ALBERTA'S ENERGY LEGACY

Ideas for the Future

edited by

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In 1970, the One Prairie Province Conference was held in Lethbridge, Alberta. Sponsored by the University of Lethbridge and the Lethbridge Herald, the conference received considerable attention from concerned citizens and community leaders. The consensus at the time was that research on the West (including BC and the Canadian North) should be expanded by a new organization. To fill this need, the Canada West Foundation was created under letters patent on December 31, 1970. Since that time, the Canada West Foundation has established itself as one of Canada's premier research institutes. Non-partisan, accessible research and active citizen engagement are hallmarks of the Foundation's past, present and future endeavours. These efforts are rooted in the belief that a strong West makes for a strong Canada.

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Chapter 8

An Apple a Day: Creating Demand for a Disease Prevention and Health Promotion System

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This chapter contemplates a curiosity. Albertans, like most Canadians, feel entitled to health care and are passionate about it, but they do not seem to have the same thinking about prevention. If they did, we would be forced to be more responsive to their needs and the health of the population could be radically improved.

This chapter outlines ways to reorient the current system more toward disease prevention, health promotion, and wellness. The ideas rest on the premise that to improve any system we have to amplify feedback about its current level of performance, in this case with regard to who is currently benefiting from prevention policies and programs and who is not. The true power for sustained change lies in enabling the people of Alberta to better scrutinise the way their health destinies are shaped by policies and decisions right now. We present a bold new future with a new kind of disease prevention and health promotion system, one that works across all sectors of government and community and provides structural economic incentives for all kinds of constituencies to provide the type of environments in which health thrives. This makes health promotion and disease prevention everybody's business and in everyone's interest. Responsibilities and contributions must work at many levels. But it is not complicated. Good health is within remarkably easy reach. The greatest mechanism for health improvement is a new, broad-based integrated system to tackle the diverse determinants of health, alongside increased accountability to those whom we profess to serve. This is not only possible in Alberta at present, it is imperative that we make it happen.

ON July 24, 2007, *The Banff Crag and Canyon* carried a story about the Calgary Health Region introducing a policy that would reduce heart disease rates by up to 22% ("Health region pushing trans fat ban"). It was not an announcement of more hospital beds or the adoption of new technology. The idea was to avoid premature deaths through prevention—by stopping people getting sick in the first place. The policy called for the elimination of trans fats in the cooking oils used in restaurants located in the region. This is good news, but only for those who dine in the Calgary Health Region.

In August 2007, Statistics Canada released a study showing that workplaces that have smoke-free policies have double the number of smokers quitting smoking for good compared to workplaces where there are no restrictions on smoking (Statistics Canada 2007). Given that a smoker who quits can increase his or her life expectancy by as much as nine years, this is another example of a preventive policy that saves lives (Tsevat 1992). However, some people benefit from it and some don't; it depends on where you work.

Sound fair? Probably not. Canadians care deeply about, and have high expectations of, the health care system. If medical science has a treatment for an illness, we feel entitled to it when we get sick. But if prevention science has a means to avoid us getting ill in the first place and yet local authorities do not provide that means, we don't make a fuss. Why? Because most of the time we simply don't know what we are missing.

The task the Canada West Foundation set the authors of this chapter was to come up with an idea that could be used to transform Alberta in terms of the province's approach to wellness, health promotion, and disease prevention. What would place us out in front in Canada and internationally? We were told to look for ideas that go beyond more money for existing programs. More of the same was not acceptable.

Lots of people we spoke with had suggestions. Eliminating poverty, concentrating on disadvantaged youth, focusing on depression (especially among mothers such that the impact would be felt on a generation of children as well), and addressing issues related to the aging of the population were all mentioned.

These are all worthy ideas. But to make a lasting difference on any or all of the health dimensions of these problems we need to shift to higher order thinking. Tackling one problem well in 2007 or 2008 is not going to make lasting difference to a system that perpetuates neglect of preventive health issues in the first place.

To make a lasting difference with this "blue sky" opportunity, we have to address a more fundamental issue: Canadians don't feel entitled to disease prevention and health promotion in the way that they feel entitled to health care. If they did, the whole population might be a lot healthier because the system would have to bend to meet this new consumer demand.

But if we create demand for policies and practices that prevent disease, could the demand be met? Yes. How to promote health and prevent illness right across our population is not a secret. A lot of the science and expertise is already in place (Zaza 2005). Alberta already has some first rate practitioners in the field. It is not a future 10 years hence. It is also not a future dependent on a new technological or genetic breakthrough. It is a future within reach right now if, alongside the creation of demand for prevention, we invest in some tools to build the capacity of the current system to respond.

We start this chapter by sketching some background about health and health promotion. We then outline vital new strategies to reorient the health system toward prevention and health promotion and to harness sectors outside the current health system for the purpose of averting disease and promoting health. This broader arena constitutes the currently untapped prevention and health promotion system. We conclude by reviewing the Alberta we could become.

Disease Prevention, Health Promotion, and Wellness

Practitioners, researchers, and students in the fields of disease prevention, health promotion, and wellness make fine-grained distinctions between what the various terms mean. Put simply, success in disease prevention means that fewer people have heart disease, cancer, and so on. But that achievement does not really capture the full dimensions of health. According to the World Health Organisation, health includes complete physical, mental, and social well-being, not just the absence of disease (Nutbeam 1998). A spiritual dimension is also recognized. The more one moves toward

the notion of well-being, the more the spiritual and holistic dimensions are emphasized, along with a positive sense of connection and contribution to one's own life and to that of others. In other words, health is both an individual and a community concept.

Some people embrace these ideas as a philosophy. Others need cold hard facts. Happily, since the 1970s, there has been no shortage of studies that demonstrate unequivocally that individual and community health and well-being are inextricably linked. Regardless of an individual's personal risk factors (meaning things like their age, gender, genetics, income, education, employment and lifestyle), health status is additionally determined by where people live (Kawachi 2003). Sometimes the reason for this is obvious. Living next to a hazardous waste dump has a direct effect on health, for example. But so too does living in a neighbourhood which is physically unattractive, unsafe, covered with graffiti, and lacking good schools, parks and places to shop. These types of social contexts seem to erode people's well-being and affect their health even if, ostensibly, their income, education, job and lifestyle might together spell better things for them. In Alberta, for example, a database kept by heart surgeons on people who have undergone cardiac catheterization shows that low income patients have poorer survival rates and lower quality of life scores after a stroke if they live in low income neighborhoods, but not if they live in high income neighborhoods (Southern 2005). Community context matters.

What does this mean for disease prevention and health promotion? It means that the most effective ways to promote health work on two levels simultaneously—at the *individual* level (to improve a person's health related choices) and at the *environmental* level (the places in which we live and work and the policies that affect these). Countries which are ahead of Canada in terms of health promotion are the ones that have taken the policy approaches at the environmental level seriously—being first off the mark, for example, when it came to seat belt laws and the impact on road deaths, bicycle helmets and the impact on head injuries, shade shelters and the impact on skin cancer rates, and restrictions on the use of cell phones in cars and the impact on motor vehicle collisions (Hawe 2001). A national study in the US aptly entitled *The State Sets the Rate* illustrates how the extent of state-level alcohol control policies determines the proportion of people binge drinking (Nelson 2005). In short, if supportive preventive policies are in place, health thrives.

Other examples include: making fresh food available at schools; providing gyms and childcare at work; making our streets safe and walkable; and ensuring smoke free restaurants, shops, and workplaces. *A Framework for a Healthy Alberta*, a plan developed by Alberta Health and Wellness after the Mazankowski Report (Government of Alberta 2002) calls this "making healthy choices the easy choices." It is an approach successfully adopted by jurisdictions around the world (World Health Organisation 1991). The policies do not just benefit the people encouraged to change their lifestyle. We all benefit because we would all otherwise pay the costs—for the treatment of head injuries, lung cancer, diabetes, stroke and so on. That part is not a choice.

How much effort is put into health promotion and disease prevention right now? Not much and not enough. In any given health region in Alberta, only a small number of full time staff will be responsible for designing, implementing and evaluating programs to prevent disease and promote health. About 2% of the total health care workforce is responsible for programs in areas like healthy living, wellness, school health, prenatal and postpartum education and care, disease surveillance and environmental health.

Funding for prevention programs is not guaranteed. Permanent staff often write grants for temporary staff to run particular programs—like a one-year program for substance abuse prevention among school children, or a two-year program for health information and health skill building among newly arrived refugees. These types of programs are not considered routine care (i.e., mandated so that they are always delivered). Instead, the case for having special programs has to be made annually or biannually and a grant written to obtain the funds from private foundations or provincial authorities.

It is a risky business. Funds may not always be available. Sadly, this kind of system is what has sufficed for health promotion and disease prevention up until now. We acknowledge that it has produced some outstanding programs. Take, for example, the success of a team in Edmonton with a falls prevention program for seniors living in the community. It produced a relative reduction in falls of 26% overall and 42% among those with highest risk (Robson 2003). But uncertain funding means that performance overall is always destined to be patchy and not guaranteed. Effective programs often end or are never even implemented. It would be like if we decided to run our health care system by only treating people with diabetes or breast cancer in some years and not others. Or if we made our surgeons write grant proposals every year in order to

fund all the hip replacements they wanted to do. The health care system does not run this way and neither should the prevention system.

We are not the only ones to neglect our power to prevent distressing and premature illness and death. Dr. Michael McGinnis led the development of the US prevention agenda as former Assistant Surgeon General for almost 20 years. He lists several reasons why prevention and health promotion has to work constantly against being put on the back burner, even though evidence for its effectiveness is strong. It includes our society's "technophilic culture" whereby we favour high-tech and dazzling solutions which bring about dramatic results in individuals, but we yawn at the diverse, small, and integrated ways to prevent problems in the first place. He gives the example of a spinal chord injury in a teenager who has been in a car crash after drinking at a party. This represents an immediate and straightforward therapeutic challenge for the heroes in the health system. However, the work to prevent the injury occurring in the first place requires the long haul engagement right across the system of car manufacturers, police, schools, liquor retailers, community groups, the media, and even city planning and zoning officers (McGinnis 2001). No jurisdiction it seems has ever really faced up to this type of multifaceted against-the-odds challenge in prevention and health promotion, but Alberta can and Alberta should.

Four Strategies for Change

To care about something the public first has to know about it. The people responsible for delivering health promoting programs and policies also have to be empowered to improve them and shape them to community needs. The impetus to reorienting any system is to *amplify the feedback* about current performance and bring expectations about accountability to the surface.

1. Create demand for prevention by measuring, mapping and communicating the current distribution of preventive policies and programs

The advent of geographic information systems software has allowed health and social planners to map the distribution of all kinds of phenomena. So imagine how powerful it

would be if, alongside maps of the distribution of smoking rates rate by neighbourhood or obesity, premature mortality, or per capita prescriptions for depression, our analysts were mandated to report on the distribution of health promoting polices and practices (including what is known about their costs and impacts). Imagine how much easier it would be for the public to claim their entitlement to prevention if they could see how unequally policies and programs such as smoke-free public places, affordable housing, early childhood development centres, fresh cheap food, confectionery-free schools, family-friendly workplaces and so on were currently distributed (so that people could see the help they were not getting).

"Geography is destiny" is an old saying. If this was made more public it would be political dynamite, not for the factors the public tend to think they cannot change (who they are and where they live), but because such maps would expose the inertia of the current system in allocating the resources that could alter those destinies (Hawe forthcoming).

Data is the new mantra in business. *Competing on Analytics* is the new source book for companies and even sports teams making tough decisions with limited resources (Davenport 2007). The competitive edge comes from being able to recognise and respond to trends in a way that is not possible if a company is "analytically impaired." Right now the prevention system is analytically impaired and studies of health decision-makers in Alberta show that they are frustrated by it (Shiell submitted).

It would not be hard to build a new data system that mapped the distribution of healthy policies and programs. We have the design capability. We also have the commitment from diverse inter-sectoral agencies to take part. There are precedents in other countries to list or "stock take" their healthy public policies in some fields. But no one has taken the next step to do so routinely and comprehensively and make the information available to the public. Data pooling and data sharing agreements are being devised in the province to map understandings of health and social problems, but not yet the solutions in place to tackle them. Alberta would be the first, thereby setting a whole new landmark in accountability.

The time to act is now. Dr. Paul Veugelers at the University of Alberta, for example, has demonstrated that children in schools with coordinated programs and policies for

healthy eating have healthier diets and significantly lower rates of overweight and obesity than children from schools without nutrition programs (Veugelers 2005). If that is the case, should not every parent be entitled to know if the school that their child attends has the right program? Should not all our schools be assisted to meet the grade in this regard?

2. Make new investments in evaluation and quality improvement in prevention

Unfortunately, just as health promotion and disease prevention are neglected, so too are the research and development that should accompany it. For many programs, we simply do not have sufficient evidence to know whether they are working well or not. Therefore, the second strategy is to ensure investment in evaluation and quality improvement. These are accepted as basic tenets of good practice in most sectors.

The same is true in health promotion, but in this instance there is also an ethical imperative to evaluate. Some interventions in disease prevention and health promotion have done more harm than good. Rather than turn children off drugs, some drug-abuse prevention programs have increased their use (Berberian 1976). Some driver education programs have increased crash rates (Robertson 1980). Some suicide prevention programs have increased the number of suicides (Rosenman 1998). The problem is a combination of good intention coupled with ignorance about the field of prevention science. People mean well, but many do not know the difference between a sound program and one likely to be unsound.

The proliferation of poor programs is potentially greater in Alberta where there is wealth, because it is easier to make a charismatic "sell" for a program direct to donors and foundations, by-passing available expertise of people with the training to detect harmful programs or predictable failures. The tendency for medicine to be seen as science, but prevention to be seen as charity, has made some people feel that rigorous assessment of well meaning programs is not warranted. Practitioners shy away from evaluation, for fear of what it might uncover. Fundraisers understandably also tend to be nervous of anything that might undermine donor confidence. This unwittingly builds a fragile, self-serving system when something far more robust is deserved and possible.

In health care, we readily accept the premise that drugs and new technologies have to be tested. The same is true in prevention, wellness, and health promotion. At any one time, perhaps as much as one half of all the new programs we try might not work. There is, however, no shame in failure. The shame lies in not having a means in place to evaluate the impact of new programs and adjust the course of action accordingly.

The system boost required in this regard would start with the mapping process outlined in strategy 1 (above) and the application of the classification system to rate program and policies on likely effectiveness—based on existing published evidence. This would identify programs and policies that are promising enough to warrant new investment in evaluation. To produce this information well, research and evaluation partnerships between practitioners and university-based researchers are needed. Emphasis should be placed on methods which strengthen the role and contribution of practitioners and communities themselves in the evaluation process (Fetterman 1996).

3. Open pathways to enable the switch from ineffective programs to effective ones with new customized decision-support tools

We anticipate that the two strategies mentioned above will uncover some uncomfortable information. For example, Dr. John MacLennan at the University of Calgary recently published a census and review of all the group-based education programs offered in the field of parenting in an Ontario city about the size of Calgary. Parenting programs are hugely important for providing information and developing parental skills in diverse areas such as nutrition, safety, social skills, reading skills, and behaviour problems. The research team found that none of the 12 programs offered by the various agencies across the city had any evidence of effectiveness to support them (MacLennan 2006). However, there were at the same time several programs in existence that were of proven effectiveness that could have been offered in their place.

This is likely to be a common scenario in many Canadian cities. Entrenched ineffective programs continue unchallenged for historical reasons, doing a disservice to the people who attend them, wasting the money of the people who fund them, and, ultimately, demoralizing the people who provide them. On its own, this kind of feedback has the potential to be quite paralyzing. But imagine if one was able to show that for the same investment of resources (or possibly even less), effective programs could be put in their

place. The constituency would still be served, a better product would be in place, and health gains would be more likely.

Managers of health promotion need concrete tools that enable them to translate evidence about the likely effectiveness of their programs directly into a set of decisions to redeploy their resources more beneficially. This might include web-based "calculators" into which decision-makers could plug local information about the prevalence of the problem they wish to address; the likely effect of the program being considered; local contextual factors likely to boost or dilute the program effect; and the costs of critical inputs such as staff and administration. Together, these would then be used to calculate the savings and health gains to be realized by transferring resources from the less effective programs to the more effective programs.

The process of scrutinizing the current allocation of resources would start within specific service areas, such as programs directed at children and youth. The aim initially might be to see where resources might be reallocated within this service area in ways that improve health at no extra cost. Then another area could be tackled, such as seniors. We could then move on to look at what extra money flowing into the field could buy in terms of health gains. Reallocating resources between service areas, could also be considered (i.e., taking resources from relatively ineffective activities in one area in order to provide more effective services in another area). In this way, moving through all population groups, this strategy would transform the face of our investments in prevention and health promotion.

4. Create "healthy strings attached" economic incentives to provide prevention policies and supportive environments for health across sectors and government departments

Incentives have always had a role to play in improving health. Family doctors in some parts of Canada are eligible for incentive payments if they provide services such as counseling for smoking cessation, colorectal screening, or diabetes management based on recommended guidelines (Ministry of Health 2006). Since January 1, 2007, Canadian families are eligible for a small tax break if they participate in authorized physical activity programs (Canada Revenue Agency 2007).

Such policies have their place, but they are often expensive and not always effective. We often end up giving money to people who would have undertaken the behaviour in any case. Incentive payments can simply set up a transfer mechanism whereby private sector providers earn more for supplying existing services to the same groups of people (generally people with higher socioeconomic status). Hence, little true change is brought about. If anything, health inequities are increased.

Part of the problem is that most ideas about using incentives to improve health have been narrowly construed. Schemes have been confined to the health sector. But if the evidence of the last 100 years and more is true, and the primary roots of a population's health lie in factors like education, housing, employment, job control, and a personal sense of meaning or coherence (Evans 1994), then our ideas about health incentives will have to become a lot more imaginative. *To have a major impact, we have to look beyond incentives that encourage individuals to be healthy and consider how best to encourage governments, the business sector, and the nonprofit sector to provide the type of supportive environments that benefit everyone.*

Governments, businesses and nonprofit organizations have capabilities and responsibilities to help create a healthier Alberta. The problem is that what is good for Alberta may not always seem good for particular individuals, employers, organizations, or government departments. Early childhood development programs, for example, are typically funded out of the health budget, but they have their greatest impact on improving educational achievement and reducing crime and delinquency. Rigorous enforcement of traffic laws reduces road injuries and benefits the health sector, but costs are born by the police force. Friction and non-cooperation can arise whenever one sector pays the cost, but another sector reaps the benefits. We therefore need to think more systematically about incentives and try to bring into line costs and benefits across all sectors so that promoting health really does become everyone's business and in everyone's interest.

This is an ambitious agenda that requires bold action. It means more than establishing cross-governmental committees in an effort to break down departmental silos that allow one department to say "that's your problem" and another to say "no it's yours." We need to assign responsibility for disease prevention, health protection, and health promotion so that a government's every policy—on employment, education, trade, housing, criminal

justice, welfare and so on—is recognized as potentially affecting public health and is scrutinized according to its affect on the health and well-being of all Albertans.

The Public Health Agency of Canada is encouraging inter-sectoral action in health, based on a review of experiences from 15 countries (Public Health Agency of Canada 2007). Alberta has the capacity to shine at this, given our successes so far, such as the recent groundbreaking data sharing agreement among nine government departments that has been secured in the field of children's health, education, and well-being (Alberta Centre for Child, Family and Community Research 2007). This sets the example of the type of infrastructure needed to track the impact of our policies. It shows that people here have the leadership, confidence, and commitment to do things better by working together.

Pilot projects on structural incentives for prevention could start within the health sector immediately. Our hospitals are major generators of local economic activity. They employ large numbers of people and spend lots on supplies and services. Many other businesses—food outlets and new housing developments for example—wish to locate near them to benefit from their activity. City councils could work with health regions to introduce a "healthy strings attached" zoning policy that would require businesses benefiting from the health sector's location and spending to be healthy-employers with smoke free workplaces, support for smoking cessation, family-friendly employment policies, payment of a living wage, and showers and cycle sheds to encourage people to leave their cars at home. We could require that all contractors wishing to work with a health region would need to demonstrate how they were addressing the health needs of their own workforce by way of policies and programs that are known to be effective.

These sorts of incentives and requirements change social norms. In Australia, for example, for the last 20 years sponsorship of sporting teams and grants to community groups from health promotion foundations in two states have had conditions attached that require agreements to promote healthy policies (Health Promotion Journal of Australia 1993). Sporting venues have to be smoke free and offer healthy food choices and low alcohol beverage choices. Sporting clubs have to provide the means for low income and ethnically diverse groups to take part. Community groups that attract grants to build shade shelters in neighbourhood playgrounds have to require that the building contractors who win the contract follow sun protection policies for their workers. The

effect of such polices is impressive. In Canada, skin cancer has increased by 30% in the last 10 years ("New cases of skin cancer…" 2006). Australia is the only country where rates are going down (The Cancer Council of Australia 2006). Prevention is becoming entrenched as a way of life.

In addition, we could decide as a province that private sector spending on workplace health promotion programs and policies of *proven effectiveness* should qualify for tax deductions. Rather than being a cost to the employer, being able to showcase their investment in employee wellness should add competitive advantage in today's tight labour markets. With our new tracking system on healthy policies and programs by geographic area we should start to see a domino effect whereby these "health zone precincts" start to influence neighbouring workplaces and businesses, with the consequent impacts on health and well-being detected in the regular population surveys that our health regions currently undertake.

Conclusion

Sir Norman Gregg was the doctor who first observed the relationship between German measles in pregnancy and deafness in newborns, which led the way to the development of the rubella vaccine more than 60 years ago. He made the comment that:

> "Epidemics that used to be excused as acts of God are now not excused as the results of the inactivity of mankind. In short, the incidence of many diseases has moved from the area of chance to the area of choice" (Gregg 1949).

Although the choices of individuals matter, the organized efforts of society that shape those choices matter more when it comes to controlling disease rates. That is the observation about public health that Gregg was making, and it still defines the field of public health today (Acheson 1998).

Our vision for a healthy Alberta depends on tapping individual responsibilities *and* collective responsibilities, as well as relying on mutual help rather than self help. Our strategy starts first and foremost with arming a powerful force with hitherto unrevealed

insight: ordinary Albertans. It is totally unacceptable that knowledge exists today that could improve the health of Albertans directly that is not being put into practice effectively or equitably.

The strategy we offer is simple. Make current practice visible and accountable to increase public demand for health promotion and then provide the expertise, information, incentives and pathways to help the system respond to this increased demand. Advocacy for prevention, health promotion and wellness would become commonplace. The opportunity to make a *sustainable* difference to the issues raised in our introduction—youth, depression, poverty, seniors, and more—would thus be created. Transparency. Accountability. Opportunity. Fairness. These are things that matter to Albertans. This is what our strategy provides.

We will need to establish a new, well-placed structure or entity to enshrine the vision of change and further the ideas we hope will come forth in the ensuing dialogue. The role is to lead, enact, implement and evaluate the system's transformation and increase the public profile of prevention, health promotion, and wellness.

Using revenue generated by a large non-renewable natural resources endowment fund would provide a firm foundation for this transformation and set Alberta on the path to becoming a world leader in the areas of disease prevention, health promotion, and wellness.

In pointing out what we could do, and what we should do, it is also important to point to what would not help. Prevention and health promotion require pervasive system-level change and sustained support. What we do not need is a new body set up to give out short-term health promotion and wellness grants to agencies and groups. This tends to prioritize innovation at the expense of the ongoing provision of high quality, effective programs and services, and gives preference to short-term objectives over long term-change. Lack of money is not the problem in Alberta. Lack of *sustained* capacity is.

The current health workforce, spread as it is currently throughout health regions, schools, school boards, municipal government, community groups and private agencies will need to be better supported, funded, trained, facilitated, challenged, empowered, celebrated and prized. They are more than the "delivery system," they are its change agents. A first class disease prevention and health promotion workforce could become our hallmark, the jewel in Alberta's crown—the reason to move or stay here, to study here, to make a contribution here. The universities will also be required to step higher in many of the new roles that are already emerging, such as in public health research and teaching, and in the establishment of inter-disciplinary research alliances with health regions, municipal governments, and school boards.

The challenge of this book was to focus on transformative ideas—not simply tinker on the margins or add more programs into the mix. We have not costed-out the ideas presented here. That is a further task. The point is this: the resources we need to reorient and recalibrate our health system to enable it to better encompass prevention are nothing compared to the resources we will gain—healthy people leading socially and economically productive, creative and enriched lives.

Finally, it is worth remembering that the greatest resource people ever have to solve any problem is how they think about it. The ideas presented here and the conversations we hope will ensue are designed to change the way we as a community think about health and our future entitlement to it. Changing thinking is what changes history.

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saving for what?

Most people in Alberta understand the value of having the provincial government save some of the non-renewable resource revenue it collects for future use. The provincial government has responded by stashing away money in a variety of endowments and by adding to the Heritage Fund. But without a clear sense of what the money will be used for, it is difficult to get Albertans excited about a more aggressive savings program. Rightly so, saving for the sake of saving does not make a lot of sense—you can't take it with you and there are pressing needs facing the province right now. If we are saving for a rainy day, many argue that it is time to break out the umbrella.

As a result, it is hard to justify delaying gratification and saving more for the future. Albertans need and deserve a sense of what the earnings on a super-sized Heritage Fund would be used to achieve. They need a sense of what is possible. That is where this book comes in. It presents ten ideas for how Albertans could use the money generated by a larger savings fund to permanently transform the province in positive ways.

It is up to Albertans to decide where they want their province to go. The ideas found on these pages will help them answer this critical question and they will help them determine if saving for this future makes sense.

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