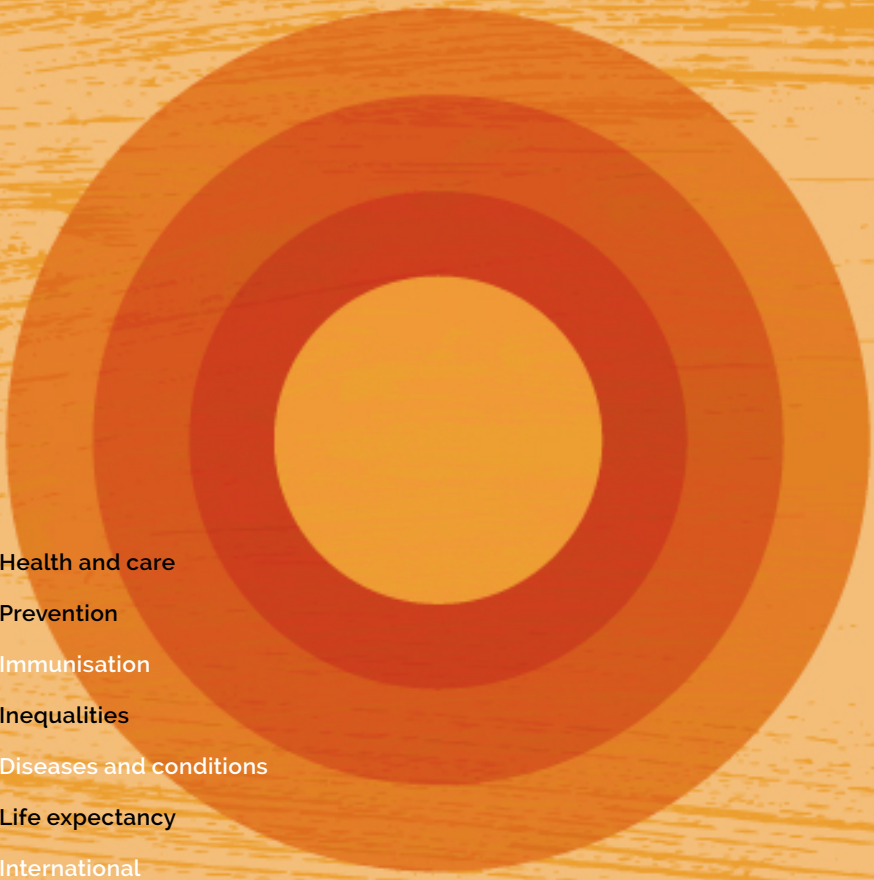
ilc...

ILC
International Longevity Centre Canada
Human Rights do not have a best before date

Money talks

Investing in proactive health measures to support healthy ageing



Health and care

Prevention

Immunisation

Inequalities

Diseases and conditions

Life expectancy

International

Executive summary

We've won the argument on proactive health measures - which is the blanket term for preventative health interventions and health promotion that we use in this report. We know these measures work, are cost-effective, and can save lives. The effects of the COVID-19 pandemic have made investment in this arena a matter of increased urgency.

But despite international consensus on the importance of prevention and promotion, there's been too little action for too long - particularly in the form of expenditure commitments. Across the Organisation for Economic Co-operation and Development (OECD), on average countries spend just 2.8% of their health budgets on these interventions: such as screenings, vaccinations, early intervention and management of disease. In an ageing world, still recovering from the disastrous effects of the pandemic, we can't afford to be complacent.

Canada spends more of its health budget on proactive health measures than any other country in the OECD – at 6%, it's more than double the OECD average. Within Canada this expenditure is classified as 'public health', which includes health promotion, preventative health interventions, occupational health, addiction services and community health services. All of these measures are consistent with the OECD's definition of 'preventative health'. This relatively high level of spending has contributed to positive outcomes that include:

- A steady decrease in avoidable mortality rate: from 150 for every 100,000 citizens in 2000 to 116 for every 100,000 in 2017
- An increase in life expectancy from 79 to 82.1 years
- One of the OECD's highest five-year survival rates for lung and breast cancers

But Canada's healthcare system is still far from perfect. Most importantly, there are fundamental inequalities in access to, and quality of, care; compared to other OECD countries, different Canadian provinces fall anywhere from 3rd to 15th place in the list. As a result, we see variations in health outcomes for different demographics:

- The average life expectancy for Indigenous Canadians is 5 years less than the general population
- Indigenous Canadians are 3 to 5 times more likely than the general population to develop diabetes

- Members of Canada's poorest socioeconomic group spend less time in good health: an average of 11.3 fewer years than those in the wealthiest group
- Canada's poorest socioeconomic group saw an avoidable mortality rate of 1,616 for every 100,000 people, compared to 536 per 100,000 for the wealthiest group
- 88% of older Canadians are considered to have low health literacy

We can take Canada's situation as a case study that shows spending on proactive health measures is effective. Emulating Canada's spending target – 6% of total health expenditure – would be ambitious for some countries, but not unachievable. For the UK, reaching this target would represent a £2.687 billion investment: that's just 4.5% of the £60 billion the Department of Health and Social Care received for COVID-19 measures.

But it's important to remember that reaching this expenditure target is only a starting point. We'll also need long-term, meaningful investment in proactive health measures to address health inequalities, engage all actors involved in population health, and ensure we have data and technology infrastructures that work for all.

In the context of an ageing world, where inequalities are rife and on the rise, countries around the world must continue to increase their spending in this area to support a long-term shift from 'illness services' to 'health services' and promote healthy ageing throughout everyone's lives.

Recommendations

- Spend at least **6% of health budgets** on proactive health measures, and continue to increase this in line with the rise in preventable diseases
- Target interventions to address health inequalities
- Invest in health education and awareness programmes
- Take a 'health in all policies' approach that considers the health and social implications of proposed policies
- Adopt better policies and procedures for the collection and use of patient data to support the delivery of preventative and promotional services

Delivering prevention in an ageing world

This policy report from ILC-UK and ILC Canada is part of ILC-UK's *Delivering prevention in an ageing world* programme.

Following our year-long programme, *Prevention in an ageing world*, which sparked conversations in Abu Dhabi, Taipei, Austin, Geneva, Sydney and London, all the way to the G20 Health Ministers, the message is clear: it's never too late to prevent. And the health and economic costs of failing to invest in proactive health measures across the life course are simply too high to ignore.

The ongoing COVID-19 pandemic has made the facts unequivocable, bringing home the urgent need to match commitment with action. We've identified how we can deliver prevention in an ageing world by:

- Inspiring and engaging policy makers, healthcare workers and individuals to invest, promote and take action
- Democratising access to reduce health inequalities
- Using technology effectively to improve access, uptake rates, reduce barriers, and empower patients

During 2020 and 2021, ILC-UK has been conducting research and engaging with stakeholders around the globe to understand not only *why* we must prioritise proactive health measures across the life course, but *how* we can deliver them, including how best to make investments.

This programme has been supported by:

AMGEN · Home Instead. To us, it's personal · GILEAD · gsk do more feel better live longer · MSD INVENTING FOR LIFE · Pfizer · Seqirus A CSL Company

Authors: Shain Raichura, Lily Parsey

About the International Longevity Centre UK (ILC-UK)

ILC-UK is the UK's specialist think tank studying the impact of longevity on society, and what happens next. It was established in 1997 as one of the members of the *International Longevity Centre Global Alliance*, an international network on longevity.

Since our inception, we have published over 250 reports and organised over 300 events, including the annual Future of Ageing conference.

We work with central and local government, the private sector, and professional and academic associations, in the UK and around the world, to provoke conversations and pioneer solutions for a society where everyone can thrive, regardless of age.

About ILC Canada

The International Longevity Centre Canada (ILC Canada) is an independent think tank created in 2015, situated in Ottawa, Ontario. Our mission is to propose ideas and guidance for policies that address population ageing, based on international and domestic research and practice, with a view to bettering the lives of Canadians. We do this through a human rights lens, using knowledge development and exchange, recommendations of evidence-based polices, social mobilisation and networking.

Contents

Executive summary 2

Delivering prevention in an ageing world 4

Why we must invest in proactive health measures 7

The case for prevention and promotion in an ageing world 7

Policy makers are starting to respond 10

We need commitments to be matched with investment 11

Canada: a pioneer in proactive health measures? 13

A quick history 14

What's the impact of higher spending? 16

What more could be done? 19

What happens next? 21

References 22

Why we must invest in proactive health measures

The case for prevention and promotion in an ageing world

What do we mean by proactive health measures?

These measures include:

Primary prevention: interventions that aim to prevent diseases or injuries before they occur. These include preventing exposure to hazards, altering unhealthy or unsafe behaviours, and increasing resistance to disease or injury should exposure occur.

Secondary prevention: interventions that aim to reduce the impact of a disease or injury that's already occurred. These include detecting and treating disease or injury as soon as possible to halt or slow its progress.

Tertiary prevention: interventions that aim to soften the impact of an ongoing illness or injury with lasting effects. These include helping people to manage long-term, often complex, health problems and injuries.[1]

Health promotion: interventions that aim to enable people to improve their health by increasing their control over it and its determinates. These include public health policies that address health determinates such as income, food security and housing, as well as developing personal skills and strengthening communities to prevent disease onset and improve health.[2]

In the UK we refer to all of these interventions as **prevention**, but in Canada they're normally classified as **health promotion**. They include:

- **Targeted screening programmes** to identify diseases early or identify those at risk of developing them
- **Embedding prevention** into all aspects of society to achieve health equity
- **Helping people to adopt healthier lifestyles**, including stopping smoking, increasing levels of physical activity, and adopting healthy nutrition

- **Vaccinations** against communicable diseases, and preventative medications
- **Helping people manage long-term conditions**, through medication or other therapies, in ways that improve their wellbeing and help them to enjoy longer, more active lives[3]

Across the G20, societies are ageing. In most G20 countries, the ratio of people aged 65 and over to those aged 15-64 will at least double by 2060; the proportion of people aged 80 and over will triple.[4]

But while we're generally living longer lives, those extra years aren't necessarily spent in good health. Our *Prevention in an ageing world* programme highlighted that citizens of better-off countries lived 27.1 million years in poor health in 2017 alone, due to a number of largely preventable age-related diseases. The number of years spent in ill health is set to increase by 17% over the next 25 years if governments fail to prioritise proactive health measures throughout everyone's lives.[5]

Globally, healthcare systems have experienced significant capacity issues during the COVID-19 pandemic. We can see that healthcare systems simply won't be able to deal with the additional demand of these increased years in ill health if we don't move upstream: to prevent conditions from developing in the first place and help people to manage their conditions more effectively.

Proactive health interventions don't just help people to live healthier and more active lives. They save healthcare costs down the line by reducing the risk of serious and costly interventions, and enable people to continue contributing to society for longer, not just by working but also by volunteering or spending in the community.

Among people aged 50-64, preventable illnesses cost better-off countries at least $692 billion in lost productivity every year:[6]

- $390 billion as a result of cardiovascular disease
- $250 billion as a result of type 2 diabetes
- $39 billion as a result of flu
- $9 billion as a result of lung cancer
- $4 billion as a result of HIV

Comparing countries across the G20, we also know that in countries that spend more on health older people work, volunteer and spend more:

- People who report being in good (rather than poor) health are over four times more likely to be working between the ages of 50 and 65, and over 10 times more likely between 65 and 74
- A mere 0.1 percentage point increase in spending on preventive health measures, as a proportion of each country's GDP, can unlock a 9% increase in annual spending by people aged 60 and over and an additional 10 hours of volunteering for each person aged 65 and over[7]

The disastrous effects of COVID-19 have made the case for investing in life-long proactive health measures more urgent. Older people have been disproportionately affected by the virus, which has locked them out of working, spending, caring and volunteering. We expect this to lead to a significant further toll on health services in years to come:

- In many countries COVID-19 has partially or completely disrupted health services. Hypertension treatment services have been partially or completely disrupted in over half (53%) of the G20 countries; 49% have seen disruption in treatment for diabetes and diabetes-related complications; 42% have seen disruption in cancer treatment; and 31% have seen disruption in treatment for cardiovascular emergencies.[8]
- In England, it has been estimated that delays in diagnosis will increase the number of deaths over the next five years due to cancer by about: 16% for colorectal cancer; 9% for breast cancer; 6% for oesophageal cancer; and 5% for lung cancer. A British Medical Association survey of doctors found that more than half believe the pandemic has worsened care for patients who don't have the virus.[9]
- In the US there were over two months of excess surgical demand across all treatment groups by the end of 2020.[10]

Post-pandemic recovery, as well as the broader sustainability of G20 economies and health systems, relies on governments significantly increasing their efforts to help people live not only longer, but healthier lives.

Policy makers are starting to respond

Recent decades have seen increased international debate on healthy ageing and the need to shift healthcare systems towards proactive health measures.

In 2011, the United Nations resolution entitled *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* (NCDs) committed to scaling up proactive health measures. And in 2013 the WHO's *Global Action Plan for the Prevention and Control of NCDs 2013-2020* included a voluntary target, agreed at the World Health Assembly (the WHO's decision-making body). The target is a 25% reduction in premature mortality rates as a result of NCDs by 2025. More recently, the WHO has declared this (2020-2030) the Decade of Healthy Ageing; it plans to focus on improving the lives of older people and their communities. This ambitious agenda requires institutions and organisations across society to work together. In 2019 we saw a strong commitment from G20 leaders and health ministers to addressing proactive health measures across the life course.

"We will promote healthy and active ageing through policy measures to address health promotion, prevention and control of communicable and non-communicable diseases […]"

June 2019: G20 Osaka Leaders' Declaration[11]

We will promote the prevention, control, and management of communicable and non-communicable diseases and promote health by implementing policy measures including raising awareness about healthy lifestyle and health literacy […] over the life course.

October 2019: the Okayama Declaration of Health Ministers[12]

The EU has published a *Green Paper on Ageing*,[13] which has a heavy focus on healthy ageing and how proactive health measures can drive this.

The COVID-19 pandemic has further fuelled awareness of the need to invest in these measures, including an unrivalled focus on and investment in national immunisation programmes.

The pandemic has also prompted some countries to make longer term changes to the organisation of their healthcare systems. The UK has published the *NHS Long-Term Plan*, which has a heavy focus on prevention and seeks to better integrate services to allow all actors

within the health system to collaborate effectively.[14] New Zealand has announced a radical shake-up of its health system to create a national health service.

"The pandemic really crystallised a lot of things. And people really did make things work. But you can't make things work against existing structures. As a consequence of that and following a review, we made the decision to collect all our 20 health boards into one single nation-wide entity. So we run our hospital network as a national network."

Andrew Little MP, Minister for Health, New Zealand at ILC UK webinar

Yet, despite ongoing public and political support at the national and international level, there's still a gap between rhetoric and action on proactive health measures and investment in them.

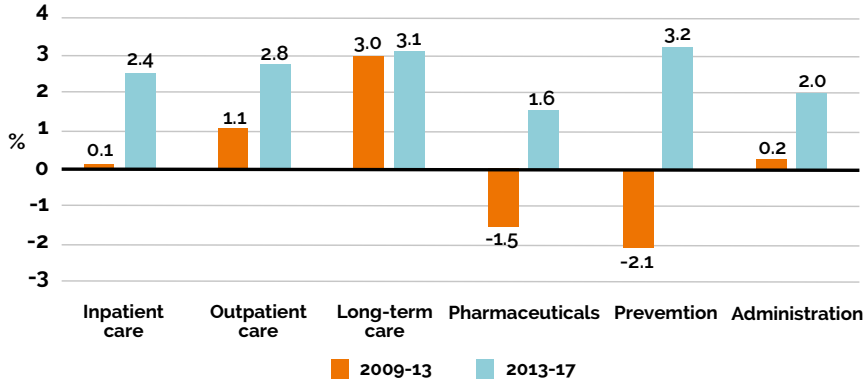
We need commitments to be matched with investment

While the growing consensus is promising, the oft-repeated commitments to this goal are not being translated into action consistently. Proactive health measures often bear the brunt of cuts to health spending.

Of course, spending is an incomplete measure of a government's commitment to this area, because the cost of proactive health measures can vary significantly between countries, as can the number and nature of interventions classified as such. Furthermore, many of the best interventions come without large price tags.

However, spending trends do paint a picture – and recent trends suggest a worrying complacency, demonstrating the gap between intent and action. Across the OECD spending on proactive health measures accounts for only 2.8% of average total healthcare spending.

Figure 1: Annual growth in expenditure on selected services in real terms - OECD average (2009-13 and 2013-17)[15]



Source: OCED (2019) 'Annual growth in health expenditure for selected services (real times), OCED average, 2009-13 and 2013-17', Health expenditure, OECD Publishing. Paris, doi.10.1787/996c5659-en

As a 2017 OECD report noted, programmes for proactive health measures bore the brunt of cuts to healthcare spending during the financial crisis. Despite increased post-crisis expenditure, over the longer term OECD countries kept their spending on this relatively stable, at between 2% and 4% of overall healthcare spending, suggesting a "surprisingly low level of investment".

As the pandemic has had a significant impact on government budgets in many countries, there's a real risk that these trends will be repeated. But if this period has shown us anything, it's that we can't afford to leave these worries until tomorrow.

As we rebuild in the wake of the pandemic in an ageing world, complacency is a luxury we can no longer afford. The social and economic costs of failing to act are too great to ignore. We need to see action on proactive health measures.

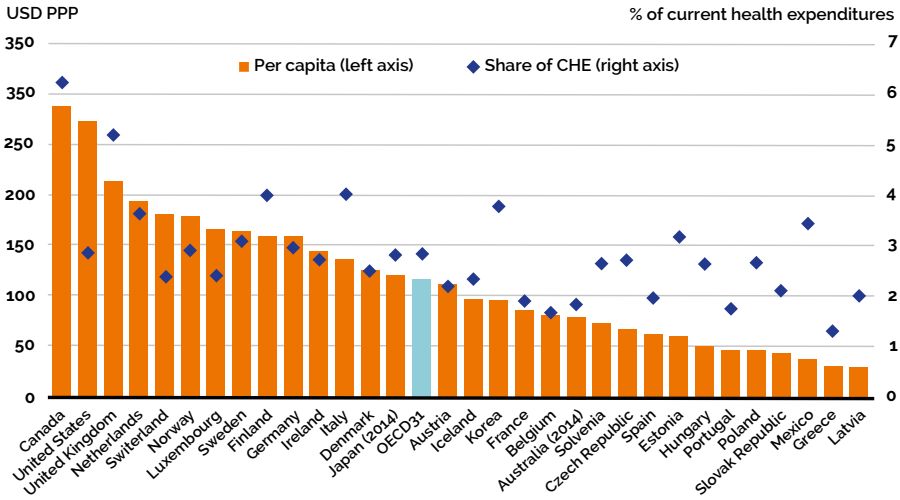
Canada: a pioneer in proactive health measures?

Average spending across the OECD is low, at 2.8% of total health budgets, Canada spends the greatest amount on proactive health measures: 6%.

While there is considerable variation across the OECD, Canada's spending target would not be unachievable for other countries.

For instance, for the UK, reaching this target would represent a £2.687 billion investment: that's just 4.5% of the £60 billion the Department of Health and Social Care received for COVID-19 measures.

Figure 2: Expenditure per capita and as a share of current health expenditure (2015)[16]



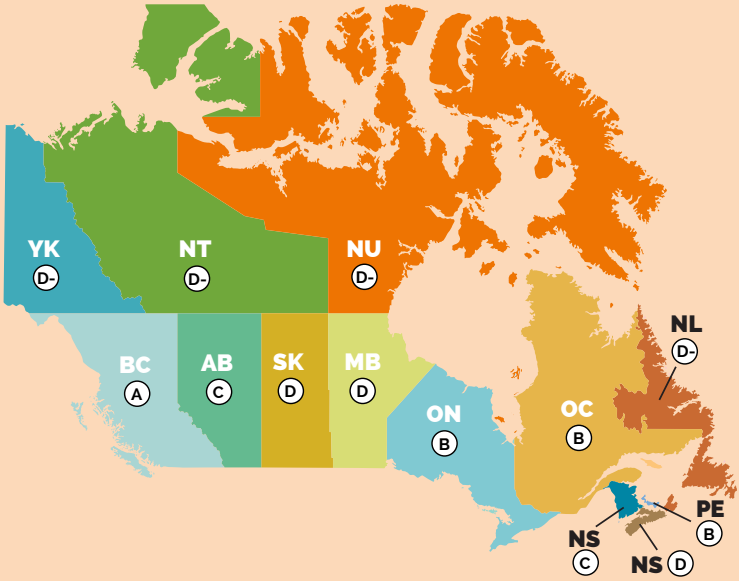
Source: OCED Health Statistics 2017

A quick history

Canada's healthcare system

Canada's healthcare system consists of 13 distinct provincial and territorial insurance plans, collectively named Medicare. Provinces receive about a quarter of their public health funding from the federal government through the Canadian Health Transfer, which equitably distributes funds on a *per capita* basis.[17] The remaining costs are covered by provinces and private sources.

As a result, expenditure and programmes may vary considerably between different provinces and territories, leading to differences in overall performance. However, the federal government still has significant influence in this area through guidelines and national proactive health programmes.



Source: The Conference Board of Canada

Canada has been at the forefront of the proactive health debate for decades. Canada's efforts in this area are often attributed to the release of the Lalonde report in 1974. Informally named after Marc Lalonde, then Minister of Health, the report was a product of the government's Long Range Health Planning Branch, established three years earlier.

Its purpose was to express a shifting perspective in healthcare that extended beyond traditional hospital-based treatment. The aim was to promote better outcomes by targeting interventions at those most at risk to address health inequalities, and by enabling people to take control of their own health.

The report also proposed the concept of 'the health field', where health is determined by four fields: environment; lifestyle; biology; and healthcare systems. It referred to these fields collectively as the determinants of health. Work by departments such as the Federal/Provincial/Territorial Advisory Committee on Population Health continued to expand the list of determinants and by 1996 the number had grown to 12, including social determinants relating to each person's place in society, and their influence on health outcomes.[18]

The Lalonde report was praised internationally for its unique perspective; the UK and the US released reports shortly afterwards that mirrored it.[19] This led to the selection of Ottawa as the site of the WHO global health promotion conference in 1986, hosting 1,200 participants from 38 countries. It was held in response to growing global calls for proactive health measures to be implemented on a wider scale, and sought to fulfil the 1978 *Declaration of Alma-Ata*, a document that recognised primary health care as a means to achieving health for all people of all nations. To this end, the conference developed the Ottawa Charter. This set the goal of providing "health for all" by the year 2000 by developing personal skills, strengthening community action, creating and supporting healthy environments, building healthy public policy, and reorienting health services.[20]

Domestically, this commitment to proactive health measures also extended to the nation's federal budget. Expenditure gradually rose from 3.2% of health budgets in 1970 to 4.1% in 1977. This put Canada among those spending the most on proactive health measures - but it saw a further substantial increase to 6% at the turn of the millennium.

During the early 2000's a number of public health crises exposed Canada's proactive health measures were inadequate. These included the SARS pandemic and the Walkerton water crisis, in which thousands of citizens of the small town of Walkerton contracted an E-coli-related illness from their well water. This, combined with health promotion receiving increased recognition in the late 90's contributed to increases in spending. Many provinces responded by establishing

public health offices; the federal government followed suit in 2004 with the Public Health Agency of Canada.[21] Ultimately, spending rose to 6%, where it has remained ever since.

The other main innovation during this decade was the re-establishment of the Canadian Task Force on Preventive Health Care (after a hiatus in 2005). The task force creates evidence-based disease screening guidelines, to be used by primary practitioners to better identify risk factors for certain diseases. Many Canadian physicians rank the task force's work highly, and the guidelines they produce are used widely around the world.[22]

What's the impact of higher spending?

Since Canada's budget for promotion and prevention first rose to 6% of all health spending in 2000, the avoidable mortality rate has steadily decreased, falling from 150 per 100,000 citizens in 2000 to 116 per 100,000 in 2017. 'Avoidable mortality' measures the number of deaths that could have been averted through preventative care or timely treatment; it's considered a strong indicator for the quality of a country's system for proactive healthcare. Canada ranks below the OECD average of 133 for avoidable mortality, showing the effectiveness of spending in this area.

Over the same time period, life expectancy increased from 79 years to 82.1, and the mortality rate associated with certain chronic diseases decreased. This encompassed various cancers, including lung, cervix, breast and colorectal cancers, as well as acute myocardial infarctions. All of these conditions are associated with better outcomes when detected and treated early. As a result, Canada has one of the highest five-year survival rates for lung and breast cancers in the OECD.[23]

Canada also experienced improvements in certain health behaviours during the same period through the use of health promotion policies. This is most readily apparent in the efforts over many years to curb tobacco use, promote healthy eating and create age-friendly cities.

Decreasing tobacco use

Canada has been a leader in smoking prevention since 1963, when it was among the first countries to declare a link between smoking and lung cancer.[24] What followed was a series of public health decisions and laws aimed at curbing tobacco use.

In 1969, the Canadian Broadcasting Company became the first Canadian media corporation to ban smoking adverts (this became a Canadian industry standard in 1972). In 2001, all cigarette packaging was required to include a black and white warning label that took up 50% of the label, and in 2010 all flavoured cigarettes were banned. More recently, 2020 saw the introduction of plain packaging laws for tobacco products. Provincial tobacco taxes have been increasing since 2010, with Newfoundland and Labrador and Nova Scotia having the highest rates of taxation.[25]

These measures had a significant impact. By 2019 the proportion of the population aged over 15 that smoked had decreased to 11.3%, compared to 42.5% in 1964. Consequently, the lung cancer incidence rate per 100,000 people has decreased from 43.7 in 2002 to 37.9 in 2012.

But the effectiveness of Canada's anti-smoking efforts becomes most apparent when looking at the numbers of young smokers. In 2001, approximately 21% of those aged 15-24 classified themselves as daily smokers; by 2018, this had dropped to 7.7%. This decrease can be attributed to a combination of causes, including better education and increased restrictions, but increased taxation appears to be the strongest factor. One study conducted in Ontario between 1996 to 2012 found that taxation policies contributed to 35.1% of the reduction in smoking prevalence. This was followed by smoke-free air policies at 27% of the reduction.[26]

Promoting healthy eating

Obesity rates in Canada rose from 22.4% to 28.1% between 2004 and 2015. Moreover, Canada had one of the OECD's highest rates of diabetes around this time period, ranking fourth amongst OECD countries in 2010.[27] While this is partially explained by stringent screening measures that may detect more cases, we must consider other causes. During this time, unhealthy eating was the second leading risk for disability in Canada, with over 75% of Canadians exceeding the daily recommended salt intake, and over half surpassing recommended sugar levels.

In 2016 Canada began redesigning its national healthy eating policy to combat this, culminating in the release of a new food guide in

2019. Other policy changes during this time include the banning of partially hydrogenated oils in food and sodium reduction targets for manufacturers. Alongside this, Canada introduced the Nutrition North programme, designed to improve food accessibility and education for 37 isolated Indigenous communities. These communities experience high rates of diet-related disabilities due to a lack of healthcare access.[28]

The results of these efforts are promising. So far obesity rates have steadily declined from 28.1% of the population in 2015 to 24.3% in 2019.[23]

Age-friendly communities

The Age Friendly Community project started in 2006, with the release of the WHO *Global Age-Friendly Cities* project. Its aim is to promote active senior living and better health, through alterations in certain cities' physical and social environments. Four Canadian cities joined the project: Saanich, BC; Portage la Prairie, MB; Sherbrooke, QC; and Halifax, NS, along with 29 other cities around the world.

The WHO report , *Global Age-friendly Cities,* identified eight key topic areas that can help make communities more age friendly. 2007 saw the release of a Canadian-centred report, aimed at creating these age-friendly communities within smaller cities.[29]

Results are promising so far: in addition to increased age-friendly development within these cities, one Manitoba study found that life satisfaction and self-rated health were improved as a result of the changes.[30]

What more could be done?

Despite leading the agenda for proactive health measures, particularly on spending, the Canadian system isn't perfect. While the 6% target may be a starting point, it's by no means the be all and end all. Targeting interventions at those who need them most is crucial.

There are significant inequalities in access to, and quality of, services. When compared to OECD nations with similar healthcare systems, Canada ranked second to last for healthcare access and third for health equity.[31] There are significant inequalities in health outcomes, depending on various social health determinants: these include age, socioeconomic status, and being part of an Indigenous community.[32]

Compared to the general population, Indigenous Canadians are at greater risk of developing a chronic disease and have a shorter life expectancy. Indigenous Canadians are 3 to 5 times more likely to develop diabetes;[33] cardiovascular disease affects 7.1% of Indigenous Canadians compared to 5.0% of the general population.[34] In regions with a primarily Indigenous Canadian population, the average life expectancy is 11.2 years less than the Canadian average.[35]

Cumulatively, these stats indicate a clear gap in health equity and a lack of proper health resources for this demographic. The deficits are magnified for Indigenous communities that live in remote and northern areas. The age-standardised diabetes rate for communities living on reservations (17.3%) is significantly higher than that for communities that live off-reserve (10.3%).[36] This is in part due to a lack of healthcare access: emergency care and primary care clinics are prioritised, leaving fewer resources for preventative measures.[37]

Similar disparities can be seen with other demographic groups. Socioeconomic status has a strong correlation to poorer health outcomes. In 2018, on average, there's an 11.3 year difference in the life spent in good health when we compare the highest and lowest income groups.[34] Similarly, between 2011 and 2016 avoidable mortality rates ranged from 536 per 100,000 for the wealthiest group to 1616 for the poorest group.[38] These differences are also partially responsible for the health inequities observed in older Canadians. 1 in 5 older Canadians live near the poverty line; many struggle to access healthcare services.[39] This is exacerbated by low health literacy: 88% of older Canadians are considered as having low health literacy.[39]

Changes in how policy decisions are made can also help to bridge the health equality gap; one example might be the adoption of a "Health in all policies" mandate, which would require government departments to consider the health and social implications of all proposed policies.[40]

Healthcare access could be improved for older Canadians by investing further in targeted health promotion interventions. One promising intervention, conducted in various cities in Ontario and Quebec, is the Cardiovascular Health Awareness Program (CHAP).

Cardiovascular health awareness programmes

CHAP was first implemented in the early 2000s as several pilot projects in Ontario communities. Its purpose was to provide a low-cost community-based programme to identify and provide resources for adults at risk of developing cardiovascular disease.

Assessment centres were set up in public locations. Volunteers took blood pressure readings and completed risk assessment questionnaires with participants. Participants were provided with individualised plans of action; with their consent, their readings were shared with their primary care providers. Through this method, participants were given greater control of their health. In locations where access to primary care was limited, this assessment helped to identify at-risk individuals early on.

The programme was particularly beneficial for older Canadians (those aged over 65). One study found that the presence of CHAP in the local community was associated with a 9% decrease in myocardial infarction and congestive heart failure among older residents.[41]

What happens next?

We can take Canada's situation as a case study that shows spending on proactive health measures is effective. Canada's spending target is ambitious, but not unachievable.

But it's only a starting point. While Canada has been a world leader in investment in proactive health measures, it's far from perfect - there's still a lot to be done.

In the context of an ageing world, where inequalities are rife and still on the rise, countries around the world must continue to increase their spending on proactive health measures to support a long-term shift from 'illness services' to 'health services' and to promote healthy ageing throughout everyone's lives.

We call for countries across the G20 to invest at least 6% of their health budgets on prevention and promotion, and to continue increasing spending in line with population ageing and the rise in preventable diseases.

We must also ensure that this money is spent in the right places to ensure equity of access, an efficient, holistic and person-centred approach to healthcare, health literacy among the population, and good use of data.

Following the COVID-19 pandemic, the call for action is more urgent than ever. Health affects all parts of society. We can't afford to be complacent. We need to invest in proactive health measures now.

Recommendations

- Spend at least 6% of health budgets on proactive health measures, and continue to increase this in line with the rise in preventable diseases
- Target interventions to address the social health determinants associated with health inequalities
- Invest in health education and awareness programmes
- Take a 'health in all policies' approach that considers the health and social implications of proposed policies
- Adopt better policies and procedures for the collection and use of patient data to support the delivery of preventative and promotional services

References

[1]https://www.iwh.on.ca/what-researchers-mean-by/primary-secondary-and-tertiary-prevention

[2]https://www.canada.ca/en/public-health/services/health-promotion/population-health/implementing-population-health-approach/implementing-population-health-approach.html#health_pro

[3]https://ilcuk.org.uk/wp-content/uploads/2020/02/ILC-Prevention-report.pdf

[4]2019. United Nations. "World population projections. 2019 Revision". Available from: World Population Prospects - Population Division - United Nations

[5]2020. ILC-UK. "Never too late: Prevention in an ageing world". Available from: https://ilcuk.org.uk/never-too-late-prevention-in-an-ageing-world/

[6]2020. ILC-UK. "Never too late: Prevention in an ageing world". Available from: https://ilcuk.org.uk/never-too-late-prevention-in-an-ageing-world/

[7]Health equals wealth: The global longevity dividend - ILCUK

[8]https://www.who.int/news/item/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases

[9]https://www.novumlaw.com/services/medical-negligence/delayed-cancelled-treatment-covid-19/delays-to-diagnosis-treatment-due-to-covid-19/

[10]https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/cutting-through-the-covid-19-surgical-backlog

[11]G20 Leaders' Summit Declaration (2019) G20 Osaka Leaders' Declaration, www.consilium.europa.eu/media/40124/final_g20_osaka_leaders_declaration.pdf (accessed 1 December 2019)

[12]G20 Health Ministers (2019) Okayama Declaration of the G20 Health Ministers October 19-20, https://www.mhlw.go.jp/seisakunitsuite/bunya/hokabunya/kokusai/g20/health/img/G20Okayama_HM_EN.pdf (accessed 1 December 2019)

[13]GREEN PAPER ON AGEING - Fostering solidarity and responsibility between generations | EPALE (europa.eu)

[14]NHS Long Term Plan

[15]OECD (2019) Health expenditure, OECD Publishing, Paris, doi.10.1787/996c5659-en

[16]How much do OECD countries spend on prevention? | READ online (oecd-ilibrary.org)

[17]Naylor, C. D., Boozary, A., & Adams, O. (2020). Canadian federal–provincial/territorial funding of universal health care: Fraught history, Uncertain Future. *Canadian Medical Association Journal*, *192*(45).

[18]Glouberman, S., & Millar, J. (2003). Evolution of the determinants of Health, health policy, and Health Information Systems in Canada. *American Journal of Public Health*, *93*(3), 388–392. https://doi.org/10.2105/ajph.93.3.388

[19]MacDougall, H. (2007). Reinventing public health: A new perspective on the health of Canadians and its international impact. *Journal of Epidemiology & Community Health*, *61*(11), 955–959. https://doi.org/10.1136/jech.2006.046912

[20]Kirk, M., Tomm-Bonde, L., & Schreiber, R. (2014). Public Health Reform and Health Promotion in Canada. *Global Health Promotion*, *21*(2), 15–22. https://doi.org/10.1177/1757975913512157

[21]Health Care in Canada 2009: A Decade in Review. Retrieved 2021, from https://publications.gc.ca/collections/collection_2009/icis-cihi/H115-15-2009E.pdf.

[22]Birtwhistle, R., Pottie, K., & Shaw, E. (2012). Canadian Task Force on Preventive Health Care. *Can Fam Physician*, *58*(13). https://doi.org/PMC3263997

[23]OECD. (n.d.). Retrieved September 2021, from https://www.oecd.org/.

[24]Blum, A. (2014). The tobacco reliquary. *Canadian Medical Association Journal*, *187*(2), 133–134. https://doi.org/10.1503/cmaj.14123

[25]CBC News. (2012, November 19). A legal history of smoking in Canada | CBC News. CBC-news.Retrieved September 12, 2021, from https://www.cbc.ca/news/health/a-legal-history-of-smoking-in-canada-1.982213.

[26]Technical Report of the Ontario SimSmoke. (2012). Ontario Tobacco Research Unit.

[27]*Health: The high cost of diabetes*. OECD. (2012). Retrieved October 29, 2021, from https://www.oecd.org/newsroom/healththehighcostofdiabetes.htm.

[28]Bacon, S. L., Campbell, N., & Raine, K. (2019). Canada's New Healthy Eating Strategy: Implications for healthcare professionals and a call to action. *Canadian Journal of General Internal Medicine*, *14*(4). https://doi.org/10.22374/cjgim.v14i4.340

[29]Canada, P. H. A. of. (2016, March 29). *Government of Canada*. Canada.ca. Retrieved October 2021, from https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/friendly-communities.html

[30]Levasseur, M., Dubois, M.-F., & Généreux, M. (2017). Capturing how age-friendly communities foster positive health, social participation and health equity: A study protocol of key components and processes that promote population health in aging Canadians. BMC Public Health, 17(1). https://doi.org/10.1186/s12889-017-4392-7

[31]*Health: Provincial and Territorial Rankings*. Conference Board of Canada. (2015). Retrieved from https://www.conferenceboard.ca/hcp/provincial/health.aspx.

[32]Canadian Institute for Health Information, Health Care in Canada 2009: A Decade in Review (ON, CIHI, 2009).

[33]Walker, J. D., Slater, M., Jones, C. R., Shah, B. R., Frymire, E., Khan, S., Jacklin, K., & Green, M. E. (2020). Diabetes prevalence, incidence and mortality in First Nations and other people in Ontario, 1995–2014: A population-based study using linked administrative data. *Canadian Medical Association Journal*, *192*(6). https://doi.org/10.1503/cmaj.190836

[34]Foulds, H., Bredin, S., & Warburton, D. (2018). Cardiovascular dynamics of Canadian Indigenous peoples. *Int J Circumpolar Health*, *77*(1). https://doi.org/10.1080/22423982.2017.1421351

[35]Key Health Inequalities in Canada A National Portrait. (2018). Retrieved 2021, from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf

[36]Diabetes Canada Clinical Practice Guidelines Expert Committee. *Diabetes Canada 2018 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada*. Can J Diabetes. 2018;42(Suppl 1):S1-S325.

[37]Oosterveer, T., & Young, T. (2015). Primary health care accessibility challenges in remote indigenous communities in Canada's north. *International Journal of Circumpolar Health*, *74*(1), 29576. https://doi.org/10.3402/ijch.v74.29576

[38]Shahidi, F. V., Parnia, A., & Siddiqi, A. (2020). Trends in socioeconomic inequalities in premature and avoidable mortality in Canada, 1991–2016. *Canadian Medical Association Journal*, *192*(39). https://doi.org/10.1503/cmaj.191723

[39]Quesnel-Vallée, A., Willson, A., & Reiter-Campeau, S. (2016). Health inequalities among older adults in developed countries. *Handbook of Aging and the Social Sciences*, 483–502. https://doi.org/10.1016/b978-0-12-417235-7.00023-8

[40]Hancock, T. (2011). Health Promotion in Canada: 25 Years of unfulfilled promise. *Health Promotion International*, *26*(suppl 2), ii263–ii267. https://doi.org/10.1093/heapro/dar061

[41]Ye, C., Foster, G., Kaczorowski, J., Chambers, L. W., & Angeles, R. (2013). The impact of a cardiovascular health awareness program (CHAP) on reducing blood pressure: A prospective cohort study. *BMC Public Health*, *13*(1). https://doi.org/10.1186/1471-2458-13-1230

International
Longevity Centre UK

Vintage House
36-37 Albert Embankment
London SE1 7TL
Tel : +44 (0) 203 242 0530
www.ilcuk.org.uk

Published in November 2021 © ILC-UK 2021
Registered Charity Number: 1080496.