

The Coalition for Active Living

**Making the Case for a Crucial Role
for Physical Activity in the Future of
Canada's Health Care System**

Acknowledgements

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Making the Case for a Crucial Role for Physical Activity in the Future of Health Care in Canada is dedicated to the thousands of organizations and individuals that work towards a vision of a healthy, active Canada with passion and not much else in the trenches every day, many for decades.

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COALITION FOR ACTIVE LIVING

Working to ensure that the environments where Canadians live, learn, work and play support regular physical activity

I. Who We Are and What We Do

The Coalition for Active Living was founded in November, 1999 in response to the alarming low rates of physical activity among Canadians. The Coalition for Active Living is national action group advocating for health promotion /disease prevention and the broader determinants of health. The goal of the Coalition is to ensure that the environments where Canadians live, work, learn and play support regular physical activity. Together, members of the Coalition contribute financial and human resources to develop, implement and evaluate the outcomes of joint actions which will enable physical activity to be integrated into the lives of all Canadians. The Coalition's Six Point Plan for Action is included with this document.

Physical inactivity has been identified as a health care burden (Katzmarzyk, Gledhill & Shephard, 2000). It is a primary risk factor for both psychological and physical ill health, including many disease states that often originate during childhood years yet only become apparent in adulthood (Malina, 1996). Community-based initiatives promoting physical activity to prevent heart disease and diabetes have been found to be highly cost effective relative to traditional care (Tuomilehto et.al., 2001; Segal, Dalton & Richardson, 1998; Baxter et. al, 1997). There is also evidence from the exercise physiology and gerontology literatures that physical activity, in increasing seniors' levels of physical function, also functions to decrease dependence and the relative risk of admission to nursing homes (Guralnik et. al., 1994; Schroeder et. al., 1998). For example, an evaluation of the Program for All-Inclusive Care for the Elderly (PACE) in New York found that seniors attending day health centres offering nutrition, exercise and social contact in addition the usual range of seniors' health services, reduced their overall health care costs by 5%, compared to seniors receiving only conventional care. Included in this figure was a 34% decrease in hospital costs and a 70% reduction in nursing home utilization (Rachlis, Evans, Lewis & Barer, 2001).

Despite the irrefutable evidence linking physical activity with physiological and psychosocial health benefits for people of all ages (The Surgeon General's Call to Action, 2001; 1999; Bouchard, 2001), Canadians find little time in their daily life to be physically active. Approximately 57-64% of all Canadians are not active enough to reap such health benefits (Towards a Healthy Future, 1999; CFLRI, 1999). The situation may actually be much worse: it has been suggested that the activity rate of Canadians is inflated due to small percentages of the adult population accounting for a large majority of total participation in the 10 most popular activities (Barber & Havitz, 2001).

Further, evidence demonstrates that the least physically active Canadians are un- or under-employed, have lower incomes and education levels, are smokers, experience more stress, and have poorer overall health. Those who could benefit the most from including exercise in their lives, are the least active. Those with college or university education, high incomes and ‘professional’ jobs are most likely to be active and least likely to be sedentary (Frankish, Milligan & Reid, 1998). These are the individuals with the money, knowledge, organizational resources, support and motivation – the personal life skills - to engage in active living.

The Canadian Fitness Lifestyle Research Institute’s *Physical Activity Monitor* tracks Canadians’ participation in, as well as their attitudes toward and knowledge of physical activity. Of all the health practices needing change in their lives, exercise is the most often cited (Toward a Healthy Future, 1999). It seems that Canadians that know they should be more physically active, but concerns of cost, safety, time, accessibility, as well as a lack of culturally, gender, age and skill appropriate opportunities, thwart even the best of intentions. Many Canadians (30-40%) expressed difficulty in finding someone to be active with, or to find a program where they can participate with their children (CFLRI, 1999). Increasing outreach programs, creating social connections among people to be active, and provision of family-oriented services were recommended by Canadians as ways to increase their physical activity. Almost one-quarter of adult Canadians find their neighbourhood unsafe to exercise, citing traffic, crime, poorly lit and maintained side walks and cycling lanes as specific examples (CFLRI, 1999). Finally, nearly half of the families with yearly incomes below \$20,000 identify that high costs are a significant barrier to participation in physical activity (McCarger, 2000).

II. Moving Beyond Blaming Lifestyles to Understanding Life Circumstances

Canadian governments prioritize funding health care interventions based on the medical model and, to a lesser extent, fund interventions aimed at discouraging unhealthy lifestyles. The established course of action to promote health and prevent disease has been individually-focused and behaviourally-oriented. Gillies (1998) suggests that, at best, such programs are useful for only 25% of participants. Moreover, these program participants usually represent those who are more motivated, more wealthy and more educated. As Lyons and Langille (2000) argue, interventions aimed solely at “one-size-fits-all” individual behaviour change are limited:

Specifically, they have had only modest results; require individual or small group counseling and so entail high cost; require voluntary, sustained, and often intense effort on the part of the individual; and have limited impact on overall health because they usually focus on only one aspect of health . . . “Lifestyle” is an adaptation to one’s social environment. Unless lifestyle is constructed (as a category of intervention) in concert with the way that lifestyle is experienced by target group(s), interventions are unlikely to succeed (Lyons & Langille, 2000, p. 34; 42).

It has been estimated that only 5 of the last century's 30 added years to life expectancy can be attributed to clinical medicine (Bunker, Frazier & Mosteller, 1994). This is in spite of the fact that a minimum of 95% of health expenditures are spent on treatment and 5%, at most, are devoted to prevention (Brown et. al., 1992). As well, the limitations of the 'risk factor' paradigm approach, and the unsatisfactory results from community-based intervention trials aimed at their reduction have turned researchers' attention to explore what lies "upstream" (McKinlay, 2000). In contrast to the traditional lifestyle approach to health, the social determinants literature provides evidence that factors with the greatest impact on whether we develop life-threatening diseases are usually out of our personal control. They reflect lifestyle choices not of one's choosing, as they are fundamentally tied to culture and socio-economic status (Wilkinson & Marmot, 1998).

Many large-scale studies find that poverty, income and education levels, rather than medical and lifestyle factors, are better predictors of whether individuals develop diseases such as heart disease and cancer (Lantz et. al., 1998; Feldman et. al., 1989). In an attempt to understand the lifestyle behaviours of adult Finnish men, Lynch, Kaplan and Salonen (1997) found that poor adult health behaviours and psychosocial characteristics (sense of hopelessness, depression, lack of coherence or meaning in life) were more prevalent among men whose parents were poor, regardless of their socioeconomic standing as adults. The authors suggested that the environmental influences in childhood play themselves out later in adulthood. As such, the "free choice" associated with lifestyle behaviours may not be totally under an individual's control.

Supporting such a thesis, Chernomas (1999) argues that health habits, particularly exercise, smoking and diet, are less individual choices than they are a product of one's place in society. Rather than focusing on health practices as rational behaviours that one chooses to do at random, the notion of lifestyle is more useful once we understand the determinants of lifestyle choice – that is, what factors and conditions influence our lifestyle habits (Gillies, 1998). In 1998, the World Health Organization defined a healthy lifestyle as a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions and socioeconomic and environmental living conditions. With this definition in mind, Lyons and Langille (2000) offer the following determinants of lifestyle choice:

1. Personal life skills are those abilities for adaptive and positive behaviours that enable people to deal effectively with the demands of everyday life. Personal life skills include literacy, numeracy, decision-making and problem-solving, creative and critical thinking, empathy, mutual support, self-help and advocacy, communication and coping. These are not necessarily linked to specific health practices, but all contribute to helping people increase control over their life and health.
2. Perceived stress in life influences the choices people make about their lifestyle. In coping with the time pressures citizens face, Canadians report watching television, eating comfort foods, smoking cigarettes or consuming alcohol. In fact, 'health enhancing' activities, such as exercise, are perceived as even more stressful when time is limited (Heart and Stroke Foundation, 2000).

3. The influence of community norms and culture both reflect and limit lifestyle choice.
4. Control over one's life and a sense of coherence about the world enhance one's ability to choose the healthy behaviour over the unhealthy one.
5. A sense of belonging is critical to health. To a large extent, connectedness and belonging may overcome the traditional epidemiological risk factors of smoking, physical inactivity, obesity, poor nutrition (Putnam, 2000); risks which are more prevalent among those with lower incomes (Towards a Healthy Future, 1999).
6. The healthy choice in life is not always the most pleasurable and the benefits of healthy living are not always immediately reaped nor apparent. To make matters worse, persons living with low incomes are more likely to engage in risk behaviours as they provide respite from difficult and painful life situations (Stewart et.al., 1996).
7. Personality traits such as learned helplessness or individuals who are 'other' directed (believe that luck/fate is responsible for their lot in life) can discourage uptake of healthy behaviours.
8. Overabundance of choice and information about what is the 'right' thing to do can confuse and paralyze people rather than galvanize them into action.

While these determinants of lifestyle choice lie outside the traditional responsibilities of a medical model of care, a balanced model that includes both care and promotion/prevention must allocate its investments to shape supportive environments that encourage positive lifestyles. What interventions, then, are likely to succeed? Offord and others (1999) comment on the need for a combined clinical (tertiary prevention/downstream), targeted (secondary prevention/midstream) and universal (primary prevention/upstream) approach to the health interventions. Using criteria of effectiveness, reach, compliance and cost, Offord suggests that universal interventions are better than clinical treatment alone when the condition is quite common (e.g., high levels of physical inactivity), the treatment costs are large (e.g., to manage diabetes, obesity, heart disease), the preventive intervention is relatively inexpensive (e.g., walking trails, subsidized recreation programs, quality daily physical activity in schools, workplace facilities), and there is a high cure rate (e.g., an active life can lower blood pressure, increase aerobic capacity, control insulin levels etc.).

Moreover, the best investments in healthy lifestyles are community-based initiatives and strategies that improve basic living conditions and strengthen communities (Lyons & Langille, 2000). Social policies such as subsidized recreation and quality daily physical education (QDPE) and activity in school programs, reflect a population health approach (Toward a Healthy Future, 1999) and reduce health inequities (McKinlay, 2000). As your research team well knows "the solutions lie in social interventions, such as restoring and enhancing physical education programs in schools, building community playgrounds, or creating bike paths" (Romanow, 2001a). In B.C., the City of Surrey has created an urban environment supportive of recreational and commuter walking and cycling that increased the levels of physical activity (Hunter, 2001). Similarly, an American study found that the development of walking trails fostered active living among local residents,

particularly among its single parents who had previously led sedentary lives (Brownson et.al., 2000).

Yet, such simple solutions are simply disappearing. According to her recent review of provincial curricula, Luke (2000) found physical education was no longer required beyond grades eight (Ontario), nine (Saskatchewan, P.E.I. and Newfoundland) and ten (BC, Alberta, Manitoba and New Brunswick); only Quebec mandated PE until graduation. However, when implemented, effects of QDPE have been found to be significant and long lasting: A longitudinal study following elementary students who received either one hour/day of quality physical education or one hour/week, found that by the age of 30, those who had the former PE experience perceived themselves to be substantially healthier, and for women, those who exercised at least three times per week in strenuous activity was significantly greater than those who received one hour of PE per week (Shephard & Trudeau, 2000).

III. What Role for Health Canada?

Since 1974 with the release of the Lalonde Report and other landmark documents (Achieving Health for All; Ottawa Charter, 1986), the Canadian government has led international thinking in what makes people healthy. The emphasis on health promotion and disease prevention and its importance to the health care system have been strongly articulated but followed by a paucity of action. Currently, there exists but a few nationally organized and supported, mostly small and self-appointed, canoeists paddling upstream. The provincial ministers of sport, recreation and physical activity have set a target to reduce physical inactivity by 10% by 2003. Nonetheless, fiscal resources supporting active living initiatives, ParticipAction and Quality Daily Physical Education/Activity, have dwindled drastically from their original 'shoestring' budgets despite Health Canada's continued commitment to a population health orientation:

Since A New Perspective on the Health of Canadians first identified lifestyle behaviours as a primary determinant of health, many governmental and non-governmental programs have worked to change individual behaviours. This approach has worked for some – but less so for those lacking the requisite environmental, social and personal supports and resources. Efforts to educate individuals and build personal skills for change must now work hand-in-hand with efforts to structure an environment around the individual that supports healthy lifestyle decisions (Toward a Healthy Future, 1999, pg. 132).

While Health Canada has embraced a population health approach to its research programs and services, the health care system has not adopted such an orientation to the delivery of health care in this country. Admittedly, the long-term health outcomes of health promotion initiatives do not match well with political time lines and Canadians' groomed expectations for a 'magic pill.' A few years ago, public health argued that the social determinants of health are not known or understood by citizens (Lomas & Contandriopoulos, 1994; Millar, 1994; Federal, Provincial & Territorial Advisory

Committee on Population Health, 1994). More recently, it appears that Canadians do grasp that their health is broadly influenced by social and environmental variables, including issues of social support, supportive environments and income (Reutter, Dennis & Wilson, 2001). As such, Canadians may also appreciate the power that prevention and promotion serve to improve their health.

Prevention initiatives face the added challenges of: targeting multiple causes of disease within multiple sectors of society (unlike the biomedical profession which is the sole proprietor of categorizing diseases into distinct and distinguishable biologic pathways); and, relying mainly on policy changes and political acts. Finally, prevention and health promotion are mired in the “paradox of self-responsibility: Even if we know the power of regular physical activity with respect to physical and mental health benefits, formidable barriers may reside in our work, family, neighborhood, and cultural circumstances” (McGinnis, 2001, pg. 393).

If health care dollars are to be invested “according to a well thought-out plan,” and one that “will stand the test of time” (Romanow, 2001b), investments in health care and treatment must be balanced with investments in disease prevention/health promotion. This requires not only leadership from the federal government, but resources to implement both national policies and local efforts to create environments enabling physical activity to be integrated into the lives of all Canadians. With childhood obesity, and adult diabetes rising to epidemic proportions in this country, along with an aging population, physical activity is a cost-effective and efficacious strategy for curtailing spiraling health care costs and improving quality of life. The Coalition for Active Living applauds the Commission’s goal to balance investments in prevention and health maintenance with those directed at care and treatment. We also strongly urge the Commission to go even further ‘upstream,’ and consider universal and health promoting physical activity strategies and policies as part of the future of health care in Canada.

References

- Achieving Health for All, A Framework for Health Promotion. (1986). Ottawa: Ministry of Health and Welfare.
- Barber, N. & Havitz, M.E. (2001). Canadian participation rates in ten sport and fitness activities. Journal of Sport Management, 15, 51-76.
- Baxter, I. et. al. (1997). A cost effective, community based heart health promotion project in England: Prospective comparative study. British Medical Journal, 315 (7108), 582-585.
- Bouchard, C. (2001). Physical activity and health: Introduction to the dose-response symposium. Medicine and Science in Sports and Exercise, 33(6), 347-350.
- Brown, R., Corea, J., Luce, B., et. al. (1992). Effectiveness in disease and injury prevention - estimated national spending on prevention - United States 1988. MMWR, 41, 529-531.
- Brownson, R., Housemann, R., Brown, D., Jackson- Thomson, J., King, A., Malone, B. & Sallis, J. (2000). Promoting physical activity in rural communities - walking

- trail access, use and effects. American Journal of Preventive Medicine, 18(3), 235-240.
- Bunker, J.P., Frazier, H.S. & Mosteller, F. (1994). Improving health: Measuring effects of medical care. Millbank Quarterly, 72, 225-258.
- CFLRI. (1999). Physical Activity Monitor.
<http://www.cflri.ca/cflri/pa/surveys/99survey/99survey.html>
- Chernomas, R. (1999). The Social and Economic Causes of Disease. On line at: www.policyalternatives.ca
- Federal, Provincial & Territorial Advisory Committee on Population Health. (1994). Strategies for Population Health: Investing in the Health of Canadians. Health Canada Publications, Ottawa
- Feldman, J.J., Makuc, D.M., Kleinman, J.C. & Cornoni-Huntley, J. (1989). National trends in educational differentials in mortality. American Journal of Epidemiology, 129, 919-933.
- Frankish, C. J., C. D. Milligan, et al. (1998). "A review of relationships between active living and determinants of health." Social Science and Medicine 47(3): 287-301.
- Gillies, P. (1998). "Effectiveness of alliances and partnerships for health promotion." Health Promotion International 13(2): 99-120.
- Guralnik, J.M., Simonsick, E.M., Ferrucci, L. et. al. (1994). A short physical performance battery assessing lower extremity function: Association with self-reported disability and prediction of mortality and nursing home admission. Journal of Gerontology in Medicine and Science, 49, M85-M94.
- Heart and Stroke Foundation. (2000). Annual Report Card on Canadians' Health. Toronto: Heart and Stroke Foundation of Canada.
- Hunter, D. (2001). Physical activity and active transportation. Proceedings from Communicating Physical Activity and Health Messages, Science Into Practice, Whistler, BC, December 8-11, 2001, p 34.
- Katzmarzyk, P.T., Gledhill, N. & Shephard, R.J. (2000). The economic burden of physical inactivity in Canada. Canadian Medical Association Journal, 163(11), 1425-1440.
- Lantz, P.M., House, J.S., Lepkowski, J.M., Williams, D.R., Mero, R.P. & Chen, J.J. (1998). Socioeconomic factors, health behaviors, and mortality. Journal of the American Medical Association, 279, 1703-1708.
- Lomas, J. & Contandriopoulos, A. (1994). Regulating limits to medicine: Towards harmony in public- and self-regulation. In B. Evans, M. Barer & T. Marmor (Eds.), Why are Some People Healthy and Others Not?, pp. 253-283. NY: Aldine DeGruyter.
- Luke, M. (2000). Physical and health education curriculum: Cross-Canada perspectives. Canadian Association for Health, Physical Education, Recreation and Dance Journal, 66(2), 4-15.
- Lynch, J.W., Kaplan, G.A. & Salonen, J.T. (1997). Why do poor people behave poorly? Variation in adult health behaviours and psychosocial characteristics by stages of the socioeconomic life course. Social Science and Medicine, 44, 809-819.
- Lyons, R. & Langille, L. (2000). Healthy Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Ottawa: Health Canada, Population and Public Health Branch.

- Malina, R.M. (1996). Tracking of physical activity and physical fitness across the lifespan. Research Quarterly for Exercise and Sport, 167, 48-57.
- McCarger, L. (2000). Should the 1988 Canadian Guidelines for Healthy Weights be Updated? University of Alberta.
- McGinnis, J.M. (2001). Does proof matter? Why strong evidence sometimes yields weak action. American Journal of Health Promotion, 15(5), 391-396.
- McKinlay, J. (2000). US public health and the 21st century: Diabetes mellitus. The Lancet, 356 (August), 757-761.
- Millar, J. (1994). A consensus on the causal role of social factors in population health: Implications for action. In M. Hayes, L. Foster, & H. Foster (Eds.), The Determinants of Population Health: A Critical Assessment, pp. 201-206. Victoria, BC: University of Victoria.
- Offord, D., Chmura Kraemer, H., Kazdin, A., Jensen, P., Harrington, R. & Gardner, J.S. (1999). Lowering the burden of suffering: Monitoring the benefits of clinical, targeted, and universal approaches. In D.P. Keating & C. Hertzman (eds.), Developmental Health and the Wealth of Nations, pp. 293-310. NY: The Guilford Press.
- Physical Activity and Health: A Report of the Surgeon General. (1999). www.cdc.gov/nccdphp/sgr/sgr.htm
- Putnam, R. D. (2000). Bowling Alone, The Collapse and Revival of American Community. New York, Simon & Schuster.
- Rachlis, M., Evans, R.G., Lewis, P., & Barer, M.L. (2001). Revitalizing Medicare: Shared Problems, Public Solutions. A study prepared for the Tommy Douglas Research Institute. Vancouver, B.C. <http://www.tommydouglas.ca>
- Reutter, L., Dennis, D. & Wilson, D. (2001). Young parents' understanding and actions related to the determinants of health. Canadian Journal of Public Health, 92(5), 335-339.
- Romanow, R. (2001a). Paddling Upstream: Who Has the Canoe? Notes for Remarks - Canadian Public Health Association, Saskatoon, October 23, 2001. online at www.healthcarecommission.ca
- Romanow, R. (2001b). Reflections on Public Healthcare. Speaking notes - Oxford England, November 26, 2001. online at www.healthcarecommission.ca
- Segal, L., Dalton, A.C. & Richardson, J. (1998). Cost-effectiveness of the primary prevention of non-insulin dependent diabetes mellitus. Health Promotion International, 13(3), 197-209.
- Shephard, R.J., & Trudeau, F. (2000). The legacy of physical education: Influences on adult lifestyle. Pediatric Exercise Science, 12, 34-50.
- Schroeder, J.M., Nau, K.L., Osness, W.H. & Potteiger, J.A. (1998). A comparison of life satisfaction, functional ability, physical characteristics, and activity level among older adults in various living settings. Journal of Aging and Physical Activity, 6, 340-349.
- Stewart, M.J., Brosky, G., Gillis, A., Jackson, S., Kirkland, S., Leight, G., Pawliw-Fry, B., Persaud, V, & Rootman, I. (1996). Disadvantaged women and smoking. Canadian Journal of Public Health, 87, 257-260.

- The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.
(2001). Rockville, MD: U.S. Department of Health and Human Services.
- Toward a Healthy Future, the 2nd Report on the Health of Canadians. (1999). Prepared
by the Federal, Provincial and Territorial Advisory Committee on Population
Health. Ottawa, 1999
- Tuomilehto, J., et. al. (2001). Prevention of type 2 diabetes mellitus by changes in
lifestyle among subjects with impaired glucose tolerance. The New England
Journal of Medicine, 344(18), 1343-1350
- Wilkinson, R. & Marmot, M. (1998). Social Determinants of Health, the Solid Facts.
Copenhagen: Centre for Urban Health, WHO.
- World Health Organization. (1986). Ottawa Charter for Health Promotion. Copenhagen:
WHO Regional Office.

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COALITION FOR ACTIVE LIVING

Working to ensure that the environments where Canadians live, learn, work and play support regular physical activity

The Coalition for Active Living was founded in November 1999. Coalition members are committed to work together towards a healthy, active Canada.

1. What is the VISION of the Coalition?

The vision of active living in Canada is one in which Canadians value and integrate regular physical activity into their daily lives.

2. What is the Coalition's MISSION?

The members of the Coalition will work together to develop, implement and evaluate the outcomes of joint actions which will enable physical activity to be integrated into the lives of all Canadians.

3. What is the GOAL of the Coalition for Active Living?

To ensure that the environments where Canadians live, work, learn and play support regular physical activity.

4. What is the Coalition doing to take action on physical inactivity?

The Coalition has a six-point action plan (attached). The Action Plan identifies issues and recommends solutions decision-makers.

5. How do members of the Coalition work together?

The Coalition is not separate from its parts. It IS the membership and the participants. Members must have a commitment to the Coalition's vision, mission and goals. Leadership is provided by a Board of Directors, representing various regions and interests. Funding for the Coalition is provided by Health Canada. Members contribute financial and human resources to getting the job done.

6. What is important to the Coalition?

- shared leadership
- partnerships
- shared power and decision making
- empowerment and belief in the value of collective action
- need to be community-relevant through community participation
- need to be inclusive
- a multi-sectoral, multi-level approach
- accountability to the Coalition membership
- respect for the individual mandates of the members
- respect for the individuality and autonomy of each and every member
- respect for both official languages

- representation by volunteers, staff or both
- shared credit, effective communications and networking

7. Is there a fee to join?

No. Rather members will be expected to contribute human and financial resources to furthering the work of the Coalition.

8. I/my organization would like to become a member. How do I do that?

Go to the Coalition Website: www.activeliving.ca and sign on.

Board of Directors: 2001-2

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A Plan for Action

A. PREAMBLE

In order to determine the issues that the Coalition for Active Living could address, nationwide consultations were held from December 2000 to January 2001. Some 200 active living leaders across Canada were asked to identify

- (a) the most critical national issues relating to physical activity,
- (b) some effective and realistic solutions to these issues and
- (c) the specific actions that CAL could take in the short term.

The consultations affirmed the need for a strong national voice and an identification of five national issues:

- infrastructure
- Access
- Children and Youth
- Diversity
- Communication.

In April 2001, active living leaders from across Canada met to develop compelling descriptions of the five national issues; identify the evidence of the nature, scope and importance of the issues; propose policies and actions to address the issues; and identify decision-makers who could act on the proposed policies and actions.

Representatives from 38 organizations across Canada met in June 2001 to adopt the Plan of Action and to discuss ways of influencing key decision-makers to act on the six-point plan. They also determined that the Coalition should be defined as an “action” coalition whose only purpose is to advocate for and promote the Coalition for Active Living Plan of Action.

B. STATE OF AFFAIRS

Physical Inactivity: A Canadian Epidemic

During the 1970s and 1980s, Canadians embraced physical activity with enthusiasm and vigour. Throughout the 1990s, however, participation slackened alarmingly, and in all segments of the population. Today, the trend to physical inactivity is reaching epidemic proportions.

The irony is that most Canadians recognize the benefits of physical activity to their overall well-being, health, independence, and quality of life. They say they understand the vital role that physical activity plays in controlling the costs of health care. They acknowledge that physical activity has a positive impact on academic performance, youth behaviour, and workplace productivity.

Still they remain inactive, despite the many pitfalls of physical inactivity. One of the most compelling is the escalating incidence of childhood and youth obesity which has doubled in recent years. A major factor is the nationwide failure to adopt mandatory physical education in Canada's schools, despite widespread support for such action. Another factor is the failure to support initiatives that ensure other physical activity opportunities for our children.

Canada is not alone. In every country around the world where physical inactivity is a concern, efforts to promote healthy behaviours are clear on one point: even when citizens support a healthy lifestyle, they must first be educated about its value and second, must be assured of access to physical activities that are attractive and safe.

Why the Erosion?

The Coalition for Active Living knows why physical activity in Canada has steadily eroded over the past decade.

FACT: Physical education in our schools has been cut — drastically.

FACT: Physical activity opportunities during non-school hours have been cut.

FACT: Recreation budgets have been cut to a dangerous level resulting in fewer leaders, fewer training opportunities for those who remain, and reduced programming.

FACT: Poor maintenance of aging municipal facilities, workplaces, and schools has led to an inability to attract clientele or to adequately serve the needs of those who do come.

FACT: Schedules and programs fail to consider accessibility.

FACT: Safety factors and integration barriers prevent seniors and persons with a disability from participating in physical activity.

FACT: Fees for programs and facilities, both indoors and outdoors, discourage physical activity among the economically disadvantaged.

FACT: Programs and facilities fail to keep up with changing cultural and demographic trends.

FACT: Transportation and urban planning are designed for cars, not legs, creating environments that fail to support and encourage active living.

FACT: A motivating media campaign that portrays physical activity as the norm and shows how easily a physically active lifestyle can be achieved is not in place.

FACT: Governments, health professionals, service providers, and the media fail to provide consistent messaging about the values and varieties of physical activity.

Stamping Out the Epidemic

The Coalition for Active Living calls upon parents, health care professionals, and decision-makers at all levels, public, private, and non-governmental sectors to stamp out the physical inactivity epidemic.

Because this issue is on a par with the plagues of tobacco, drug abuse, and HIV/AIDS, physical inactivity demands open and frank discussion backed by a meaningful allocation of resources and a six-point action plan.

C. A SIX-POINT PLAN OF ACTION FOR A PHYSICALLY ACTIVE CANADA

POINT 1

Establish national, targeted, ongoing, and state-of-the-art communications for distribution to the media and advertising agencies. Develop messages that are consistent, reach all levels of the population, and strongly promote specific opportunities for physical activity where Canadians live, learn, work, and play.

POINT 2

Implement a comprehensive plan to educate children and youth about the importance of physical education and how to access activity within the community in order to make healthy lifestyle choices.

POINT 3

Advocate for new and upgraded transportation systems that include the creation of safe, effective, and accessible paths and networks for cycling, walking, and wheeling.

POINT 4

Advocate for the removal of barriers to publicly funded facilities and programs. Address unaffordable fees, poorly maintained facilities, reduced schedules and programs, diminished human resources, and the ever-increasing cultural diversity of activity interests.

POINT 5

Advocate for adequately funded health promotion and for physical activity to be recognized as a priority to be integrated into a wide range of community health initiatives.

POINT 6

Advocate that employers adopt policies that promote, support, and reward physical activity in the workplace.

The Coalition for Active Living pledges to urge elected officials and decision-makers in health, education, recreation, and business to develop and adopt policies that will stamp out the physical inactivity epidemic.