué aux 190 régions sanitaires. (130 ont répondu; taux de réponse : 68%).

Le nombre d'objectifs de santé par province ou territoire varie de 4 à 10. Pour les besoins de l'analyse, les 66 objectifs de santé à travers le Canada ont été regroupés en dix catégories en fonction de la nature de chacun d'eux. Les objectifs les plus communs concernaient "l'environnement social et économique" et "les systèmes/services de santé".

L'état d'implantation des objectifs de santé peut être décrit de multiples façons. Les objectifs de santé étaient le plus souvent utilisés comme un outil conceptuel (i.e. comme un cadre de planification) tant au niveau des ministères que des régions. La plupart des régions ont finalisé la définition de leurs objectifs et buts alors que les indicateurs, cibles et stratégies régionaux étaient encore en développement. Les objectifs de santé ont favorisé un plus grand intérêt et une meilleure compréhension des déterminants de la santé. Ce fait a été observé dans les ministères, les réseaux de santé et au niveau régional.

Plusieurs questions de l'enquête régionale concernaient l'implantation d'objectifs *précis.* Par comparaison avec d'autres types d'objectifs, les objectifs de système/services de santé sont ceux qui ont suscité le plus d'actions dans les régions sanitaires concernées (i.e. les régions des provinces/territoires qui avaient ce type d'objectif). Plus de la moitié des régions pour lesquelles nous avons reçu un questionnaire ont indiqué qu'il n'y avait aucun changement dans les actions à travers le temps et ce pour tous les types d'objectifs. Cependant, parmi les régions ayant signalé un changement dans les actions, la plupart du temps il s'agissait d'une amplification des actions. Pour chaque type d'objectif, le facteur le plus fréquemment identifié contribuant à un niveau général d'actions plus important était le fait qu'une région travaillait déjà dans le même sens que l'objectif. La plupart des régions ayant un ou des objectifs de système/services de santé considéraient que les cinq facteurs identifiés dans l'enquête contribuaient à une augmentation des actions allant dans ce sens. Pour la majorité des objectifs, là où des réponses soulignaient une plus grande compatibilité avec le mandat de la région, de meilleurs résultats concernant le niveau d'action étaient obtenus.

Selon les interviewés ministériels et les répondants au questionnaire régionaux, une variété de facteurs ont influencé l'implantation. Les interviewés ont identifié des influences positives comme la stabilité d'un gouvernement jugeant pertinents les objectifs de santé, l'approbation des objectifs de santé par le Cabinet (légitimisation) et la connaissance du modèle de "santé de la population" et des grands déterminants de la santé. Plusieurs influences environnementales négatives ont été rapportées par les interviewés. Celles-ci étaient similaires à celles identifiées par les répondants au questionnaire et qui jugeaient que d'autres priorités entraient en concurrence avec les objectifs de santé et ce tant au niveau de la province/territoire qu'au niveau régional (i.e. les questions de la prestation des services de santé, de financement, de restructuration/réorganisation). De plus, les répondants au questionnaire ne considéraient généralement pas que les objectifs étaient prioritaires tant au niveau de la province/territoire qu'au niveau de la région.

La nature et les caractéristiques des objectifs de santé ont été signalées comme ayant une influence mais comme pouvant agir tel un couteau à double tranchant sur l'implantation. L'étendue des sujets couverts par les objectifs a favorisé l'engagement et l'adhésion alors qu'elle a aussi contribué à rendre les

objectifs difficiles à opérationnaliser. Dans un nombre limité de cas, la spécificité et la précision des objectifs (i.e. spécification de buts, cibles, etc.) ont pu augmenter la clareté mais de façon écrasante.

Différents acteurs ont été mentionnés par la plupart des interviewés comme ayant influencé positivement le développement des objectifs de santé – le leadership et l'appui politique des politiciennes et politiciens, les fonctionnaires de la haute hiérarchie, les Conseils de Santé (lesquels étaient responsables de superviser l'implantation dans certaines juridictions). Le démentellement des Conseils de Santé a été perçu comme ayant ralenti l'implantation des objectifs. D'un point de vue organisationnel, les changements de structures, plutôt que les structures en tant que telles, ont été soulignés comme ayant nuit à l'implantation.

L'appui disponible pour les régions a aussi été perçu comme ayant eu une influence sur l'implantation. La plupart des mécanismes provinciaux/territoriaux identifiés dans le questionnaire servant à assurer l'utilisation des objectifs par les régions ont été jugés inexistants. Pour la plupart des mécanismes, toutefois, la croyance de leur existence était associée à des perceptions de leur influence qui encourageaitt l'utilisation des objectifs dans la région en question. La plupart des régions ont signalé un niveau limité de fonds alloués par le gouvernement pour répondre spécifiquement aux objectifs. Les fonds dans les régions étaient perçus comme largement insuffisants pour répondre aux objectifs. La moitié des régions signalent avoir tenté d'évaluer le progrès dans l'atteinte des objectifs. Les données sur l'état de santé et l'utilisation des services de santé ont été signalées comme étant très disponibles alors que les autres types de données l'étaient moins. Une proportion modérée des données disponibles était perçue comme étant consistante, à jour et valide comme mesures des objectifs de santé.

Des corrélations positives (basées sur des analyses statistiques) ont été observées entre tous les facteurs pertinents du questionnaire et "le niveau d'implantation régional" (une mesure visant à réfléter l'état d'implantation des objectifs au niveau régional).

Différentes conclusions sont tirées. Malgré le fait que les objectifs de systèmes/services ont été l'objet de plus d'attention, les objectifs provinciaux/territoriaux de santé se concentraient aussi sur d'autres déterminants non-médicaux de la santé. Les faits suggèrent que certaines régions ont agi sur ces autres types d'objectifs. Si le contexte semble avoir une large influence sur l'implantation, d'autres facteurs ont été identifiés pouvant la favoriser. Cette observation suggère que des facteurs autres que le contexte peuvent être utilisés pour favoriser l'implantation des objectifs. (i.e. la répartition des fonds, les mécanismes provinciaux/territoriaux qui assurent l'utilisation, etc.). L'utilisation des objectifs de santé comme cadre conceptuel de planification a été la plus fréquente. Les objectifs avaient une vocation philosophique plutôt que pratique ou de gestion. Une utilisation à des fins administratives permettrait une plus grande imputabilité, plus d'informations et de contrôle. Ce fait pose la question de l'engagement réel des provinces/territoires envers les objectifs de santé à travers l'appui politique, l'utilisation récurrente des objectifs et la répartition des fonds. Il n'est pas clair si l'engagement va jusqu'à développer les capacités des régions, territoires et provinces à être imputables, à agir et à évaluer le progrès des objectifs de santé.

Ces conclusions ont plusieurs implications pour les principaux intervenants. Santé Canada a déjà démontré du leadership pour promouvoir l'idée que la santé est influencée par de larges déterminants, dont plusieurs sont parties intégrantes des objectifs de santé provinciaux/territoriaux. Toutefois, l'augmentation récente du financement fédéral pour la santé a été largement dirigée vers l'infrastructure du système de santé et la prestation des services et non vers les déterminants non-médicaux de la santé. Santé Canada pourrait accompagner les provinces et territoires pour traiter des déterminants non-médicaux de la santé à travers ses initiatives nationales (i.e. l'approche de la santé de la population, le développement de la petite enfance, les initiatives contre la pauvreté).

De façon similiaire, si les Ministères/Départements et gouvernement reconnaissent les déterminants non-médicaux de la santé comme une priorité politique et administrative, alors il devient important pour eux de fournir des lignes directrices et des attentes précises concernant ce qu'eux et les régions peuvent ou devraient faire pour agir sur l'ensemble des objectifs de santé. Les régions elles-même peuvent tenter de clarifier leur rôle pour agir sur les déterminants non-médicaux de la santé, en particulier si leur mission ou

mandat couvre ces déterminants. De plus, les régions pourraient être appuyées par les initiatives nationales ou provinciales/territoriales (i.e. Instituts canadiens d'information sur la santé) dans leurs efforts pour recueillir les données ou développer des systèmes de données pour évaluer les progrès des objectifs de santé. De façon générale, une niveau élevé d'intérêt existe pour promouvoir la conscience des et l'action sur les grands déterminants de la santé. Des initiatives ont déjà été créées pour financer la recherche liée à ces déterminants, et les chercheurs, en soumettant des demandes pour obtenir ce financement, ont montré leur intérêt.

1. OVERVIEW OF THE RESEARCH METHODOLOGY

1.1 Objectives

During the past 10 years, every province and territory in Canada except the Yukon has developed a set of "health goals" or "health and social goals" related to enhancing the health of populations (1-11). These goals were initiated at the level of the provincial/territorial government. However, during the same ten years, authority and responsibility for substantial aspects of the health system have shifted to the regional or community level in most provinces/territories. The objectives of the study were to examine:

1. the implementation status of the provincial/territorial health goals in each Canadian province/territory and regional health authority (RHA);

2. various limiting and enhancing factors associated with the implementation of the health goals in these jurisdictions; and

3. the ways in which the health goals were perceived to be influential in the study sample.

1.2 Study Design

A multi-level case study design was used to answer the research questions. A number of data sources (triangulation) were used. The study began with a review of international literature related to policy implementation and health goals implementation, and was the basis for the development of a framework for classifying and analyzing factors which influence implementation. The results of the literature review are discussed in Section 2. Next, a review of documents published by each provincial/territorial government, and which related to their respective health goals and to planning, was conducted. The purpose of the document review was to provide an overview of health goals processes, strategies, and activities in which each province/territory had engaged. The results of the literature and document reviews were used to develop an interview guide for use at the Ministerial/Departmental level, and a survey for use at the RHA level.

The interview guide, with core questions and probes, related to each level and stage of the framework that was developed based on the literature review. The interview guide was pilot-tested, revised, and translated into French for the interview in Québec. Late in 1998, faxes were sent to the ministers responsible for health in the 10 provinces and 2 territories, requesting the name of an employee who could provide information about health goals in the respective province/territory; a name was obtained from each province/territory. Between April and June 1999, telephone interviews, averaging one hour in length, were conducted with these 12 employees. The interviews were audiotaped and transcribed. All interviewees held high-level positions (e.g., Assistant Deputy Minister, Provincial Health Officer, Executive Directors of planning, policy, population health, or health promotion). One half reported that they had been involved in the development of the health goals, and all but two reported being still involved in working with the goals at the time of the interview.

A survey directed at the RHA level, with questions parallel to those in the interview, was developed to allow comparison between Ministerial/Departmental and regional levels of governance. The survey was refined based on feedback from 3 pilot surveys conducted with individuals from Alberta, British Columbia, and Manitoba. Each province received a customized version of the survey, listing its own health goals and using the appropriate terms to refer to its health regions (e.g., regions, districts, communities). The survey was initially distributed by mail in May 1999, with a self-addressed stamped return envelope, to the Chief Executive Officer in each region, with a request to either complete it or pass it on to another appropriate person to complete. There were two rounds of follow-up, including multiple telephone calls, identification of possible alternate respondents, and redistribution of surveys by fax. Data collection was completed in mid-September 1999. The response rate to the survey was 68%, or 130 regions. More than one half of the survey respondents were CEOs or held a comparable position, while most of the remaining respondents held planning positions in their health regions. More than 80% of respondents

reported being responsible for planning in their regions based on the provincial/territorial health goals, and about one-half reported being responsible for initiating intersectoral collaboration and evaluating regional services and programs based on the goals. About 40% had been involved in the development of the goals, either by providing feedback on a draft of the goals or helping to write them.

1.2.1 Data analysis

The interview and document review data from each province/territory were analyzed qualitatively, and summarized under the categories of "implementation status" and "influencing factors" (facilitating or limiting). One member of the research team categorized the responses in accordance with the questions in the interview guide. The categorization of interview data was validated by having a second member of the research team read through each of the transcripts and then discuss the categorization with the first member. The health goals themselves were grouped into ten categories based on the topic focus of the goal (see Appendix A).

Most of the survey contained closed-ended questions (i.e., yes/no, rating scales). The responses to the close-ended questions were entered into and analyzed in the statistics software program SPSS®, which was used to generate frequencies and medians and ranges for each province/territory and at a national level. The possibility of an "implementation score" (a summary measure that reflects implementation in its different forms) was explored using factor analysis (the results of this are presented in Section 3.1.5). Statistical tests for correlation were then conducted between potential influential factors and the "implementation score." The open-ended responses to the survey were categorized and summarized using qualitative data analysis.

1.2.2 Limitations of the Study

The study is retrospective, given that a period of time had elapsed (in some cases almost 10 years) during which the Ministries/departments and regions have had the opportunity to implement the health goals. Thus, the study is subject to recall bias. While the document review provides some descriptive data, the documents do not reflect a complete picture. For example, published plans are not always implemented. The rest of the data, which are from interviews and surveys, is based on self-reports (perceptions). Therefore, the study does not demonstrate any causation between health goals and the actions being taken by the Ministries/departments and the RHAs, only correlations or associations.

2. LITERATURE REVIEW

Across Canada, policy-makers and decision-makers are implementing a host of policies and programs marked by an emphasis on accountability and evidence-based decision making (12-14). These initiatives are being undertaken in the context of broad social movements including the adoption of a "population health" perspective (13) and the reform and renewal of the health system (15-16). Within this context, there is growing emphasis on the use of health goals as a strategy for decision-making (17).

2.1 Adoption of a Population Health Perspective

It is now 25 years since the "determinants of health" were introduced as the "health field" concept in the Lalonde Report (18). The "determinants of health" approach is based on the notion that both individual and collective factors influence well-being and quality-of-life. Population health status results from the aggregation of the impact of multiple determinants. This view was also seen in the "prerequisites for health" identified in the 1986 Ottawa Charter.

Recently, a population health approach has been articulated by groups such as the Canadian Institute of

Advanced Research and adopted by Health Canada. Groups of researchers and policy-makers have identified various determinants of health. For example, Evans et al. (19) suggest that determinants of health include health services, genetics, environmental sanitation, nutrition, shelter, stress, and the social environment. An Ontario framework (20) conceptualizes the determinants of health in terms of four domains: social environment, physical environment, individual responses and productivity and wealth. The Federal Committee on Population Health adopted these determinants as targets for national and provincial strategies for population health.

The conceptualization of "determinants of health" remains problematic, as the determinants are not mutually exclusive of each other, and the quality of evidence regarding the relationships between the determinants and specific aspects of health is varied. It is unclear which determinants are most amenable to intervention and are most likely to contribute to meaningful improvements in health and quality-of-life. Questions arise about which level of government or society should be responsible for action on specific determinants of health (13). We also lack information regarding the factors that might support or hinder action on specific determinants by important groups such as the RHAs (and health-related non-governmental organizations) across Canada.

2.2 Health Reform and Regionalization

Governments at all levels across Canada are emphasizing a view of health that encourages personal responsibility and public involvement in decisions regarding health and the health care system (15, 21). This trend has contributed to an expansion of local governance and emphasis on accountability for health services, as most provincial/territorial governments institute broad health policy initiatives and health-system restructuring that has led to the creation of regional health authorities (RHAs) (15, 21-25). It has been suggested that regionalization offers a means of better integrating services and controlling expenditures, and promises enhanced citizen participation (20, 25).

2.3 Health Goals as a Strategy for Population Health and Health Reform

Health goals can be defined as broad statements of aim for health and well-being. Health goals have gained increased acceptance as a strategy for population health promotion by countries around the world (e.g., Australia, New Zealand). The first widely disseminated health goals appeared in the late 1970's in the US. A comprehensive framework for health was outlined in the US's Healthy People document (26) that has led to several iterations of national health objectives. Similarly, the Alma Ata conference on primary health care called for health goals in "Targets for Health for All" (27). Other countries and regions followed in the adoption of health goals and targets (28-30). Canada does not have a similar set of national health goals, but most provinces and territories have articulated health goals and have gone on to develop objectives, targets, strategies and action plans to varying degrees. While most provinces/territory have health goals that address the functioning of the health services system, an equally large number of provinces/territory have health goals that address the broader determinants of health, termed by our research team as "non-medical determinants of health" (NMDH). Within the provinces/territory, action on health goals has fallen, in many cases, to the regional level. Few guidelines on the health goals' implementation process have been published, however, and limited study has occurred on variations in the approach to health goals planning or on the complex forces that influence the implementation process (34).

2.4 Creation of the Theoretical Framework for Analysis

A review of the policy implementation literature (31-46) and of recent international literature related to health goals implementation (47-67) resulted in the creation of a theoretical and empirical framework of key factors and conditions that play a role in the implementation of health goals (see Figure 1). There are two levels in the framework. The first level is the "prevailing context and policy environment" (economic, legal, political and social factors). The second level consists of a number of categories of factors more

specific to the goals' implementation, including the "nature of the goals;" support for goal implementation in the form of "individual players," "organizations," and resources;" the "process" of implementation; and "results" of health goals implementation.

Figure 1: Factors influencing implementation of the health goals

Level 1: Prevailing context and policy environment	Level 2: Immediate influences			
Economic, legal, political, and social factors	A. Goals	B. Support	C. Process (actions)	D. Results (outcomes)
	Stimulus, tractability of the problem Clarity Specificity Complexity Flexibility/adaptability Number of goals Degree of change required Priorities addressed Trialability Theory underlying policy (validity of causality)	Players (characteristics and attributes): attitudes motivation support knowledge skills "champion" Organizations (intra-, inter-organizational, and intersectoral levels) norms, procedures, decision and control processes and rules authority, supervision, incentives, compliance mechanisms, communication channels accountability, requirements, responsibility, planning Resources money training capacity building consultation	Development Implementation Monitoring Data Collection Evaluation	Change

3. MAIN FINDINGS

All the Tables in the Main Findings section can be found in Appendix B.

Note: Because the Yukon was considered to not have a set of health goals, the findings relate mainly to the other 11 provinces/territories. For the purposes of this study, the data from Nunavut has been incorporated into that for the Northwest Territories, since Nunavut had only split from the Northwest Territories at the time data was being collected.

3.1 General Implementation Status of the Provincial/Territorial Health Goals

3.1.1 Overview of Health Goals

The number of health goals per province/territory varies from a low of 4 in the Northwest Territories to a high of 10 in Manitoba. For the purpose of analysis, the 66 health goals in the 11 provinces/territory across Canada (see Appendix A) were grouped into ten categories, based on the topic focus for each goal (see Table 1). The topic foci most commonly found in the provincial/territorial health goals across Canada relate to the social and economic environment (13 goals in 10 provinces/territory) and the health services/system (14 goals in 9 provinces/territory).

Main Finding #1: The topic foci most commonly found in the provincial/territorial health goals across Canada relate to the social and economic environment and the health services/system.

3.1.2 Inclusion or Citation of Original Goals in Ministerial/Departmental Level Documents

In seven of the eleven provinces/territory, the original health goals were included or cited in subsequent Ministerial/Departmental level documents. In two provinces, the health goals, or reference to them, were not found in subsequent planning documents; one interviewee, however, reported that the goals had been "rolled into" the new strategic plans of the Department. In the remaining province (Newfoundland) and territory (Northwest Territories), the health goals had only been published about a year prior to the survey; thus, it was not expected that this province and territory would have published subsequent documents related to the goals.

Goals are generally broad statements of aim. They may be used to develop more specific objectives, indicators, targets, and/or strategies.[1] This occurred in eight of the eleven provinces/territory. In three provinces/territory, these were articulated in the original health goals document, while in five provinces they were articulated at a later date.

The interviews and surveys were conducted in 1999 (until mid-September). Since then, three provinces/territory have published additional documents, such as annual or health status reports and business plans, which include or cite the original health goals. In Nova Scotia, the Provincial health council that was responsible for goal implementation was re-established in September 1998, and the Premier re-affirmed the government's commitment to the health goals in November 1999.

Main Finding #2: There is evidence to show that subsequent to the publication of the original health goals, most Ministries/departments had considered the goals in their planning (e.g., included or cited in subsequent documents, development of more specific objectives, indicators, targets and/or strategies).

3.1.3 Ways in Which the Health Goals Have Been Used, at the Ministerial/Departmental and the Regional Levels

The interviewees reported that the health goals were most commonly used as a conceptual tool at the Ministerial/Departmental level. For example, the goals were used for setting strategic directions and/or as a framework for planning, as a broad philosophical orientation or "backdrop", and for developing policies and programs (see Table 2).

All the Ministerial/Departmental interviewees also commented on the ways in which the goals were being used at the regional level. In Newfoundland the regions have yet to use the goals, which had been published for less than a year at the time of the interview. In two provinces, the regions were reported to be planning based on Ministerial/Departmental plans and goals that were published more recently than (and not explicitly related to) the original health goals. In the other eight provinces, the regions were reported to be either using the provincial/territorial health goals, or to have developed their own regional goals and objectives based on the provincial/territorial goals. Similar to the Ministerial/Departmental level, the health goals were reported to be most commonly used as a broad philosophical orientation or "backdrop" for planning at the regional level. This was confirmed by the data from the regional surveys (see Table 3), where high usage of the goals being adopted as a framework for planning was reported in 44% of the regions. Other common uses of the health goals at the regional level included: initiating collaborative action on the goals with sectors other than health; developing new policies and programs based on the goals; and allocating resources based on the goals.

Main Finding #3: The health goals were most commonly used as a conceptual tool (e.g., as a framework for planning) at both the Ministerial/Departmental and the regional levels.

[1] Goals are defined as broad statements of aim. Objectives are specific quantifiable statements of aim (who, what, by when). Indicators are measures (e.g., mortality). Targets reflect what is to be achieved for an indicator (e.g., reduce mortality from 20% to 15%). Strategies are statements of how the targets, objectives, and goals will be achieved (e.g., actions such as introducing a no-smoking policy in shopping malls). Although the research team distinguishes these terms as being separate, the terms are often used interchangeably and in place of one another in the literature and in practice.

3.1.4 Ways in Which the Provincial/Territorial Health Goals Have Been Influential

The Ministerial/Departmental interviewees reported that the health goals were influential in a variety of ways. First, the development of the health goals led to an *increase in knowledge and an understanding of the broad determinants of health* by those in the government (including ministries/departments outside of health) and in the health sector, and by the general public. Of notable interest is the fact that several interviewees thought that the process of developing the health goals, rather than their implementation, was of most benefit (e.g., "buy-in" into the health goals). Second, the health goals development process *helped provide direction for planning* (e.g., strategic planning, focus on outcomes, philosophical framework). Finally, the health goals process *enhanced communication* among ministries/departments, the regions, and local non-governmental organizations.

At the regional level, respondents to the survey were asked to rate the overall degree of influence that the health goals had on decision-making in the regions. Thirty-four percent of the respondents reported a high degree of influence, while one half reported that the goals had a moderate level of influence (see Table 4). Among individual provinces/territory, the degree of influence ranged from being limited to high.

Given specific statements regarding ways in which the health goals may have been influential, the respondents were asked to rate their degree of agreement/disagreement with these statements (see Table 5). Although the responses varied across the provinces/territory, an overall moderate level of agreement was observed for every statement. Almost one half of the respondents (47%) agreed that the health goals had emphasized a broader focus on the determinants of health in their regions.

Main Finding #4: Although health goals have been influential in a variety of ways, they were reported to have been most influential in increasing the focus on, and an understanding of, the determinants of health; this occurred in Ministries/departments of the government, in the health sector, and at the regional level.

3.1.5 Regional Implementation Score

In the regional survey, there are seventeen items that reflect a variety of ways in which regions may have "implemented" the provincial/territorial health goals. These items include: ways in which the health goals may be used (see Table 3); the degree to which health goals influence decision-making (see Table 4); and specific ways in which the health goals may have been influential (see Table 5). The possibility of creating a summary score, which incorporates all these survey items, was explored using the statistical technique called factor analysis. Factor analysis can be used to determine whether or not a large number of variables (e.g., the seventeen items in the survey) can be summarized with a smaller number of derived variable(s) (e.g., a summary score). Based on the results of the factor analysis[2], it was determined that a summary score could be derived by summing the responses to sixteen of the seventeen items; the excluded item was that the goals have "helped to educate the public in the region about health issues." For the purpose of comparison (same scale from 1 to 6, as for the individual items), the summary score was divided by 16 (number of items) to calculate an average implementation score for each region.

The median implementation scores ranged from a low of 2.5 in Nova Scotia to a high of 4.4 in Saskatchewan (see Table 6). The overall (national) median was 3.6 (i.e., a moderate degree of implementation). Only three provinces had regions whose implementation scores were 5 or higher (i.e., high implementation). There were eight such regions – four in Saskatchewan, and two each in Alberta and British Columbia.

[2] A statistical summary of the results of the factor analysis follows. To develop the "implementation score", a principal component analysis of the relevant 17 items (medians were used in place of missing data) was conducted. Two factors were extracted initially with maximum likelihood estimation. All factors loaded on the first factor at >0.67 with the exception of the item related to the health goals having "helped to educate the public in the region about health issues." This item was subsequently excluded and the 16 remaining items were analyzed with principal component analysis. One factor was extracted that explained 62% of the variance; all loadings exceeded 0.68. Consequently, a summary "implementation score" was derived by summing responses to the 16 items. This summary score, however, does not necessarily reflect all the ways in which implementation may occur.

Based on the factor analysis, the regional implementation score represents a summary score of implementation at the regional level. Further analyses were conducted using this summary score; we examined the correlations between various influencing factors and the regional implementation score (see individual sections below).

Main Finding #5: Statistical analyses suggest that most of the items in the regional survey that were intended to reflect implementation were able to be aggregated as a summary regional implementation score.

3.1.6 Development of Regional Goals, Objectives, Indicators, Targets, and Strategies

Planning at the regional level may involve the development of regional goals, objectives, indicators, targets, and/or strategies. The respondents to the regional survey were asked to identify the stage of development for each of these, and to indicate the degree to which these reflect the provincial/territorial health goals (see Table 7; Québec, which had procedures that were slightly different, was not included in this Table).

Most of the respondents reported that regional goals (68%) and regional objectives (61%) had been completed. These were the most highly developed of the five procedures. Over one half of the regions were reported to be still working on their regional indicators (81%), regional targets (80%), and regional strategies (62%). Statistical analyses[3] indicate that a higher stage of development for each of these five procedures was associated with higher regional implementation scores.

Main Finding #6: Most regions had completed work on their regional goals and objectives, while regional indicators, targets, and strategies were still being developed. The stage of development of each of these procedures was positively correlated with regional implementation scores.

3.2 Results Related to Specific Types of Goals

As discussed in Section 3.1.1, the health goals in each province/territory were classified into one of ten categories based on the topic focus (see Table 1). The results in this Section (3.2) report on the implementation status of each type of goal, and the factors that influenced the implementation status. Note that each set of provincial/territorial goals does not address all ten topic foci. Thus, the results reported for each type of goal only relate to the regions in the provinces/territory that have this specific type of goal; this will henceforth be referred to as “relevant regions” in this report.

3.2.1 Degree of Action on Specific Types of Goals

The respondents to the survey were asked several questions related to their regions’ action on the goals relative to the time of the survey: action during the past 12 months; action before the past 12 months; and the two types of goals that had been most acted on overall.

For each of the ten types of goals, no change in action over time was reported by over one half of the relevant regions (63% to 86%). Among those regions reporting change in action, statistically significant increases in action over time were observed for all types of goals, except those relating to the physical environment and healthy public policy.[4] Of the ten types of goals, the health services/system goals were reported to be most acted on during each of the two time periods (see Table 8).

[3] This is based on the Pearson correlation, which showed a positive association of regional implementation scores ($p<.001$) with the stage of development of regional goals (Pearson correlation coefficient 0.63), objectives (0.65), indicators (0.52), targets (0.65), and strategies (0.67).

[4] This is based on Wilcoxon Signed Rank tests: shared responsibility ($p=0.03$); personal responsibility/individual practices and capacities ($p=0.03$); population sub-group health status ($p=0.01$); research and information ($p=0.01$); health equity ($p=0.01$); population health status ($p=0.01$); the social and economic environment ($p=0.01$); and the health services/system ($p<0.001$).

The health services/system goals were selected as being most acted on overall by a majority of the respondents in the relevant regions (84%). This, in comparison, was considerably greater than the next-to-highest percentages observed for research and information goals (45%), population health status goals (40%), and healthy public policy goals (40%). A small percentage of the respondents in the relevant regions selected the following types of goals as being most acted on overall: health equity goals (9%); physical environment goals (9%); personal responsibility/individual health practices and capacities goals (13%); and social and economic environment goals (16%).

Although both social and economic environment goals and health services/system goals are found in most provinces/territory (see Table 1), a small percentage of the relevant regions selected social and economic environment goals as receiving higher overall action (16%), while a large percentage of the relevant regions selected health services/system goals as receiving higher overall action (84%). Thus, health services/system goals were reported to receive comparative higher overall action than social and economic environment goals, although these two types of goals are found together in almost every province/territory.

Main Finding #7: Compared to the other types of goals, the health services/system goals were reported to consistently receive higher action overall and over time. In addition, the higher overall action for this type of goal was markedly greater than the social and economic environment goals, although these two types of goals were found together in almost every set of provincial/territorial health goals.

Main Finding #8: Over one half of the relevant regions reported no change in action over time for all types of goals. Among those regions that reported change in action, statistically significant increases in action over time were observed for eight of the ten types of goals (except the physical environment and healthy public policy).

3.2.2 Factors Influencing Action on Specific Types of Goals

For each type of goal that was selected as receiving overall higher action, the respondents in the relevant regions were asked to indicate (yes or no) whether a variety of factors had contributed to this overall higher action (see Table 9). The five factors included: funding was allocated for the specific purpose of addressing the goal; the goal is more compatible with the regional health mandate than the other goals; the goal is more easily measurable than the other goals; the region was already working toward the same end as the goal; and the provincial/territorial government viewed the goal as a higher priority than the other goals.

Of the five factors listed, one was reported by over one half of the respondents to contribute to a higher degree of action across all goal types – the region was already working toward the same end as the goal (55% to 93%). This factor was the one most commonly identified as contributing to higher overall action for six of the ten types of goals: the health system/service (96% of respondents in the relevant regions), population health status (89%), the physical environment (89%), research and information (89%), the social and economic environment (78%), and shared responsibility (75%). A goal being more compatible with the regional health mandate than the other goals was the most commonly identified factor contributing to higher action for two types of goals: population sub-group health status (92%); and population health status (86%). Funding that was allocated for the specific purposes of addressing a goal was the most commonly identified factor contributing to higher action for two types of goals: health equity (100%); and healthy public policy (80%).

Among the list of five factors, either one of two factors was identified as contributing the least toward higher overall action, i.e., the goal was more easily measurable than the other goals (17% to 66%) or the provincial/territorial government viewed the goal as a higher priority than the other goals (22% to 50%).

The health services/system goals are the only type of goal for which the majority of the respondents in the relevant regions (66% to 93%) reported each of the five factors as having contributed to higher overall action.

In addition to reporting on the degree of action (Section 3.2.1), the respondents to the survey were asked to rate the degree to which each goal (type) was compatible with their regional health mandates (see Table 10). A minority of the respondents in the relevant regions (0% to 19%) rated each type of goal as having low compatibility. Over one half of the respondents in the relevant regions reported high compatibility with regional health mandates for eight of the ten types of goals (all except personal responsibility/individual health practices and capacities, and the physical environment). Of the ten types of goals, the health services/system goals were reported most commonly to have high compatibility (83%). Statistical analyses[5] suggest that for every type of goal, except those focusing on research and information, a higher degree of compatibility is associated with a higher degree of action.

Main Finding #9: A majority of the respondents in the relevant regions believed that a region already working toward the same end as a goal contributed to higher overall action for all the types of goals. The factors least commonly reported as contributing to higher overall action were either that a goal was more easily measured than the other goals, or that a goal was perceived to be of higher priority by the provincial/territorial government.

Main Finding #10: Most of the respondents in the relevant regions believed that the allocation of funding to address healthy public policy goals and health equity goals contributed to higher overall action on these goals.

Main Finding #11: At least two thirds of the respondents in the relevant regions believed that each of the five factors contributed to higher overall action on the health services/system goals.

Main Finding #12: Ratings of higher compatibility were mostly associated with ratings of greater degree of action (every type of goal except research and information).

3.3 Factors Influencing Implementation of the Health Goals

3.3.1 Contextual Factors Perceived to Have Influenced Implementation of the Health Goals

The Ministerial/Departmental interviewees identified three factors that negatively influenced implementation of the health goals, including: the federal and provincial governments' focus on *cost restraint* (perceived to have led to a focus on health services); the *health reform/restructuring* that was occurring in the provinces (perceived to have drawn time and energy away from implementation of the health goals); and a *change in government* (the new governments were reported to not have continued pursuing the implementation of health goals).

Three positive influences on the implementation of health goals were identified by the interviewees, including: a stable government that was supportive of the health goals; the approval of the health goals by Cabinet which made the goals more "legitimate"; and the fact that the concept of population health had become general knowledge which enhanced the integration of health goals (population health focus) into government business plans.

The results of the regional survey show that the perceived commitment of the provincial/territorial governments to the health goals varied greatly across Canada, from being low to high (see Table 11). Statistical analysis[6] suggests that perceptions of higher commitment of the provincial/territorial government were associated with higher regional implementation scores.

The respondents to the survey were also asked to rate the relative priority of the health goals compared to other existing priorities, at both the provincial/territorial and regional levels (see Table 12). At the

[5] This is based on Chi-square tests between the degree of compatibility and the degree of action taken during the past 12 months (relative to the time of the survey) for each type of goal. The results were significant (p#0.004) for all types of goals except those relating to research and information.

[6] This is based on the Pearson correlation, which showed a positive association between the perceptions of the commitment of the provincial/territorial government to the health goals and regional implementation scores (p<0.001, Pearson correlation coefficient 0.50).

provincial/territorial level, the goals varied from low to moderate priority. At the regional level, the goals were of moderate priority. In none of the provinces/territory were the goals rated to have overall high priority. Statistical analyses[7] suggest that higher ratings of relative priority, at both the provincial/territorial and regional levels, were associated with higher regional implementation scores.

When asked to identify the priorities that they believed had competed most with the provincial/territorial health goals, the respondents to the survey reported many of the same issues at both the provincial/territorial and regional levels (see Table 13). In general, the three priorities that were cited most frequently as having competed most with work on the health goals at both levels were: competing health areas; funding issues; and restructuring/re-organization and regionalization. These results from the survey corroborate the results from the Ministry/departmental level interviews, in which these three priorities were reported to have limited implementation of the health goals.

The respondents identified a variety of health areas that they considered to be priorities competing with the health goals at both the provincial/territorial and regional levels (e.g., acute care and emergency services, surgical wait lists, continuing care, long-term care and community/home care, and maintaining current level of services). This suggests that, to some degree, the respondents perceived these competing "health" areas as somehow separate or distinguishable from the "health goals."

Main Finding #13: The majority of the contextual factors (both negative and positive influences) that were identified by the Ministerial/Departmental interviewees were related to the provincial/territorial government (e.g., priorities, decisions, changes). In addition, regional perceptions of a higher commitment of the provincial/territorial government toward the health goals were associated with higher regional implementation scores.

Main Finding #14: The health goals were not reported to be relatively high priority at either the provincial/territorial or regional levels. The priorities that were believed by regional respondents to have competed with the health goals were similar at both the provincial/territorial and regional levels. The three most commonly identified priorities were also those reported by the Ministerial/Departmental interviewees to have limited implementation of the health goals (i.e., competing health areas, funding issues, restructuring/re-organization).

Main Finding #15: The respondents to the regional survey appear to have perceived competing health areas as being distinguishable from the "health goals" although these health goals include health services/system goals.

3.3.2 Immediate Influences on Implementation of the Health Goals

3.3.2.1 Nature/Characteristics of the Health Goals

The Ministerial/Departmental interviewees were asked to identify ways in which the nature/characteristics of the health goals influenced implementation (i.e., the specificity and clarity of the goals, and the breadth of focus of the goals).

There was consensus among the interviewees that the health goals are broad in focus; this is corroborated by our review of the topics addressed by the goals (see Table 1). However, the interviewees differed in their perceptions about whether this breadth enhanced or limited implementation of the goals. In some instances, the breadth was believed to have enhanced implementation due to buy-in of a wide range of stakeholders; nobody could disagree with the topics addressed by the health goals. On the other hand, the breadth of the goals makes them difficult for people to readily relate to or operationalize. In addition, the goals relate to issues that "can arguably almost be completely beyond

[7] This is based on the Pearson correlation, which showed a positive association between relative priority of the health goals at each of the provincial/territorial and regional levels with regional implementation scores (both were $p<0.001$, Pearson correlation coefficients of 0.47 for the provincial/territorial level and of 0.67 for the regional level).

anyone's control because you start looking at broader and global economic issues" (quote from a ministerial/departmental interviewee).

Some interviewees discussed the specificity and clarity of the goals in terms of objectives and targets. The development of specific targets and a clear plan of how these would be used were perceived to have enhanced implementation of the goals. However, the development of detailed objectives and how they would be monitored, if perceived to be overwhelming, was considered to be a limiting factor.

Main Finding #16: Although there is consensus that the health goals are broad in focus, this can be a double-edged sword. While helping to gain buy-in on the one hand, the breadth of focus may, on the other hand, make the goals difficult to relate to or operationalize.

Main Finding #17: The specificity and detail of the health goals (i.e., objectives, targets, etc.) can also be a double-edged sword, providing clarity on the one hand, yet be overwhelming on the other hand.

3.3.2.2 Players

Most (7) of the Ministerial/Departmental interviewees identified a particular person, or group of people, who had positively influenced the *development* of the health goals. The influential players included: politicians; government employees in high-level positions; and the health councils that were responsible for the development/implementation of the health goals. Politicians, such as the Deputy Minister, and government employees were perceived to possess qualities such as strong leadership, an understanding of the determinants of health, and commitment to the health goals process. A health council existed in four provinces (Saskatchewan, Ontario, Nova Scotia, and Prince Edward Island), but these councils had been disbanded by the time of the study. The health council, being a political entity, gave evidence of political support. In addition, the health council was composed of people who were high profile and well-respected, thus lending credibility to the health goals process. The disbanding of the health councils was perceived by the interviewees to have slowed the *implementation* of the health goals.

Main Finding #18: The *development* of health goals in most of the provinces/territory was reported to have been positively influenced by the leadership and political support of politicians, government employees in high-level positions, and the health councils (existed in 4 provinces). The disbanding of the health councils was perceived to have slowed the *implementation* of the health goals.

3.3.2.3 Organizations

The Ministerial/Departmental interviewees were asked to identify how the organizational structure of their Ministry/department may have influenced the implementation of the health goals. Four interviewees stated that organizational structure had no influence on implementation.

Some positive influences of organizational structure on health goals implementation were reported: the Ministry being organized around the priorities that resulted from the health goals; and the creation of a body that reports to the Premier and comprised people from outside the government (contributed to broad buy-in to the goals).

Negative influences of organizational structure on implementation were also reported. In one instance, where the body responsible for overseeing the implementation of the health goals was called a "Health" Council (Department of Health) and not a "Premier's" Council (provincial government), this was believed to have limited broader interest in the goals; "the goals were broader than [the Department of Health]" (quote from an interviewee). *Changes* in organizational structure, such as re-organization of the department or regionalization, rather than the organizational structure itself, were reported to have negatively affected implementation of the health goals.

Main Finding #19: Two influences on implementation that relate to organizational structure were identified (i.e., a body responsible for overseeing implementation, and an actual change in organizational structure). The influence of the health council depended on whether it was a "Health" Council (limited interest) or a "Premier's" Council (broader interest and buy-in).

3.3.2.4 Mechanisms to Ensure that Regions Use the Provincial/Territorial Health Goals

It is recognized that a variety of mechanisms may be developed at the provincial/territorial level to ensure that the goals are used at the regional level. Given a list of such mechanisms, the survey respondents were asked whether each mechanism existed (yes or no), and to rate how this limited or enhanced their regions' use of the goals (see Table 14).

For five of the six mechanisms, over one half of the respondents reported that the mechanism did not exist. Thus, provincial/territorial funding to the regions was mostly not based on a demonstrated linkage between regional health outcomes and the goals (90%), and there was mostly no provincial/territorial time frame by which the goals were to be achieved (89%), no provincial/territorial legislation requiring regions to use the goals (85%), no provincial/territorial body to oversee use of the goals (57%), and no provincial/territorial requirement that regions develop progress reports that relate to the goals (58%). The non-existence of these mechanisms was reported to have an overall limiting effect on the regions' use of the goals.

The results of the interviews and the review of the Ministerial/Departmental documents suggest that formal responsibility for implementing the health goals was mostly non-existent or unclear at the time of the study (e.g., the Councils that were charged with overseeing the implementation of the health goals had been disbanded). This corroborates the results of the survey, in which most of the respondents believed that a provincial/territorial body to oversee use of the goals did not exist.

Only one of the six mechanisms was reported to exist by over one half of the respondents. Sixty-nine percent believed that there was a provincial/territorial requirement that the regions develop business plans incorporating the goals. In general, the existence of this mechanism was reported to have enhanced the regions' use of the goals. Statistical analyses[8] suggest that the existence of five of the six mechanisms was associated with an enhancing influence on the use of the goals (except a time frame by which the goals would be achieved).

Main Finding #20: All provincial/territorial-level mechanisms to ensure that regions use the health goals were reported to be mostly non-existent, with the exception that regions develop business plans that incorporate the goals. For most of the mechanisms, a belief in its existence was associated with perceptions of it having an enhancing influence on the regions' use of the goals.

3.3.2.5 Funding for Addressing the Health Goals

It is recognized that the provincial/territorial government may allocate funding to the regions for the specific purpose of addressing one or more of the health goals. The survey respondents were asked to indicate the degree to which the provincial/territorial government had allocated specific funding to the regions, ranging from "no specific funds" to "specific funds for all goals." The responses varied from almost no specific funding in three provinces, to a moderate degree of specific funding in two provinces/territory (see Table 15). Although the responses were highest for these latter two provinces/territory, the respondents in these jurisdictions did not generally believe that funds were any more sufficient for addressing the health goals in their respective regions than did the respondents in the

[8] For each of the six mechanisms, Mann-Whitney U tests for two independent samples were conducted to compare the perceptions of influence on implementation between respondents who believed the mechanism existed and those who believed the mechanism did not exist. The tests showed significant differences for five of the six mechanisms ($p=0.06$ for time frame for goals to be achieved, and $p<0.001$ for all other mechanisms).

other provinces. The responses in most of the provinces/territory suggest that funds were largely insufficient for addressing the goals.

Statistical analyses[9] suggest that higher regional implementation scores were associated with reports of a greater degree of specific funding from the provincial/territorial government and reports of higher sufficiency of funds for addressing the goals.

Main Finding #21: Most regions in the individual provinces/territory reported that a limited degree of funding was allocated from the government to the regions for the specific purpose of addressing the goals. Funds in the regions, in general, were largely insufficient for addressing the goals. Higher regional implementation scores were associated with a greater degree of specific funding, and with a higher sufficiency of funds for addressing the goals.

3.4 Data Collection and Monitoring Progress Toward Achieving the Health Goals

One half of the participating regions in Canada (65/130) reported having attempted to assess their progress toward achieving the health goals (see Table 16). Only in three provinces did most of the regions report having attempted assessment. At the Ministerial/Departmental level, some interviewees commented that there was a lack of clarity regarding the expected outcomes of the health goals. For example, it is difficult to determine success regarding the goals because there were no measures attached to, nor performance indicators developed for, the goals.

It is recognized that a variety of region-specific data may be used to assess progress toward achieving the goals in the regions. Given five types of data (see Table 17), the respondents reported three types to be moderately available (broad determinants of health, behavioural risk factors, environmental risk factors), and two types to be fairly highly available (health status data, health service utilization data). Recognizing that the quality of the data may vary, the respondents were given a list of three aspects of quality, and asked to rate the proportion of data that possessed these qualities (see Table 18). A moderate proportion of the data were reported to possess each quality (reliability, timeliness, valid measure of the goals).

Main Finding #22: One half of the regions had attempted to assess progress toward achieving the health goals. Region-specific data ranged from being moderately to fairly available. A moderate proportion of the data possessed various qualities (reliable, timely, valid).

3.5 Summary of Correlations with Regional Implementation Scores

All relevant factors from the survey (reported in the above sections) were found to have significant positive correlations with regional implementation scores. These factors included (Pearson correlation coefficients are shown in parentheses): the stage of development of regional goals (0.63), objectives (0.65), indicators (0.52), targets (0.65), and strategies (0.67); the perceived commitment of the provincial/territorial government to their health goals (0.50); the perceived relative priority of the health goals at both the provincial/territorial (0.47) and regional (0.67) levels; the perceived degree of funding allocated from the provincial/territorial government to the regions for the specific purpose of addressing the health goals (0.43); and the perceived degree to which funds in the regions were sufficient for addressing the health goals (0.38).

[9] The perceptions of the degree to which the provincial/territorial government allocated funding for the specific purpose of addressing the health goals and the degree to which funds were sufficient in the regions for addressing the goals were both found to be positively correlated with regional implementation scores (both were $p<0.001$, Pearson correlation coefficients of 0.43 for allocation of specific funds from the provincial government and of 0.38 for the sufficiency of funds).

Main Finding #23: All relevant factors from the regional survey were found to have statistically significant positive correlations with regional implementation scores.

4. CONCLUSIONS AND IMPLICATIONS

Five conclusions were drawn from the main findings listed above. The implications of these conclusions for various stakeholders are presented.

4.1 Compared to the other types of goals, a variety of influences contributed to the health services/system goals receiving the most attention overall.

Not only were the health services/system goals one of the most prevalent types of health goals across Canada, they were reported to have received higher overall action compared to the other types of goals. It was believed that the higher overall action was attributable to all five factors listed in the regional survey, but especially because the regions were already working toward the same end. In addition, the health services/system goals were perceived to be highly compatible with the regional health mandates.

Thus, a marked difference is observed in the prevalence and action between the health services/system goals and the other types of goals. That the health services/system goals are somehow separate or distinguishable from the concept of "health goals" may be implied by the fact that the respondents to the survey identified a variety of health areas as "competing" with the "health goals". This suggests that people may consider the "health goals" to be "population health goals" (determinants of health) rather than goals related to health service delivery. This is not surprising, given that other (non-medical) determinants of health are the topic foci for some of the other goals, and that both the interviewees and the respondents generally believed that the health goals had emphasized a broader focus on the determinants of health.

Although the health services/system goals were receiving the most attention overall, attention to the other types of goals may be increasing. This is supported by the results showing statistically significant increases in action over time for most of the goals in the relevant regions reporting change in action. The prevalence of provincial/territorial health goals that relate to the non-medical determinants of health implies that these topic foci should fall under the responsibility of the ministry/department of health or health and social/community services (and the health regions). These topic foci, however, have not traditionally been the responsibility of the ministries/departments of Health. Thus, it remains unclear what role the ministry/department of Health and the health regions will play in acting on these non-medical determinants of health. The determinants of health continue to be a focus at the national level (67), the provincial/territorial level, and the regional level.

The results from the regional survey (see Table 9) show that funding allocated for the specific purpose of addressing a goal may contribute to overall higher action, especially for goals that relate to health equity and healthy public policy. In addition, higher compatibility of a goal with the regional health mandate was associated with higher action for most of the types of goals. Similarly, the fact that a region was working toward the same end contributed to higher overall action for all types of goals. The stage of development of regional goals, objectives, indicators, targets, and strategies, which reflected the provincial/territorial goals, were associated with higher regional implementation scores. These findings suggest that, if the intent is to increase action on determinants of health other than the health services system, funding that is specifically tied to a goal, and mandates or directions that incorporate the determinants of health, may help to achieve this.

4.2 Context plays a significant influence on the implementation of the health goals.

The competing priorities that were most commonly identified by the regional respondents were largely similar to the contextual factors that were identified by the Ministerial/Departmental interviewees; thus, the competing priorities can be considered synonymous with the context influencing implementation. The context included changes in, and priorities and decisions of, the provincial/territorial government (e.g., cost restraint, regionalization/re-organization, commitment, allocation of funding, etc.), and a general focus on health service delivery. Compared to other priorities, the health goals were not perceived by regional respondents to be high priority at either the provincial/territorial or regional levels.

Although the context appears to play a significant influence on the implementation of the health goals, the context is not easily modified in the short term because it exists at a broader level (i.e., beyond immediate control). However, the results in this study suggest that context may not be the only influence. Statistically significant positive correlations were observed between regional implementation scores and all relevant factors, which included the context and other influences. In addition, the existence of a variety of mechanisms (albeit not highly prevalent) appeared to play an enhancing role on the regions' use of the goals. These findings imply that there may be concrete ways in which implementation of the health goals may be enhanced. For example, concrete mechanisms that link actions with the health goals may be developed (e.g., allocation of funding for the specific purpose of addressing a goal(s), development of business plans that incorporate the goals, development of progress reports that relate to the goals, etc.).

4.3 The health goals were used at both the Ministerial/Departmental and regional levels, and have been influential in a variety of ways.

The health goals were most commonly identified as having been used as a conceptual tool and framework for planning, at both the Ministerial/Departmental and regional levels. This is supported by the document review, which showed that most Ministries/departments had considered the goals in their planning, after the original health goals were published. Although the goals have been influential in a variety of ways, it was commonly believed that the goals have been most influential in increasing the focus on, and an understanding of, the determinants of health. Indeed, ten of the eleven provinces/territory have at least one goal that focuses on the social and economic environment.

How the provincial/territorial health goals are used, and the outcomes expected of them, have not been entirely clear. In addition, there is little empirical evidence regarding the influence and process of using provincial/territorial health goals as a strategy for the health and well-being of the population. Are the goals more likely to be influential if they are referred to explicitly, and form the basis of a systematic progression in planning (objectives, indicators, targets, and strategies)? This type of *practical* or *managerial* planning may be more conducive to the tracking of accountability for actions and the monitoring of the process and achievement of the goals. Or are the goals just as influential if they serve as a "philosophical backdrop", and are reflected/referenced in planning documents, although planning is not systematically based on them? This kind of *conceptual* planning may present a context in which accountability for actions and the monitoring of achievement may be less traceable. If the goals are neither referenced nor systematically used, then they no longer serve a purpose that is explicitly known, and accountability and monitoring with respect to the goals could not be expected. However, it must be noted that implementation is a process and one or more of the above influences may occur over time. In addition, planning practices (e.g., development of business plans, etc.) that do not reference (or systematically use) the original health goals can not necessarily be considered less valid or less accountable than planning based on the original health goals. Finally, are initiatives a result of the health goals, or do initiatives occur alongside, and only happen to reflect or coincide, with the health goals (and does it matter which occurs if they are said to be working toward the same aim)?

The ministries/departments and regions have not acted on the health goals in a uniform fashion, and the future importance of the original health goals will depend on the current status of the goals in each province/territory. Some ministries/departments continue to act on or reference, or have re-affirmed, the original health goals (e.g., have a body overseeing implementation, publish annual or health status

reports that refer to the goals, etc.). This suggests that these Ministries/departments are committed to implementing the original health goals. This commitment may have been in the form of leadership and political support from politicians, government employees in high-level positions, and the bodies (health councils) responsible for overseeing implementation of the goals. In addition, the results of the regional survey indicate that a higher level of commitment by the provincial/territorial government was associated with higher regional implementation scores. Other ministries/departments appear to be no longer acting on or referencing the original health goals. For these ministries/departments, a re-affirmation of the original health goals is not out of the question if the commitment is there (one province has shown that this is possible). However, it is anticipated that the original health goals will probably not be officially re-affirmed in these provinces, and that these ministries/departments will continue with their newer planning practices, which some interviewees believe reflect the same aims as the original health goals.

4.4 Although implementation may occur in various forms, the results of the survey suggest that an aggregate regional implementation score can be a useful in exploring the degree to which the health goals have been implemented.

The fact that the factor analysis supports the creation of an aggregate regional implementation score suggests that the "implementation" variables in the study are conceptually- and statistically-linked. To the extent that these variables represent valid markers of implementation, the score provides a useful and efficient means of characterizing the degree to which the health goals have been implemented.

The only influence that was omitted from the implementation score was that the health goals had "helped to educate the public in the region about health issues." An explanation for this inconsistency can only be speculated. First, "educating the public" is not an explicit topic focus of the health goals, although it may be implicit in the goals relating to personal responsibility/individual practices and capacities. Second, "educating the public" is not usually considered to be a major part of planning (e.g., creating programs and policies, allocating resources, evaluating programs and policies, etc.). It should be noted that this is only one study, and implementation in its various forms may not be completely reflected in the list of uses and influences, and that these uses and influences may differ across varied levels or jurisdictions (national, provincial/territorial, regional).

4.5 The breadth and specificity of the health goals were perceived as a double-edged sword regarding implementation (both a positive and negative influence).

Although the health goals were broad in focus (determinants of health), thus generating buy-in by people in sectors other than health, the breadth of focus also made the goals difficult for some people to relate to or operationalize. In addition, the specificity of the goals (objectives, targets) and how they would be monitored may provide clear direction on the one hand, yet be overwhelming on the other hand.

Given that the health goals address the determinants of health, buy-in by people in sectors other than health, especially from other Ministries, is important for implementation. The ministries/departments of health can not be expected to act on the determinants of health, which are broader than the responsibilities (and capacities) of the ministries/departments, in isolation of other sectors. This is supported by one interviewee who stated that a health council with representatives from sectors other than health helped to create broad buy-in to the goals. There is evidence to suggest that the health goals have already "contributed to increased partnerships and intersectoral collaboration toward addressing health issues" in some regions (regional surveys), and that the goals have been used to encourage intersectoral collaboration (Ministerial/Departmental level interviews).

While the development of objectives, indicators, targets, and/or strategies may help to provide clarity regarding the goals and how the goals will be monitored, the process itself can become overwhelming. In fact, as one interviewee commented, the process of developing the goal statements alone had been so overwhelming that there was little energy left for implementation. It appears that a balance between sufficient specificity and clarity, and too much time and detail, may be necessary.

There is some evidence that attempts had been made in monitoring progress on the achievement of the health goals. At the Ministerial/Departmental level, this has taken the form of progress reports on the goals, and annual and health status reports that refer to the goals. It is unknown how the regions monitored progress on the goals, although one half reported that they had attempted to do so. Region-specific data, in general, were reported to be available, although the data were not necessarily considered to be of high quality by the survey respondents.

It appears that most of the Ministries/departments had developed their health goals with either no explicit intention of monitoring them (not mentioned in the health goals-related documents), or had the intention but did not follow through with it (or continue to follow through with it). This is not surprising, given that the creation/refining of data systems and quality data is no easy task. On the other hand, it makes little sense to develop health goals without planning on developing the capacity to act on and monitor them (e.g., committed resources). In addition, the role of the Ministries/departments and the regions in implementing the health goals, and the purpose(s) for which the health goals were developed, are often neither clear nor explicitly stated.

4.6 Implications for Various Stakeholders

Although the health services/system goals have received the most attention overall, the provincial/territorial health goals also focus on other determinants of health; there is evidence to suggest that some regions have acted on these other types of goals. While the context appears to play a large influence on implementation, other factors were found to be associated with enhanced implementation and use of the goals. This finding suggests that factors other than the context may be used to enhance implementation (e.g., allocation of funding, provincial/territorial mechanisms to ensure use, etc.). The most common usage of the health goals has been as a conceptual framework for planning, which serves more of a philosophical purpose than a practical or managerial purpose, the latter of which may be more conducive toward greater accountability and data collection and monitoring related to the goals. This leads to the question of whether the ministries/departments and government are committed to the health goals (political support, persistence in using the goals, allocation of funding), and whether the commitment extends to developing the capacity of the ministry/department and the regions to be accountable for, act on, and monitor progress on the health goals.

4.6.1 Health Canada

Health Canada, being a federal department, has the responsibility for providing national leadership to help the people of Canada maintain and improve their health. Health Canada has already shown leadership by promoting the idea that health is influenced by various determinants, which are the foci of some of the provincial/territorial health goals. Health Canada may assist the provinces and territories in addressing the non-medical determinants of health through its related national initiatives (i.e., the population health approach, early childhood development, anti-poverty, etc.). In addition Health Canada's Sustainable Development Strategy includes some objectives and targets that reflect the health goals (e.g., health equity, the physical environment), and may be used to ensure accountability to and monitoring of the Strategy. The Strategy also includes objectives and targets that support capacity to act on the topics addressed in the health goals (e.g., providing information and tools for decision making, supporting initiatives that contribute to sustainable and healthy communities, strengthening partnerships). Finally, Health Canada may assist in supporting action on, and the monitoring of, progress toward achieving the health goals through the funding of relevant research.

4.6.2 The Federal Government

A set of federal/national health goals, similar to those found in the provinces/territory, does not exist, although there are national goals for specific health-related issues (e.g., smoking, sexually transmitted disease, etc.). It is not anticipated that a set of federal/national health goals will be developed in the near

future. Nevertheless, the federal government has the role of allocating funds to the provinces/territories for health and social programs via the Canada Health and Social Transfer (CHST). Since 1995, the provinces/territories have experienced funding cuts to the CHST (79). In September 2000, however, the federal government announced its commitment to health renewal and early childhood development through monies of over $21 billion over the next five years.

The implications of this federal investment relate to the issue of cost restraint (at both the federal and provincial/territorial levels) identified by the interviewees. The cost restraint was reported to be a result of cuts to the CHST, which led to a re-emphasis on health service delivery over other determinants of health. The assumption that is implied is that if cost restraint is less of an issue, then health service delivery issues will be better addressed, and emphasis will shift toward addressing the other determinants of health. While this cash infusion from the federal government is being heralded, it may not necessarily lead to greater focus on the other determinants of health. The funding is being directed mostly toward health system infrastructure and health service delivery, and not toward the non-medical determinants of health. The result may be even greater emphasis on health service delivery. Finally, not all the funding cuts to health care occurred at the federal level; some provinces had initiated funding cuts before the federal government reduced the transfer payments in 1995.

4.6.3 The Provincial/Territorial Ministries/Departments of Health

Despite the increase in federal transfer payments, the provinces/territories still face the issue of cost restraint, as provincial/territorial health care spending continues to increase (79). This fact, and a possible greater emphasis on health service delivery in the near future, does not seem promising in terms of implementing the health goals that address the non-medical determinants of health. It remains unclear what the roles of the health (and other) ministries/departments and the regions are, or will be, with respect to acting on the non-medical determinants of health. If the ministries/departments and government recognize these determinants as being priority, then it becomes important for them to provide clear direction and expectations about what they and the regions can, or should, do to act on the full range of health goals.

Several health ministries/departments continue to show commitment to the health goals (e.g., goals have been incorporated into plans and annual or health status reports, goals have been re-affirmed and a health council re-established). These ministries/departments may encourage further implementation in the regions (e.g., allocation of funding to the regions for the specific purpose of addressing a goal(s), provincial/territorial-level mechanisms for ensuring the goals are used). In addition, these ministries/departments may support the monitoring of progress on the goals by providing resources to develop data systems and data collection at both the provincial/territorial and regional-levels. However, the balance between acquiring broad buy-in and being too detailed and specific should be considered.

In other provinces, commitment to the original health goals appears to be lacking (e.g., change in government). If these ministries/departments are not willing to re-visit and re-affirm their commitment to their original health goals, then it makes sense to focus on the newer planning practices rather than on the original health goals. It can not be assumed that these newer planning practices are necessarily less effective than planning based on the original health goals, especially if the newer planning practices reflect the same topics addressed in the original health. Accountability for actions and the monitoring of progress should be considered regardless of whether planning is based on the original goals.

4.6.4 The Health Regions/Districts

Most regions reported that most of the provincial/territorial level mechanisms listed in the survey did not exist. Thus, the regions' use or implementation of the health goals would most likely have been driven by the regions' own interest and/or encouraged (but not necessarily coordinated) by the ministry/department. Although it is likely that the regions did not systematically incorporate the goals into their regional planning, it is promising that the regional goals, objectives, indicators, targets, and strategies generally

reflected the provincial/territorial health goals. Planning based on the provincial/territorial goals, or on the regional goals that reflect the provincial/territorial goals, may occur as outlined in the survey (e.g., develop/align policies and programs based on the health goals, allocate funding to address the health goals). Regions may also collect data or develop data systems to monitor progress on the provincial/territorial or regional health goals; they may be supported in these efforts by national initiatives such as the Canadian Institute for Health Information.

Unless a newly elected provincial/territorial government drastically alters the direction of the ministry/department of health and/or eliminates the regional health authorities, it is probable that the health regions will continue to operate as they have done and continue to reflect the provincial/territorial health goals in planning at the regional level.

However, the role of the regions in acting on the non-medical determinants of health remains to be clarified. Even if this is not attempted at the Ministerial/Departmental level, regions may do so, especially if their mission or mandate encompasses these determinants and a holistic view of health and wellness. For example, will the regions allocate funding for the specific purpose of addressing these determinants? Will the region initiate partnerships with other sectors or civic governments?

4.6.5 Research

Not only do the results of this study suggest some answers, they lead to questions for future research. The questions may relate to the effectiveness or usefulness of the goals as a planning and management tool, and to the non-medical determinants of health (given that the health service system goals are already most highly acted on, and that there is interest in the less-acted-on non-medical determinants of health). What other forms of "implementation" exist, at both the Ministerial/Departmental and the regional levels? What factors, other than those included in the survey, influence greater action on the non-medical determinants of health? What intersectoral partnerships are being formed, and with whom, to act on the health goals?[10]

There is generally no lack of interest in further promoting awareness of, and action on, the non-medical determinants of health. Various initiatives have already been created to fund research related to the non-medical determinants of health (e.g., the Canadian Population Health Initiative of the Canadian Institute for Health Information, the Social Sciences and Humanities Research Council of Canada, etc.), and researchers, by applying to these funding sources, have shown their interest in these determinants.

5. DISSEMINATION OF RESULTS

The results of this study will be widely disseminated. The survey results for each province/territory and at a national level are already available on, and can be printed from, the web site of the Institute of Health Promotion Research (http://www.ihpr.ubc.ca). The participants in this study (interviewees and survey respondents) have already been informed about the posting of the results on the web site. In addition, some of the results of the study have already been presented by members of the research team at a conference (i.e., Pacific Health Forum in October 2000) and at a seminar series (i.e., Department of Health Care and Epidemiology at the University of British Columbia in June 2000) in Vancouver.

One member of the research team (C.J. Frankish) is a member on two groups related to health goals implementation in British Columbia, and has presented the findings to these two groups. One group is the Premier's Advisory Committee for Health Goals in British Columbia. The other group is the "Health Goals Task Force" of the Health Association of British Columbia, a non-profit, non-government association that assists its members (which includes British Columbia's health authorities) in improving the quality and delivery of health services in the province. The study has been discussed nationally on

[10] The Institute of Health Promotion Research has submitted a research proposal to the Social Sciences and Humanities Research Council of Canada to examine how the regional health authorities across Canada are acting on the non-medical determinants of health.

the Health Reform Working Group of the Canadian Consortium for Health Promotion Research and on Health Canada's Advisory Committee on the Canadian Community Health Survey.

A series of three papers for submission to the Canadian Journal of Public Health are in progress. The Journal is distributed to an audience that includes the academic community, health professionals, and policy-makers. The topics for the papers relate to: the implementation status of the provincial/territorial health goals; the factors influencing implementation; and the implementation of the ten different types of goals.

Finally, this study has led to the development of proposals for future research. Members of the research team have submitted proposals to the Social Sciences and Humanities Research Council of Canada (regional action on the non-medical determinants of health) and to the Canadian Population Health Initiative of the Canadian Institute for Health Information (measuring the health of communities).

REFERENCES

1. Ontario Premier's Council on Health Strategy (1989). A Vision of Health: Health Goals for Ontario. Toronto, Ontario: Queen's Printer for Ontario.

2. New Brunswick Department of Health and Community Services (1990). Toward a Comprehensive Health Strategy: Health 2000 – Vision, Principles, and Goals. Fredericton, New Brunswick: New Brunswick Department of Health and Community Services.

3. Québec Ministry of Health and Social Services (1992). The Policy on Health and Well-Being. Québec City, Québec: Government of Qébec.

4. Manitoba Health (1992 May). Quality Health for Manitobans – The Action Plan. Winnipeg, Manitoba: Manitoba Health.

5. Nova Scotia Provincial Health Council (1992 December). Nova Scotia's Health Goals: How They Were Developed and What They Mean. Halifax, Nova Scotia: Government of Nova Scotia.

6. Alberta Health (1993). Health Goals for Alberta – Progress Report. Edmonton, Alberta: Alberta Health.

7. Saskatchewan Provincial Health Council (1994 October). Population Health Goals for Saskatchewan: A Framework for Improved Health for All. Regina, Saskatchewan: Saskatchewan Health.

8. Prince Edward Island Health Policy Council (1996 December). Health Goals for Prince Edward Islanders: Health – A Resource for Everyday Life. Charlottetown, Prince Edward Island: Prince Edward Island Health Policy Council.

9. British Columbia Ministry of Health and Ministry Responsible for Seniors (1997 December). Health Goals for British Columbia. Victoria, British Columbia: British Columbia Ministry of Health and Ministry Responsible for Seniors.

10. Northwest Territories Department of Health and Social Services (1998 June). Shaping Our Future – A Strategic Plan for Health and Wellness. Yellowknife, Northwest Territories: Northwest Territories Department of Health and Social Services.

11. Government of Newfoundland and Labrador (1998 August). People, Partners and Prosperity: A Strategic Social Plan for Newfoundland and Labrador. St. John's, Newfoundland: Office of the Queen's Printer.

12. Chernichovsky, D. (1995). Health systems reforms in industrialized democracies: An emerging paradigm. The Milbank Quarterly 73(3):339-372.

13. Frankish, J.; Veenstra, G.; Moulton, G. (1999). Population health in Canada: Issues and challenges for policy, practice and research. Canadian Journal of Public Health 90(S1):S71-S75.

14. McKinlay, J.B.; McKinlay, S.M.; Beaglehole, R. (1989). A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States. International Journal of Health Services 19:181-208.

15. Baris, E. (1998). Reforming health care in Canada: Current issues. Salud Publica de Mexico 40:276-80.

16. Church, J.; Barker, P. (1998). Regionalization of Health Services in Canada. International Journal of Health Services 28(3):467-486.

17. Chomik, T.; Frankish, J. (1999). Factors that facilitated and challenged the development of health goals and targets: The British Columbia experience. Canadian Journal of Public Health 90(S1):S39-S42.

18. Lalonde, M. (1974). "A new perspective on the health of Canadians." Ottawa, Ontario: Health and Welfare Canada.

19. Evans, R.; Barer, M.; Marmor, T. (1994). Why Are Some People Healthy and Others Not? New York: Aldine.

20. Nickoloff, B. (1995). "Regionalisation in health care." Toronto, Ontario: Premier's Council.

21. Abelson, J.; Lomas, J.; Eyles, J.; Birch, S.; Veenstra, G. (1995). Does the community want devolved authority? Canadian Medical Association Journal 153:403-412.

22. Higgins, J. (1999). The case for experiential participation in health reform. Canadian Journal of Public Health 90(1):30-34.

23. Lomas, J. (1997). Devolving authority for health care in Canada's provinces. 4. Emerging issues and prospects. Canadian Medical Association Journal 156:817-823.

24. Lomas, J.; Veenstra, G.; Woods, J. (1997). Devolving authority for health care in Canada's provinces. (2) Backgrounds, resources and activities of board members. Canadian Medical Association Journal 156(4):513-520.

25. Lomas, J.; Veenstra, G.; Woods, J. (1997). Devolving authority for health care in Canada's provinces. (3) Motivations, attitudes and approaches of board members. Canadian Medical Association Journal 156(5):669-676.

26. U. S. Department of Health & Human Services (1996). Healthy People 2000. Boston; Jones & Bartlett.

27. World Health Organization. (1978). Alma-Ata: Primary Health Care. Geneva; Health for All Series, No.1.

28. World Health Organization Regional Office for Europe. (1985). Targets for Health for All. Copenhagen.

29. Healy, N. (1999). "Health for All: Setting targets for the 21st century." Calgary; Proceedings of an International Conference.

30. Health Association of B.C. (2000). "Realizing health goals in BC: A synthesis of experiences, current initiatives and ideas for moving forward." Vancouver, B.C.; Produced for the B.C. Government.

31. Brecher, C. (Ed.) (1992). Implementation Issues and National Health Care Reform. Washington, D.C.; Josiah Macy, Jr. Foundation.

32. Chase, G. (1979). Implementing a human services program: How hard will it be? Public Policy 27(4):385-435.

33. Goggin, M.L. (1986). The "too few cases/too many variables" problem in implementation research. Western Political Quarterly 38:328-347.

34. Mazmanian, D.A.; Sabatier, P.A. (1989). "A Framework for Implementation Analysis." In, Implementation and Public Policy. Lanham, MD; University Press of America: pages 18-48.

35. Mazmanian, D.A.; Sabatier, P.A. (1986). "Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. Journal of Public Policy 6(1):21-48.

36. Mazmanian, D.A.; Sabatier, P.A. (1989). "Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. In, Implementation and Public Policy. Lanham, MD; University Press of America: pages 288-316.

37. Sabatier, P.; Mazmanian, D. (1979). The conditions of effective implementation: A guide to accomplishing policy objectives. Policy Analysis 5(4):481-504.

38. Sabatier, P.A. (1991). Toward better theories of the policy process: Political science and public policy. PS: Political Science & Politics June 1991:144-156.

39. Morah, E.U. (1990). "Why Policies Have Problems Achieving Optimal Results: A Review of the Literature on Policy Implementation." Vancouver, B.C.: UBC Planning Papers: Discussion Paper #20; School of Community and Regional Planning, University of British Columbia.

40. O'Toole, Jr., L.J. (1986). Policy recommendations for multi-actor implementation: An assessment of the field. Journal of Public Policy 6(2):181-210.

41. O'Toole, Jr., L.J.; Montjoy, R.S. (1984). Interorganizational policy implementation: A theoretical perspective. Public Administration Review 44(6):491-503.

42. Ottoson, J.M.; Green, L.W. (1987). Reconciling concept and context: Theory of implementation. Advances in Health Education and Promotion 2:353-382.

43. Pal, L.A. (1997). Beyond Policy Analysis: Public Issue Management in Turbulent Times. Scarborough, Ontario: International Thompson Publishing.

44. Parsons, D.W. (1995). Public Policy: An Introduction to the Theory and Practice of Policy Analysis. Aldershot, U.K.: Edward Elgar.

45. Rist, R.C. (1994). "Influencing the policy process with qualitative research." In, Denzin, N.K. & Y.S. Lincoln Handbook of Qualitative Research. Thousand Oaks: Sage Publications. Chapter 34: pages 545-557.

46. Van Meter, D.S.; Van Horm, C.E. (1975). The policy implementation process: A conceptual framework. Administration and Society 6(4):445-488.

47. Health Research Task Force. (July 30, 1996). What is the value of health research? [On-line]. Nova Scotia: Health Research Task Force. http://www.mcms.dal.ca/rhrtf/hrtf3.html

48. National Health Goals and Targets, Office of the National Health and Medical Research Council, and Department of Human Services and Health (1994). Summary of the Australian health goals and targets process. Health Promotion Journal of Australia, 4 (3), 3-4.

49. Diane McAmmond & Associates (1994 May). Analytic Review Towards Health Goals for Canada: Final Report.

50. Lyons, J. (February 12, 1995). Is there life for health promotion after health goals and targets? The A.C.T. experience. Presented at the Seventh National Health Promotion Conference, Brisbane.

51. d'Espaignet, E. T.; Stevenson, C. E.; and Mathers, C. (1994). Monitoring national health targets -- The perspective of the Australian Institute of Health and Welfare. Health Promotion Journal of Australia 4(3):14-18.

52. Nutbeam, D.; Wise, M. (1996). Planning for Health For All: International experience in setting health goals and targets. Health Promotion International 11(3):219-226.

53. Nutbeam, D.; Wise, M. (1993). Australia: Planning for better health: Opportunities for health promotion through the development of national health goals and targets. Promotion et Education Spec No:19-24.

54. Nutbeam, D.; Harris, E. (1995). Creating supportive environments for health: A case study from Australia in developing national goals and targets for healthy environments. Health Promotion International, 10(1):51-59.

55. Lefebvre, R.C. (1990). Strategies to maintain and institutionalize successful programs. In, Bracht, N. (Ed.) Health Promotion at the Community Level (209-208). Newbury Park, California: Sage Publications.

56. Nutbeam, D. (1996). Health outcomes and health promotion: Defining success in health promotion. Health Promotion Journal of Australia 6(2):58-60.

57. Wise, M.; Nutbeam, D. (1994). National health goals and targets: An historical perspective. Health Promotion Journal of Australia 4(3):9-13.

58. Spasoff, R.A. (1987). Health goals and the public health. Canadian Journal of Public Health 78(5):291-294.

59. Beaglehole, R.; Davis, P. (1992). Setting national health goals and targets in the context of a fiscal crisis: The politics of social choice in New Zealand. International Journal of Health Services 22(3):417-428.

60. Rathwell, T. (1992). Pursuing health for all in Britain: An assessment. Social Science and Medicine 34(2):169-182.

61. Saltman, R.B.; Figueras, J. (1998). Analyzing the evidence on European health care reforms. Health Affairs 17(2):85-108.

62. Ståhlberg, K. (1983). Local complexity and central bureaucracy in Finnish health care planning. Journal of Health Politics, Policy & Law 8(3):444-462.

63. Brasfield, J.M. (1982). Health planning reform: A proposal for the eighties. Journal of Health Politics, Policy & Law 6(4):718-738.

64. Benjamin, Jr., A.E.; Downs, G.W. (1982). Evaluating the National Health Planning and Resources Development Act: Learning from experience? Journal of Health Politics, Policy & Law 7(3):707-722.

65. Rocheleau, B. (1980). How do we measure the impact of intergovernmental programs? Some problems and examples from the health area. Journal of Health Politics, Policy & Law 4(4):605-618.

66. Haeuser, P. Decision making strategy utilizing priority setting and program data. Journal of Health Politics, Policy & Law 5(1):152-166.

67. Moscovice, I.; Armstrong, P.; Shortell, S.; Bennett, R. (1977). Health services research for decision-makers: The use of the Delphi technique to determine health priorities. Journal of Health Politics, Policy & Law 2(3):388-410.

68. Yach, D. (1996). Renewal of the Health-For-All strategy. World Health Forum 17(4):321-326.

69. Spencer, H.C. (1996). Renewal viewed from London. World Health Forum 17(4):327-328.

70. Dekker, E. (1996). The challenge of becoming mature - a view from the Netherlands. World Health Forum 17(4):336-338.

71. Reiner, Z. (1996). More action, less rhetoric - a view form Croatia. World Health Forum 17(4):338-340.

72. Galbally, R. (1996). Sharing wisdom and responsibility - a view from Australia. World Health Forum 17(4):340-342.

73. Oulton, J. (1996). Human resources are the key - the nurses' view. World Health Forum 17(4):343-344.

74. Kweyuh, P.H.M. (1996). Health for whom by when? A view from Kenya. World Health Forum 17(4):346-347.

75. World Federation of Public Health Associations (1996). Much remains to be done. World Health Forum 17(4):347-349.

76. Benjamin, K.L.; Perfetto, E.M.; Greene, R.J. (1995). Public policy and the application of outcomes assessments: Paradigms versus politics. Medical Care 33(4, Suppl):AS299-AS306.

77. Kindig, D.A. (1998). Purchasing population health: Aligning financial incentives to improve health outcomes. Health Services Research 33(2, Pt 1):223-242.

78. Health Canada. What is the Population Health Approach? Last revised November 7, 2000 [http://www.hc-sc.gc.ca/hppb/phdd/approach/index.html].

79. Provincial and Territorial Ministers of Health (2000 August). Understanding Canada's Health Care Costs: Final Report.

APPENDIX A – LIST OF PROVINCIAL/TERRITORIAL HEALTH GOALS

The ten topic foci under which the 66 provincial/territorial health goals are categorized:

hsta	Population health status
subg	Population sub-group health status
hsys	Health services/system
pol	Healthy public policy/health promotion and disease prevention
equi	Health equity
soc	Social and economic environment (including income, social status, education, employment and working conditions, social support networks)
pers	Personal responsibility/individual health practices and capacities (including coping skills)
shar	Shared responsibility and participation in health system (including public and community)
phys	Physical environment
res	Research and information

Ontario (1989)

pol Goal #1: Shift the emphasis to health promotion and disease prevention.

soc Goal #2: Foster strong and supportive families and communities.

phys Goal #3: Ensure a safe, high quality physical environment.

hsta Goal #4: Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

hsys Goal #5: Provide accessible, affordable, appropriate health services for all.

New Brunswick (1990)

hsta Goal #1: To increase the number of years residents of New Brunswick live free of major disease, disability and handicap.

pol Goal #2: To increase emphasis on health promotion and disease prevention.

soc Goal #3: To achieve and maintain healthy, strong and supportive, individuals, families, and communities.

phys Goal #4: To support the creation of healthier environments for all New Brunswickers.

hsys Goal #5: To maintain or increase the accessibility, affordability and appropriateness of health and community services for the citizens of New Brunswick.

QuJbec (Strategies) (1992)

pers Strategy #1: Encourage the reinforcement of the individuals potential.

soc Strategy #2: Provide support in social settings and develop healthy and safe environments.

soc Strategy #3: Improve living conditions.

subg Strategy #4: Act for and with groups at risk.

pol Strategy #5: Coordinate public policy and action to promote health and well-being.

hsys Strategy #6: Orient the Health and Social Services system toward the most effective and least costly solutions.

Manitoba (May 1992)

hsta Goal #1: Improve general health status of all Manitobans.

equi Goal #2: Reduce inequalities in health status.

pol Goal #3: Establish public policy that promotes health.

pers Goal #4: Foster behaviour that promotes health.

soc Goal #5: Foster environments that promote health.

hsys Goal #6: Provide appropriate, effective and efficient health services.

hsys Goal #7: Develop mechanisms to assess and monitor quality of care, utilization and cost-effectiveness.

hsys Goal #8: Foster responsiveness and flexibility in the health-care delivery system.

hsys Goal #9: Promote reasonable public expectations of health care.

hsys Goal #10: Promote delivery of alternative and less expensive services.

Nova Scotia (December 1992)

hsta Goal #1: Health Promotion. Promote and improve the health of all Nova Scotians.

phys Goal #2: Healthy Environment. Make Nova Scotia a safe and healthy place to live.

soc Goal #3: Healthy Living. Support the efforts of individuals, families and communities to lead healthy lives.

hsys Goal #4: Management. Ensure that the resources needed to support health are managed wisely and fairly.

shar Goal #5: Participation. Involve Nova Scotians in decisions affecting health.

equi Goal #6: Social Justice. Ensure that all Nova Scotians have the opportunity to achieve health.

Alberta (1993)

hsta Goal #1: To increase the number of years of good health by reducing illness, injuries and premature deaths and improving well-being.

res Goal #2: To make decisions based on good information and research.

pol Goal #3: To include a health perspective in public policy.

hsys Goal #4: To have appropriate, accessible and affordable health services.

soc Goal #5: To live in strong, supportive and healthy families and communities.

phys Goal #6: To live in a healthy physical environment.

pers Goal #7: To recognize and maximize individual potential in spite of biological differences.

pers Goal #8: To choose healthy behaviours.

pers Goal #9: To develop and maintain skills for facing the challenges of life in a healthy way.

Saskatchewan (October 1994)

soc Goal #1: Reassess What Determines Health. To change our thinking about health and to consider the broad determinants of health.

equi Goal #2: Social Justice and Equity. To provide equal opportunity for achieving health for all Saskatchewan people and communities.

soc Goal #3: Supportive Families and Communities. To foster healthy social environments for individuals, families and communities.

phys Goal #4: A Healthy Physical Environment. To preserve and promote clean, safe physical environments which support health.

pol Goal #5: Health Promotion. To place more emphasis on health promotion and illness avoidance.

shar Goal #6: Shared Responsibility. To improve health and create a healthier society through the cooperation and shared responsibility of all members of society.

Prince Edward Island (December 1996)

pol Goal #1: Understanding Health. Know and think about what determines our health and place greater emphasis on health promotion and illness prevention.

hsta Goal #2: Healthy Individuals, Families, and Communities. Strong and supportive families and communities increase the number of years of good health by improving well-being, reducing illness, injuries, and premature deaths.

phys Goal #3: A Healthy Environment. Preserve and promote healthy and safe environments.

hsys Goal #4: Quality in Health and Community Services. Work with the community to provide a range of appropriate health services and ensure that resources are managed fairly and wisely.

shar Goal #5: Public Policy - A Shared Responsibility. Public policy in social, economic, cultural and physical environments has a powerful influence on health. Actions to improve health involve a partnership with community, service providers and government.

British Columbia (December 1997)

soc Goal #1: Positive and supportive living and working conditions in all our communities.

pers Goal #2: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.

phys Goal #3: A diverse and sustainable physical environment with clean, healthy and safe air, water, and land.

hsys Goal #4: An effective and efficient health service system that provides equitable access to appropriate services.

subg Goal #5: Improved health for aboriginal peoples.

hsta Goal #6: Reduction of preventable illness, injury, disabilities and premature deaths.

The Northwest Territories (and Nunavut) (June 1998)

hsta Goal #1: To improve health status.

soc Goal #2: To improve social and environmental conditions.

hsys Goal #3: To improve integration and coordination of health and social services, including services by government, non-government agencies, and private and volunteer sectors.

hsys Goal #4: To develop more responsive, responsible and effective methods of delivering and managing services.

Newfoundland and Labrador (August 1998)

shar Goal #1: Vibrant communities and regions in which people actively participate in their collective well-being.

soc Goal #2: Sustainable regions based on strategic investment in individuals, families and communities.

soc Goal #3: Self-reliant, healthy, educated individuals and families living in safe, nurturing communities.

res Goal #4: Integrated and evidence-based policy development and monitoring as the foundation for the design, delivery and evaluation of social development programs and services.

APPENDIX B – LIST OF TABLES

Table 1: Number of Goals Per Province/Territory, Classified Based on the Topic Focus of the Goal

Province/Territory		[1] Topic Foci (Types) of the Goals									
Name	**Number of Goals**	**hsta**	**subg**	**hsys**	**pol**	**equi**	**soc**	**pers**	**shar**	**phys**	**res**
AB	9	1		1	1		1	3		1	1
BC	6	1	1	1			1	1		1	
MB	10	1		5	1	1	1	1			
NB	5	1		1	1		1			1	
NF	4						2		1		1
NS	6	1		1		1	1		1	1	
NT	4	1		2			1				
ON	5	1		1	1		1			1	
PE	5	1		1	1				1	1	
QC	6		1	1	1		2	1			
SK	6				1	1	2		1	1	
Totals	66	8	2	14	7	3	13	6	4	7	2
Number of Provinces/ Territory with Type of Goal		8	2	9	7	3	10	4	4	7	2

[1] The goals have been categorized into one of ten goal types:
hsta = population health status
subg = population sub-group health status
hsys = health services/system
pol = healthy public policy/emphasis on health promotion
equi = health equity
soc = social and economic environment
pers = personal responsibility/individual health practices and capacities
shar = shared responsibility and participation in health system
phys = physical environment
res = research and information

Table 2: Uses of the Health Goals at the Ministerial/Departmental Level, as Reported by Ministerial/Departmental Interviewees

	AB	**BC**	**MB**	**NB**	**NF**	**NS**	**NT**	**ON**	**PE**	**QC**	**SK**
For setting broad strategic directions and/or as a framework for planning		x	x	x		x	x	x	x		
To provide a broad philosophical orientation for department policy	x		x	x		x					x
To develop or structure policies and/or programs			x	x			x	x		x	
To guide resource allocation				x			x	x		x	
To encourage intersectoral collaboration		(x)[1]	(x)[1]	x		(x)[1]				x	
To align or harmonize existing programs and policies with the goals			x							x	
To guide data collection							x			x	
For education re: broad determinants of health or as a starting point for population health initiatives	x					x					
To legitimize or ensure the continuation of initiatives already being developed		x									

[1] The suggested initiative was conceded to have happened concurrent to the implementation of the health goals rather than as an outcome of them.

Table 3: Uses of the Provincial/Territorial Health Goals at the Regional Level, as Reported by Respondents to the Regional Surveys

	[1] Degree of Use, Median and Range (in Parentheses)												
Use	**AB**	**BC**	**MB**	**NB**	**NF**	**NS**	**NT**	**ON**	**PE**	**QC**	**SK**	**National Median**	**[2] Percentage Reporting High Use**
Adopted the goals as a framework for planning	4.5 (1-6)	4 (1-6)	4 (3-6)	3 (3-4)	3.5 (1-5)	2 (1-3)	4 (1-6)	4 (1-6)	3 (1-4)	5 (3-6)	5 (2-6)	4 (1-6)	44%
Initiated collaborative action on the goals with sectors other than health	4 (1-6)	3 (1-6)	3 (2-4)	3 (1-5)	2 (1-6)	2.5 (1-4)	4 (3-6)	3 (1-6)	4.5 (1-5)	4 (1-5)	5 (2-6)	4 (1-6)	32%
Developed new policies and programs based on the goals	4 (1-5)	3 (1-6)	4 (3-5)	4 (3-5)	2.5 (1-5)	3 (1-5)	4 (1-6)	4 (1-6)	3 (1-5)	4 (2-5)	5 (2-6)	4 (1-6)	29%
Allocated resources based on the goals	4 (1-6)	2 (1-5)	3 (2-5)	4 (1-4)	2 (1-5)	3 (1-5)	4 (3-5)	3 (1-5)	3 (2-5)	4 (1-5)	4 (2-6)	4 (1-6)	20%
Aligned existing programs and policies with the goals	4 (1-6)	3 (1-6)	3 (1-5)	3 (3-5)	2 (1-4)	2.5 (1-4)	4 (1-4)	3 (1-5)	2.5 (1-5)	5 (2-5)	4 (1-6)	3.5 (1-6)	23%
Allocated responsibility to agencies and organizations in the region to act on the goals	3.5 (1-6)	2 (1-5)	2.5 (1-4)	3 (3-4)	2.5 (1-5)	2 (1-3)	3 (1-5)	3 (1-6)	4 (1-4)	4 (1-5)	4 (1-6)	3 (1-6)	19%
Evaluated programs and policies against the goals	4 (1-6)	2 (1-6)	3 (1-4)	2 (2-4)	2 (1-3)	2 (1-3)	4 (1-5)	3 (1-6)	2 (1-4)	4 (2-5)	4 (2-6)	3 (1-6)	12%

[1] Scale ranged from 1 (have not used at all) to 6 (used a lot).
[2] "High use" means a rating of 5 or 6.

Table 4: Influence of Health Goals on Regional Decision-Making

[1] Influence on Regional Decision-Making, Median and Range (in Parentheses)												
AB	**BC**	**MB**	**NB**	**NF**	**NS**	**NT**	**ON**	**PE**	**QC**	**SK**	**National Median**	**[2] Percentage Reporting High Influence**
4 (2-6)	3 (1-6)	4 (4-6)	5 (4-5)	4.5 (1-5)	2.5 (1-4)	5 (3-5)	4 (1-6)	2.5 (1-4)	5 (2-6)	5 (2-6)	4 (1-6)	34%

[1] Scale ranged from 1 (no influence at all) to 6 (major influence). Medians of 1 to 2.5 suggest "low" influence, medians of 3 to 4.5 suggest "moderate" influence, and medians of 5 suggest "high" influence.
[2] "High influence" means a rating of 5 or 6.

Table 5: Opinions of contributions of the health goals

Statements	[1] Agreement/Disagreement with Statements, Median and Range (in Parentheses)												
The health goals have…	AB	BC	MB	NB	NF	[2] NS	NT	ON	PE	QC	SK	National Median	[3] Percentage Reporting High Agreement
Emphasized a broader focus on the determinants of health in the region.	4.5 (1-6)	3 (1-6)	5 (2-5)	2 (2-5)	4 (1-5)	5	4 (3-5)	4 (2-6)	4 (2-5)	4 (1-6)	5 (3-6)	4 (1-6)	47%
Contributed to a greater emphasis on health promotion and disease prevention in the region.	4.5 (1-5)	3 (1-6)	5 (2-6)	4 (2-6)	3.5 (1-5)	5	4 (2-5)	3 (2-6)	3.5 (2-4)	5 (1-6)	5 (3-6)	4 (1-6)	41%
Proven themselves to be a useful policy and planning strategy for the region.	4 (1-6)	3 (1-6)	4 (3-6)	3 (1-3)	3.5 (1-5)	4	5 (3-6)	3 (1-6)	3 (1-4)	3 (2-5)	5 (2-6)	4 (1-6)	33%
Contributed to increased partnerships and intersectoral collaboration toward addressing health issues in the region.	4 (1-6)	3 (1-6)	4 (2-5)	3 (1-5)	4 (1-5)	5	3 (2-5)	4 (1-5)	3.5 (1-5)	4 (2-6)	5 (3-6)	4 (1-6)	29%
Contributed to the creation of healthy public policy in the region.	3.5 (1-6)	3 (1-6)	3 (1-5)	3 (2-4)	3 (1-5)	3 (1-5)	4 (2-5)	4 (2-5)	3.5 (2-5)	4 (1-6)	4 (2-6)	4 (1-6)	25%
Contributed to the delivery of more effective programs in the region.	4 (2-6)	2 (1-5)	3 (2-4)	4 (2-4)	3.5 (1-4)	3	4 (3-5)	3 (1-5)	4 (2-5)	4 (1-6)	4 (3-6)	3 (1-6)	17%
Proven themselves to be a useful basis for evaluating programs and services in the region.	3 (1-6)	3 (1-6)	2.5 (1-6)	1 (1-2)	3 (1-5)	2 (1-3)	4 (2-4)	2 (1-5)	2 (2-3)	3 (1-4)	4 (1-5)	3 (1-6)	13%
Contributed to a more systematic approach to allocating resources in the region.	3 (1-6)	2 (1-5)	3 (2-5)	2 (1-4)	2.5 (1-4)	4	4 (3-5)	2 (1-5)	2 (1-4)	3 (1-5)	4 (2-6)	3 (1-6)	10%
Helped to educate the public in the region about health issues.	3 (1-6)	2 (1-5)	3 (1-6)	1 (1-5)	3 (1-4)	4	4 (2-4)	2 (1-6)	4 (2-5)	4 (2-5)	3 (3-5)	3 (1-6)	9%

[1] Scale ranged from 1 (strongly disagree) to 6 (strongly agree). Medians of1 or 2 suggest disagreement, medians from 3 to 4.5 suggest ambivalence, and medians of 5 suggest agreement.
[2] There were two respondents from Nova Scotia. However, one respondents did not answer most of the statements; therefore for some statements, only one rating is shown, with no range.
[3] "High agreement" means a rating of 5 or 6.

Table 6: Regional Implementation Score

		[1] Regional Implementation Score		
Province/Territory	Number of Regions	Median	Minimum	Maximum
Saskatchewan	23	4.4	2.8	5.6
Northwest Territories	9	3.9	3	4.6
QuJbec	9	3.9	1.9	4.8
Alberta	14	3.9	1.3	5.6
Manitoba	9	3.6	2.7	4.7
Prince Edward Island	4	3.2	1.6	4.2
New Brunswick	3	3.1	2.8	3.5
Ontario	13	3.1	1.5	4.8
Newfoundland & Labrador	6	2.9	1	4.3
British Columbia	38	2.8	1	5.3
Nova Scotia	2	2.5	1	4.1
National	**130**	**3.6**	**1**	**5.6**

[1] Table 7: Development of Regional Goals, Objectives, Indicators, Targets, and Strategies, and the Degree to Which They Each Reflect the Provincial/Territorial Health Goals

			[3] Reflection of Provincial/Territorial Health Goals	
	[2] Degree of Development		Median	Observed Range
Regional goals	Not started	7%		
	Working on it	25%	4	2-6
	Done	68%	5	1-6
Regional objectives	Not started	7%		
	Working on it	32%	4	2-6
	Done	61%	5	1-6
Regional indicators	Not started	22%		
	Working on it	63%	4	1-6
	Done	15%	5	1-6
Regional targets	Not started	22%		
	Working on it	63%	4	1-6
	Done	15%	5	3-6
Regional strategies	Not started	11%		
	Working on it	57%	4	1-6
	Done	32%	5	1-6

[1] This table does not include QuJbec, which had a slightly different procedures.
[2] Scale ranged from 1 (not started) to 3 (done).
[3] Scale ranged from 1 (provincial goals not reflected at all) to 6 (provincial goals completely reflected).

Table 8: Regional Implementation Status (Action) for Each Type of Goal

		[1] Percentage of Responses for Each Type of Goal (%)									
		hsta	**subg**	**hsys**	**pol**	**equi**	**soc**	**pers**	**shar**	**phys**	**res**
[2] Action During Past 12 Months	**L**	15	39	10	22	15	28	29	15	32	10
	M	56	44	32	39	44	47	50	44	48	50
	H	29	17	58	39	41	25	21	41	20	40
[2] Action Before Past 12 Months	**L**	26	51	26	26	29	38	35	27	32	30
	M	52	38	38	39	42	41	47	40	55	45
	H	22	11	36	35	29	21	18	33	13	25
[3] Change in action between the two time periods	**<**	7	2	1	12	0	6	3	3	5	0
	=	68	78	63	64	77	76	86	76	83	65
	>	[5] 25	[5] 20	[5] 36	24	[5] 23	[5] 18	11	[5] 21	12	[5] 35
[4] Selected as Having Higher Overall Action		40	28	84	40	9	16	13	28	9	45

[1] The goals have been categorized into one of ten goal types:
hsta = population health status
subg = population sub-group health status
hsys = health services/system
pol = healthy public policy/emphasis on health promotion
equi = health equity
soc = social and economic environment
pers = personal responsibility/individual health practices and capacities
shar = shared responsibility and participation in health system
phys = physical environment
res = research and information

[2] Degree of action was rated on a scale where L means “low”, M means “moderate”, and H means “high.”

[3] This was calculated by subtracting the response to action before the past 12 months from action during the past 12 months (< means less action more recently, = means the same degree of action, and > means more action recently).

[4] None of the provinces/territory have a set of goals that address all the categories, or topic foci. The percentages for each type of goal are based only on provinces/territory that had that specific type of goal.

[5] Statistical analyses using the Wilcoxon Signed Rank test for paired data showed that increase in action over time was significant (" =0.05) for these types of goals.

Table 9: Factors Identified as Contributing to Overall Higher Action for Specific Types of Goals

	[1] Percentage of Respondents in Relevant Regions Who Believed the Factor Contributed to Overall Higher Action (%)									
Contributing Factor	**hsta**	**subg**	**hsys**	**pol**	**equi**	**soc**	**pers**	**shar**	**phys**	**res**
Funding was allocated for the specific purpose of addressing the goal	66	77	71	80	100	72	55	63	67	38
Goal is more compatible with the regional mandate than the other goals	86	92	80	59	67	42	82	67	56	67
Goal is more easily measurable than the other goals	50	54	66	17	67	29	36	33	78	22
Region was already working toward the same end as the goal	89	83	93	66	67	78	55	75	89	89
The provincial government viewed the goal as a higher priority than the other goals.	31	50	67	50	33	37	27	25	22	44

[1] The goals have been categorized into one of ten goal types:
hsta = population health status
subg = population sub-group health status
hsys = health services/system
pol = healthy public policy/emphasis on health promotion
equi = health equity
soc = social and economic environment
pers = personal responsibility/individual health practices and capacities
shar = shared responsibility and participation in health system
phys = physical environment
res = research and information

Table 10: Compatibility of Specific Types of Goals with Regional Health Mandates

Rating of Compatibility	[1] Percentage of Respondents in Relevant Regions (%)									
	hsta	**subg**	**hsys**	**pol**	**equi**	**soc**	**pers**	**shar**	**phys**	**res**
Low	9	13	1	8	0	15	16	6	19	0
Moderate	19	35	16	39	35	32	38	31	42	25
High	72	52	83	53	65	53	46	63	39	75

[1] The goals have been categorized into one of ten goal types:
hsta = population health status
subg = population sub-group health status
hsys = health services/system
pol = healthy public policy/emphasis on health promotion
equi = health equity
soc = social and economic environment
pers = personal responsibility/individual health practices and capacities
shar = shared responsibility and participation in health system
phys = physical environment
res = research and information

Table 11: Perceptions of the Commitment of the Provincial/Territorial Government to the Health Goals

	[1] Commitment at the Time of the Survey	
Province/Territory	**Median**	**Observed Range**
Northwest Territories	5	4-6
New Brunswick	4.5	4-5
Saskatchewan	4	2-6
Alberta	4	2-5
Newfoundland and Labrador	3.5	3-5
Nova Scotia	3.5	3-4
Manitoba	3	2-5
Québec	3	2-4
British Columbia	3	1-6
Prince Edward Island	2.5	2-4
Ontario	2	1-5

[1] Scale ranged from 1 (not committed at all) to 6 (very committed). Medians of 2 to 2.5 suggest "low" commitment, medians from 3 to 4.5 suggest "moderate" commitment, and a median of 5 suggests "high" commitment.

Table 12: Perceived Relative Priority of the Health Goals at the Provincial/Territorial and Regional Levels

	[1] Relative Priority of the Health Goals	
Province/Territory	**Provincial/Territorial Level**	**Regional Level**
Saskatchewan	4 (2-6)	4 (2-6)
Northwest Territories	4 (3-5)	4 (2-6)
Nova Scotia	4 (3-5)	4 (3-5)
New Brunswick	4 (3-5)	3 (2-4)
Newfoundland and Labrador	3.5 (1-4)	4 (1-5)
Alberta	3 (2-6)	4 (1-6)
Manitoba	3 (2-5)	4 (2-4)
Québec	3 (2-4)	3 (1-5)
Prince Edward Island	2.5 (2-3)	3.5 (3-5)
British Columbia	2 (1-6)	3 (1-6)
Ontario	2 (1-5)	3 (1-5)

[1] Scale ranged from 1 (goals are relatively low priority) to 6 (goals are relatively high priority). Medians of 2 to 2.5 suggest "low" relative priority, medians from 3 to 4 suggest "moderate" relative priority.

Table 13: Priorities That Were Perceived by Respondents to the Regional Survey as Having Competed with Health Goals at the Provincial/Territorial and Regional levels

	Number of Times Cited		
Competing Priorities	**Provincial/ Territorial Level**	**Regional Level**	**Examples**
Competing health areas	44	54	*Provincial/territorial*: acute care and emergency services (23); surgical wait lists (8); cancer and specialized care and services (7); mental health services (3); long-term care (3). *Regional*: continuing care, long-term care, community/ home care (17); acute care and emergency services (16); maintaining current level of services (14); mental health services (4); specialized services (3).
Funding issues	38	41	*Provincial/territorial*: deficit/debt reduction (8); cost cutting & fiscal sustainability (7); health system funding (7); limited resources/lack of funds (5); balancing the budget (5); funding formula issues (4); tax cut agenda (2). *Regional*: limited resources/lack of funds (13); balancing the budget (6); deficit/debt reduction (7); cost cutting and fiscal sustainability (5); unspecified (10).
Restructuring/re-organization and regionalization	27	40	*Provincial/territorial*: Health reform, hospital and health system restructuring, government restructuring (22); regionalization (5). *Regional*: Amalgamation, integration, district re-organization, hospital restructuring (25); establishing regional structures and infrastructure (15).
Other ministries/areas	24	n/a	Education (12); Roads/Highways/Ferries (6); Women's, Children's and Social Services (4); unspecified (2).
Economy	22	9	*Provincial/territorial*: economic development (7); economic instability, jobs and unemployment (4); union demands, bargaining, labour (10); technology development (1). *Regional*: economic development, industry, unemployment.
Politics	9	5	*Provincial/territorial*: politics, political issues and lack of political commitment. *Regional*: unspecified.
Public opinion, perceptions or expectations	8	9	*Provincial/territorial*: public opinion, perspective, expectations, perceptions. *Regional*: community demands, high public expectations, public understanding.
Staffing, recruitment, retention, labour issues	3	17	*Provincial/territorial*: recruitment and retention of health care professionals. *Regional*: recruitment and retention of health professionals, staffing shortages (10); labour issues (7).
Physician factors	3	n/a	Physician demands/opposition/discontent.
Other	1	25	*Provincial/territorial*: accountability of Ministry of Health for its service. *Regional*: capital costs (6); programs for women, children (6); education (4); Y2K planning (3); compliance with Provincial Ministry demands (4); housing (2).

Table 14: Provincial/Territorial Mechanisms for Ensuring the Use of the Health Goals, and the Perceived Influence of the Mechanisms on Usage at the Regional Level

	Mechanism Exists?	[1] Influence of Mechanism on Use of the Health Goals	
Mechanism	Percentage of Responses	Median	Observed Range
Provincial/territorial legislation requiring all regions to use the goals.	18% yes	4	2-6
	82% no	3	1-5
Provincial/territorial body responsible for overseeing that the goals are used.	43% yes	4	2-6
	57% no	2	1-4
Provincial/territorial requirement that regions develop business plans incorporating the goals.	72% yes	4	1-6
	28% no	2	1-4
Provincial/territorial requirement that regions develop progress reports which relate to the goals.	42% yes	4	1-6
	58% no	2	1-5
Provincial/territorial funding to the regions is based on demonstrating that regional/community health outcomes are linked to the health goals.	11% yes	4	3-5
	89% no	2	1-6
Provincial/territorial time frame for goals to be achieved by a certain date.	11% yes	3	1-6
	89% no	2	1-6

[1] Scale ranged from 1 (limited region's use of the provincial health goals) to 6 (enhanced region's use of the provincial health goals). Medians of 2 or 3 indicate a limiting influence, while medians of 4 indicate an enhancing influence.

Table 15: Allocation of Specific Funds from the Provincial/Territorial Government to the Regions, and Sufficiency of Funds for Addressing the Goals

	Median and Range (in Parentheses) of Responses	
Province/Territory	[1] Allocation of Specific Funds from Government to Regions	[2] Sufficiency of Funds in Regions for Addressing the Goals
Northwest Territories	4 (1-6)	2 (1-3)
Saskatchewan	4 (1-5)	2 (1-6)
Nova Scotia	3.5 (3-4)	2.5 (2-3)
Manitoba	3 (2-5)	3 (2-4)
QuJbec	3 (1-5)	2 (1-3)
Alberta	2 (1-5)	2 (1-5)
Ontario	2 (1-5)	2 (1-4)
Prince Edward Island	1.5 (1-2)	2 (2)
British Columbia	1 (1-4)	1.5 (1-5)
New Brunswick	1 (1-4)	1 (1-2)
Newfoundland	1 (1-2)	1.5 (1-3)

[1] Scale ranged from 1 (no specific funds allocated) to 6 (specific funds for all goals). Medians of 1 to 2 suggest that "limited" funding was allocated, while medians of 3 to 4 suggest a "moderate" degree of specific funding.
[2] Scale ranged from 1 (not sufficient at all) to 6 (sufficient). Medians of 1 to 2.5 suggest that funds were "largely insufficient", while medians of 3 to 4 suggest that funds were "moderately" sufficient.

Table 16: Assessment of Progress Toward Achieving the Health Goals

Province/Territory	Percentage of Regions Having Attempted Assessment (%)
Québec	89
Saskatchewan	74
Alberta	64
Newfoundland & Labrador	50
Ontario	38
British Columbia	34
Northwest Territories	34
Manitoba	33
New Brunswick	33
Prince Edward Island	25
Nova Scotia	0
National	**50**

Table 17: Availability of Region-Specific Data

	[1] Availability of Data, Median and Range (in Parentheses)												
	AB	**BC**	**MB**	**NB**	**NF**	**NS**	**NT**	**ON**	**PE**	**QC**	**SK**	**National Median**	[2] **Percentage Reporting High Availability**
Health status (e.g. morbidity, mortality, etc.)	5 (4-6)	5 (1-6)	5 (4-6)	5 (3-5)	5.5 (3-6)	6 (6)	4 (2-6)	6 (4-6)	4.5 (1-5)	6 (5-6)	5 (2-6)	5 (1-6)	76%
Health service utilization (e.g. physician visits, hospitalization, etc.)	5 (2-6)	5 (1-6)	6 (5-6)	4 (3-5)	4 (3-6)	5.5 (5-6)	4 (3-5)	5 (4-6)	4.5 (3-6)	6 (4-6)	5 (3-6)	5 (1-6)	64%
Broad determinants of health (e.g. housing, income, etc.)	4 (1-5)	4 (1-6)	4 (3-6)	2 (2-5)	4 (3-5)	6 (6)	4 (2-4)	4 (2-6)	4.5 (2-6)	6 (5-6)	4 (2-6)	4 (1-6)	35%
Behavioural risk factors (e.g. smoking, diet, etc.)	4 (2-6)	4 (1-6)	3 (2-6)	2 (2)	3.5 (2-4)	4 (4)	4 (3-5)	4 (3-6)	3.5 (2-6)	5 (3-6)	4 (2-5)	4 (1-6)	25%
Environmental risk factors (e.g. water quality, air quality, etc.)	4 (1-5)	4 (1-6)	3 (1-6)	1 (1-2)	3 (1-5)	3.5 (3-4)	4 (2-5)	3 (2-5)	3 (1-4)	4 (3-6)	3 (1-6)	4 (1-6)	16%

[1] Scale ranged from 1 (not available for region) to 6 (highly available for region). Medians of 1 and 2 suggest "low" availability, medians of 3 to 4.5 suggest "moderate" availability, and medians of 5 to 6 suggest that data were "fairly available."
[2] "High availability" means ratings of 5 or 6.

Table 18: Quality of the Data

	[1] Quality of the Data, Median and Range (in Parentheses)												
	AB	**BC**	**MB**	**NB**	**NF**	**NS**	**NT**	**ON**	**PE**	**QC**	**SK**	**National Median**	**[2] Percentage Reporting a Large Proportion of the Data**
Reliable, with few errors	4 (1-5)	4 (1-5)	4 (1-5)	3 (1-4)	3 (1-5)	4.5 (3-6)	4 (1-5)	4 (1-5)	3 (3)	3 (2-5)	4 (2-5)	4 (1-6)	23 (19%)
Timely, up-to-date	4 (1-5)	4 (1-5)	3 (1-4)	2 (2-3)	3.5 (2-5)	5 (4-6)	3 (1-4)	4 (2-5)	3.5 (2-4)	4 (2-6)	3 (2-6)	3 (1-6)	22 (17%)
Represent a valid measure of the health goals	4 (1-5)	3 (1-5)	3 (1-4)	2 (1-3)	2.5 (1-4)	3.5 (3-4)	4 (2-4)	3.5 (2-5)	3 (3-5)	3 (2-5)	3 (2-5)	3 (1-5)	16 (13%)

[1] Scale ranged from 1 (none of the data) to 6 (all of the data). Medians of 2 and 2.5 suggest that a "low proportion" of the data possessed the quality, medians of 3 to 4.5 suggest that a "moderate proportion" of the data possessed the quality, and a median of 5 suggests that a "high proportion" of the data possessed the quality.
[2] A "large proportion" of the data reflects ratings of 5 or 6.