

HEALTH & SOCIAL WELFARE POLICY TO IMPROVE
THE POPULATION'S HEALTH: THE SCOPE OF 'NEW PUBLIC
HEALTH' IN CANADA'S PROVINCIAL AGENDAS

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Canada's leadership in population health promotion has been internationally acclaimed, especially in the years following the 1986 endorsement of the *Ottawa Charter for Health Promotion* by Canada's National Health and Welfare Department, the Canadian Public Health Association and the European Region of the World Health Organization. The Ottawa Charter recognized that health promotion goes beyond the health care sector and promoting healthy lifestyles, to introducing changes in all government sectors in order to alter social conditions associated with poor population health and to improve 'population health and well-being' more generally. The principles of the *Ottawa Charter* have since then been endorsed by 27 countries and are supported by a research infrastructure to study how social conditions determine health outcomes. The Canadian federal government has demonstrated significant international leadership in health promotion and the new public health for many years.¹

The main efforts of public health are directed at improving the population's health through protecting health (such as food and water safety), monitoring the population's health, preventing diseases and injuries and managing epidemics. But efforts undertaken since the mid-1980s comprise a broader view of health, inclusive of well-being, and refer to a certain understanding of the ways in which lifestyles, living conditions and health outcomes are interconnected.² In addition to the

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¹ Kickbush, 2003, pp. 383-388.

² Idem, *Ibidem*.

The Price of Life. Welfare Systems, Social Nets and Economic Growth, Cidadania, Lisboa, Edições Colibri/CIDEHUS/UE, 2007, pp. 29-51.

core functions of public health, 'new public health' approaches seek to create environments that are supportive of health.³ In a nutshell, the new public health aims to improve general policies, programs and services which create, maintain and protect health and well-being, such as income security, a good education system, a clean environment, adequate social housing and community services, with an emphasis, in principle at least, on reducing both poverty and social inequalities.⁴ Its vision can well be described as a combination of health and social welfare policy.

The new public health is sometimes considered a form of 'health imperialism' or of 'social engineering', and can appear as a very ambitious, if not purely idealistic concept. Indeed, the WHO definition is difficult to use as the basis for health policy because it basically includes all policy as health policy.⁵ This implies that it fosters 'health' interventions in sectors which are not under the purview of health ministries and over which little power can be enforced, not to mention that other governmental sectors may pursue priorities which leave little room for considerations about the population's health. Similarly, it is not politically and economically neutral, as its successes entail shifts in the allocation of collective resources.⁶ Last but not least, in Canada's federal system of government, provinces play a key role in public health, which is a sphere of mixed jurisdiction between the federal and provincial governments.⁷ As in other policy fields, each province defines its own policy, so there exists not one single national approach but several policy approaches to public health.⁸ Canada's decentralized federalism challenges the country's capacity to coordinate and harmonize its efforts to implement the new public health vision.

At a minimum, the new public health represents a powerful rhetoric that has made its way in health and research policy circles at the national and international levels. But is there more to it? Considering the

³ Canada. Health Canada, 2003, *Learning from SARS: Renewal in Public Health in Canada*, Ottawa, National Advisory Committee on SARS and Public Health. Available online at <http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>, accessed on 2006-07-12.

⁴ Ottawa. Canadian Public Health Association, 2001, *The Future of Public Health in Canada*, 10 p.

⁵ Evans / Stoddart, 2003, pp. 371-379.

⁶ Glouberman / Millar, 2003, pp. 388-392; Robertson, 1998, pp. 155-166.

⁷ Canada. Health Canada. 2003. National Advisory Committee on SARS and Public Health. Ottawa: *Ontario Expert Panel on SARS and Infectious Disease Control*, 43p. Available online at http://www.health.gov.on.ca/english/public/pub/ministry_reports/walker_panel_2003/introduction.pdf, accessed on 2006-07-12.

⁸ Frank / Di Ruggiero, 2003, 190-192; Colin, 2004, pp. 185-195.

important role played by the provinces in the health field in Canada, it is relevant to ask, as is done here, whether the 'new public health' concept is making its way into the provincial health agendas. A prerequisite for the new public health ideas to enter the provincial agendas in sectors other than health is first to enter the health sector and be incorporated into provincial policies aiming directly at improving and protecting the population's health. If the new public health ideas fail to enter these kinds of provincial policies, it is hard to conceive their potential to effectively influence healthcare policies, not to mention those of other governmental sectors.

This chapter seeks to assess and compare the extent to which the "new public health" concept has entered provincial health policies in Canada's three largest provinces: Ontario, Québec and Alberta. The first part of the chapter provides the policy background that is necessary for a better understanding of the significance of the "new public health" concept in Canada's health policy. The second part presents and analyzes the results of an empirical study, which are presented comparatively as follows: 1) the contents of provincial policy, and particularly the incorporation of the determinants of health into the provinces' policy frameworks; and 2) the orientations pursued by public health policy between 1994 and 2004. The third part summarizes the results and discusses some of their implications for public health policy in Canada and abroad.

The empirical observations are based on documentary sources, including the relevant specialized literature found in public health journals, official publications as well as 18 anonymous, semi-structured interviews conducted with provincial and regional policy-makers as well as academics in the three provinces between May and June 2004. The interviews were used to complete the elements of observation not available from other sources. The data collected sought to provide an overview of provincial approaches. As this research is primarily about provincial policy, local initiatives were not included as part of the observations. The observations cover a decade starting from 1994.

Public Health Policy Background

In 2004, the World Health Organization launched a Commission on the Social Determinants of Health, whose purpose is: "to enable countries worldwide to tackle the root causes of disease and health inequalities and to intervene on the social conditions in which people

live and work”.⁹ The direct roots of contemporary efforts to identify and address the social determinants of health, as advocated by the new public health, reach back to the 1974 Canadian *Lalonde Report* and to the 1980 United Kingdom’s *Black Report*. The *Lalonde Report* played a role at international level, drawing the attention to the determinants of health outside the healthcare sector, such as human biology, environment and lifestyles, as being also important in determining health. This recognition implied that a new policy approach for improving the health of Canadians was necessary. For its part, the *Black Report on Inequalities in Health* showed the extent to which ill-health and death are unequally distributed among the social classes in Britain. It showed that health inequalities had been widening (rather than diminishing) since 1948, when the British National Health Service was established. The Report concluded that health inequalities were associated with many other social inequalities influencing health: income, education, housing, diet, employment, and conditions of work. The Report thus recommended a wide strategy of social policy measures to combat inequalities in health. Its observations and recommendations had little immediate policy impact in the U.K. under the leadership of Margaret Thatcher’s Conservative Party (1979-1997), but had a sound resonance in the scientific community and inspired a number of national enquiries into health inequalities and the “social health divide” in other countries.

Since the 1974 *Lalonde report*, Canada has long remained an international leader in population health promotion. In 1986, Jake Epp, Minister of National Health and Welfare, released *Achieving Health for All: A Framework for Health Promotion*. Subsequently, his department, the European Region of WHO and the Canadian Public Health Association endorsed the *Ottawa Charter for Health Promotion*, which states that “health promotion is not the sole responsibility of the health sector, but goes beyond healthy lifestyles to well-being”. In other words the Charter recognized that policy not traditionally under the purview of the ministry of health may have a direct effect on population health and well-being. For instance, policies dealing with physical education in schools, income distribution, poverty, and access to recreational spaces have an impact on the population’s health. Health promotion professionals adopted what is referred to as ‘settings approach’ focused on improving health in schools, workplaces and communities. The

⁹ This section draws in large part on a background paper prepared by the World Health Organization. Secretariat of the Commission on Social Determinants of Health. 2005. *Action on the Social Determinants of Health: Learning from Previous Experiences*, March, pp. 8-30. Available online at http://www.who.int/social_determinants/strategy/en/CSDH_socialdet_backgrounder.pdf, accessed on 2006-07-13.

Charter stated that health promotion involved five main components beyond promoting healthy lifestyles: reorienting health services, enhancing personal skills, strengthening community action, creating supportive environments and building what is known in health promotion circles as 'healthy public policy' (favourable to health).

In the 1990s, the Canadian Institute for Advanced Research (CIAR) sponsored a very significant interdisciplinary research effort to provide answers to the question as to how to improve a democratic nation's health status. The CIAR group published its key findings and recommendations in 1994 in *Why are some people healthy and others not?*, which influenced debates in Canada and abroad. Since then, a research infrastructure has been set up in Canada to deal with the social determinants of health. In 1999, the *Canadian Population Health Initiative* was launched, to 'foster a better understanding of factors that affect the health of individuals and communities and to contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians'. Today, the social determinants of health are a legitimate theme for research sponsorship by all of the Canadian Institutes for Health Research, and 5 of the 13 institutes focus on population health areas of research.¹⁰ With its numerous limitations in actual practices, the new public health is more than mere advocacy and clearly deserves our attention.

Incorporation of the social determinants of health

Let me now focus on the question of the extent to which Alberta, Ontario and Québec have incorporated the social determinants of health perspective into their province-wide public health program. To answer this question, official policy documents were examined for each province. As Table 1 indicates, Alberta's main program is the 2003-2012 *Framework for a Healthy Alberta*. This framework sets outcomes, objectives and targets for government action to promote health and prevent disease and injury in different settings: homes, schools, workplaces and communities. It can be described primarily as a social marketing instrument, given its insistence on education and information as preferred means of intervention. It focuses on two broad health outcomes: improving healthy behaviours and reducing the incidence of chronic disease among Albertans. For the first time on Alberta's health promotion agenda, this *Framework* has a 10-year horizon instead of annual objectives to be reported on, in recognition that "it takes a long

¹⁰ Glouberman / Millar, 2003, 390.

time to make changes in health promotion, to change behaviour and to actually change health outcomes” (A2, p.3). The entire government is officially committed to this Framework, as opposed to only the Ministry of Health and Wellness. Moreover, several government departments were involved in its design. It is a direct outcome of Alberta’s *Health Sustainability Initiative*, a cross-ministry priority policy initiative since 2000 involving 10 ministries and related government agencies, as well as the Premier’s Advisory Council on Health the following year. HSI’s central objective has been to reduce the rate of expenditure growth for the provincial healthcare system. Its 2002 report provided government with a blueprint for reform, following which several reports, frameworks and strategies have been developed to bring the blueprint to life. Among the report’s key and controversial recommendations, other than “stay healthy,” were that patients should be charged out of pocket for medicare; that medicare should be scaled back to “essential services”; and that as much medicare as possible should be privatized, including services no longer deemed “essential.”

Table 1 – Incorporation of determinants into the policy framework

Province and Program	Characteristic of type of incorporation
Alberta:	
Framework for a Healthy Alberta 2003-2012	None
Ontario :	
Mandatory Programs and Services Guidelines (1997+)	Reduction of access barriers
Quebec :	
National public health program 2003-2012	Health and welfare grouped together Reduction of social health inequalities

The financial and ideological context in which the *Framework* came to be helps explain its insistence on reducing chronic diseases, inasmuch as they represent a great financial burden on healthcare, both now and in the future, and the overall policy goals pursued by the Albertan government. “Staying healthy” is definitely the number one governmental effort to curb this growth, which translates in efforts to reduce preventable chronic diseases and injuries. The *Framework* recognizes that population health is affected by the ‘determinants of health’ – which it refers to as ‘things that affect our health’ such as

gender and age, genetics, income and social status, social support, education, employment and working conditions. The document specifies that “some of these (determinants) are within our control; others are not.”¹¹ Within control is, almost exclusively, the possibility to alter health behaviours, either by using direct communications strategies that promote healthy lifestyles, or by using more comprehensive strategies (supporting healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services). The more comprehensive strategies are mentioned in the document and labelled with ‘new public health’ vocabulary. However, they are conceived in a narrow fashion, that is, only as part of a concerted effort to promote healthy behaviours and support healthy choices (e.g., encouraging employers to develop programs for their employees to be physically active), as opposed to a more structural approach which would seek action on unhealthy conditions (such as improving workplace safety or reducing environmental pollution). In addition, the ‘more comprehensive strategies’ are not part of the stated “government strategies” as such. They are mentioned in the document only as actions that could be undertaken to help Albertans make healthier choices and reach the targets.

Regarding more specifically social and health inequalities, the *Framework* recognizes that some population groups such as Aboriginal people and low-income individuals are at greater risk of poor health. This being said, the strategy to address this problem is not to improve the general conditions of these groups or to provide the extra services they might need to attain better health outcomes. Rather, the strategy is to adopt specifically designed programs and social marketing strategies to reach disadvantaged groups and ensure that they, too, will adopt healthy lifestyles and presumably attain health results that are comparable to the entire population. The bottom line is that all the stated strategies are conceived to help improve healthy behaviours, which is the exclusive means considered for reducing chronic diseases.

Ontario’s public health policy is similar to Alberta’s in several ways, considering their common emphasis on social marketing, chronic diseases, prevention of risks, reducing healthcare costs and changing lifestyles. However, there are some notable distinctions. In Ontario, there are mandatory programs and services that must be provided throughout the province. In addition, the official policy adopted a

¹¹ Alberta. Health and Wellness Ministry, 2006, *Health Policy Framework*, p. 2. Available online at www.health.gov.ab.ca/healthrenewal/policy_framework.pdf, accessed on 2006-07-12.

broader definition of health in the early 1990s. Official documents recognize and seek to act upon the influence of the determinants of health (income, social status, education, etc.), which are acknowledged as “have[ing] as much or more to do about influencing health than does the presence of health care practitioners and facilities”¹².

Ontario’s main provincial program in public health is the *Mandatory Health Programs and Services Guidelines* (1997-). This document sets minimum standards for public health to health boards across the province in three specified areas, namely, chronic diseases and injuries, family health and infectious diseases. Its 17 mandated programs focus on prevention, early detection of cancer and control of infectious diseases. The *Guidelines* are described as a “chronic disease prevention” instrument.¹³ They emphasize risk factors and stipulate that health promotion efforts by health boards must be dedicated to “community development, social marketing, mass communication and media, health education, adult education, peer education and behaviour change education.”¹⁴ Ontario’s guidelines seek to provide *Equal Access* for all Ontarians to public health programs by reducing educational, social and environmental barriers to accessing mandatory public health programs. These barriers are explicitly described: literacy level, language, culture, geography, social factors, education, economic circumstance, and mental and physical ability.¹⁵ This dimension, which acknowledges unequal chances among individuals to access public health services, is absent in the Albertan framework.

Whereas Ontario’s *Guidelines* reflect a public concern for reducing existing access barriers to mandatory public health services, the incorporation of the social determinants of health into policy is limited for several reasons. Firstly, Ontario’s policy does not ensure an equitable geographical distribution of public health services. The *Guidelines* have not been fully enforced because in the five-year period from 1998 to 2003, the Ministry conducted no regular assessments of local health

¹² Ontario. Ministry of Health, Public Health Branch, 1997, *Mandatory Health Programs and Services Guidelines*. p. 5. Available online at <http://www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/mhp.pdf>, accessed on 2005-12-19.

¹³ Elliott /Taylor et al., 2000, pp. 94-97.

¹⁴ Ontario. Ministry of Health, Public Health Branch. 1997. *Mandatory Health Programs and Services Guidelines*. p. 5. Available online at <http://www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/mhp.pdf>, accessed on 2005-12-19.

¹⁵ Ontario. Ministry of Health, Public Health Branch. 1997. *Mandatory Health Programs and Services Guidelines*. p. 6. Accessible online at <http://www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/mhp.pdf>, accessed on 2005-12-19.

units to determine whether they were complying with these guidelines.¹⁶ Estimated compliance levels with the MHPSG are at around 75%.¹⁷ This is due to the fact that health boards have seen their responsibilities increase since the 1990s without corresponding budgets.¹⁸ While the provincial average spent for public health services was at \$37 per capita in 2002, the amounts spent by the 37 local units ranged between \$23 and \$64 per capita.¹⁹ Partial compliance with the *Guidelines* denotes a fundamental, well-documented seizure between Ontario's central and local authorities, which became very apparent during the 2003 Toronto SARS crisis.

In population health promotion as such, Ontario's two key provincial programs focus on a more traditional approach to health promotion, one which leaves no room for action on the broader determinants of health. Indeed, the *Focus Community Program* is a 5-year, \$12 million program seeking to prevent alcohol and other drug abuse and focusing on children and youth. This program's numerous components are implemented by 21 of the 37 local agencies in partnership with community groups. All of the components are based on social marketing and education approaches and/or providing community support. The other key program, the *Heart Health Program*, is a 5-year, \$17 million initiative which aims to prevent cardiovascular disease. It seeks to "raise public awareness of the three key lifestyle factors linked to a reduced risk of cardiovascular disease and cancer." This program is delivered through public health units and their local partners across the province. It provides funding for the external organizations such as the Heart Health Resource Centre at the Ontario Public Health Association. In addition to these two key initiatives, the province is involved in other population health promotion activities, mainly via programs and

¹⁶ Ontario, Office of the Auditor General. 2003 *Annual Report, Chapter 3: Public Health Activity*. p. 219. Available online at http://www.auditor.on.ca:81/en/reports_en/en03/309en03.pdf, accessed on 2006-07-12.

¹⁷ Ontario. The Honourable Mr. Justice Archie Campbell. 2004. *The SARS Commission Interim Report: SARS and Public Health in Ontario*. Available online at http://www.health.gov.on.ca/english/public/pub/ministry_reports/campbell04/campbell04.pdf, accessed on 2006-07-12.

¹⁸ O'Connor, Dennis R., 2002. *Part Two: Report of the Walkerton Inquiry. A strategy for Safe Drinking Water*. Toronto: Ministry of the Attorney General. Available online at <http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/walkerton/part2/>, accessed on 2006-07-13.; Elliott / Taylor et al., 2000, pp. 94-97.

¹⁹ Ontario, Office of the Auditor General. 2003, *Annual Report, Chapter 3: Public Health Activity*, p. 219. Accessible online at http://www.auditor.on.ca:81/en/reports_en/en03/309en03.pdf, p. 219, accessed on 2006-07-12.

strategies such as reducing tobacco use, promoting physical activity, protecting children, and nutrition.

Québec's policy is contained in the *Programme national de santé publique 2003-2012*, a ten-year, comprehensive public health program. The Québec government's official program adopts a very broad definition of 'population health' that also comprises 'population well-being'. It aims to improve not only the population's health in a narrow sense but also the population's well-being more generally, in recognition that health and well-being statuses are interdependent. The *Program* goes far beyond promoting healthy lifestyles and social marketing campaigns (as in Alberta), and beyond that of reducing the barriers of access to public health services (as in Ontario). Indeed, the *Program* seeks to reduce health and well-being inequalities as such, a goal which relies on broad strategies that extend beyond the health sector and beyond individuals: comprehensive, structural interventions on the social determinants of health including strengthening individual potential, supporting community development, participating in multi-sectoral actions fostering health and well-being, providing support for vulnerable groups, and encouraging effective preventive clinical practices.²⁰ Also, in addition to the four core functions of public health (surveillance, health and well-being promotion, prevention of illnesses, psychosocial problems and traumas, and health protection) the *Program* acknowledges three public-health support functions (support for regulations; support for legislation and public policy having an effect on health; and support for research, innovation and skills development).

The Program is an outcome of the 2001 *Public Health Act*. In addition to concentrating the essential functions of public health, the new *Act* provides support for all dimensions of public health interventions. It supports not only the core functions of health protection as such, but also the health surveillance mandate, as well as the prevention and promotion mandate. It acknowledges that the laws and regulations emerging from various government sectors can influence population health and wellbeing. It empowers the Ministry of Health and Social Services (MHSS) to initiate inter-sectoral action in support of developing public policy favourable to health. Decision-making processes in all areas of government activity must take into account the potential impacts of all legislative and regulatory initiatives on the population's health and well-being. By virtue of the *Act*, all ministries and agencies are

²⁰ Québec, Ministère de la Santé et des Services sociaux. 2003, *Programme national de santé publique 2003-2012*. Québec. Available online at <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2002/02-216-01.pdf>, accessed on 2006-07-12.

required to consult the Minister of Health and Social Services when they are formulating laws or regulations which could have a significant impact on health and wellbeing. It is then incumbent upon the Ministry to advise the government.

Policy orientations 1994-2004

To sum up, the degree of incorporation of the social determinants of health perspective into provincial programming varies widely among the three provinces. Thus far, we have seen a 'portrait' of official policy in 2004. Let us now deal with whether the recent policy process, starting from around 1994, has been conducive to a better institutionalisation of public health functions at the regional and provincial levels. This is a fundamental tenet of the new public health approach, namely, to ensure that the population across the whole territory will have access to similar public health services.

In the 1990s, all provinces except Ontario took concrete steps to organize their health care systems from a local to a regional basis. The onset of the regionalization process in 1994 in Alberta and in 1993 in Québec was thus as part of a pan-Canadian movement. However, this movement had very different implications for provincial public health policy.

Alberta's discontinuity. As Table 2 shows, the three provinces have pursued a divergent path. Alberta's public health policy was marked first

Table 2 – Orientation of provincial public health:
A comparative perspective, 1994-2004

	Alberta	Ontario	Québec
Dominant feature of policy evolution	Discontinuity	Destabilization	Continuity
Institutionalization of public health (regional, provincial)	Dismantlement and reorganization	Interruption	Increase
Incorporation of determinants into public health policy	Does not apply	Retreat	Increase

and foremost by a ‘Big Bang Approach’ to healthcare reform at the beginning of the period. According to McDaniel, “nowhere in Canada has health care undergone as radical a change as in the Province of Alberta in the period since 1993.”²¹ This radical approach implied radical changes as well for public health.²² Alberta’s public health policy was subsequently followed by a ‘peaks and valleys’ approach to population health promotion.

Shortly after his election in June 1993 as the successor to the Conservative Party’s uninterrupted reign since 1971, Premier Ralph Klein initiated a three-year budget deficit elimination program. The 1993 *Deficit Elimination Act*, reinforced by the 1995 *Balanced Budget and Debt Retirement Act*, resulted in cuts in public services and in the privatization of various government services. In addition to severe cuts in the social assistance and higher education budgets, the budget program aimed at reducing health care costs by 25% over three years. In hospitals, this led to closing around half the beds reserved for intensive care. At the same time, the government policy introduced mechanisms which favoured private investments in the care system, such as service contracts between regional health authorities and private clinics. By 1996, this budget program had led Alberta to become the province that spent the least per capita on health care in Canada.

It was in this context of austerity that the regionalization of the health care system took place. It began in 1994 with the creation of 17 Regional Health Authorities (RHA) and, in the following year, with the dissolution of some 200 health boards (hospital districts, general hospitals, public health units and long-term care boards) across the province, with a view to establishing a less costly system of community health care.²³ Since then, the RHAs have been responsible for managing all aspects of care in their respective regions, including public health. The creation of the RHAs enabled the provincial government to proceed with draconian cuts in the area of health care while reducing its own accountability.²⁴ It was also in this context of budget cuts that a greater insistence was placed on individual responsibility and on minimizing public responsibility for the health of the population. The rhetoric surrounding the restructuring of health care gave rise to a sort of “punitive” notion of health promotion “with proposals being put forward for penalizing those who fail to live healthy life styles”.²⁵ In

²¹ McDaniel, 1997, p. 211.

²² Hume / Rushforth, 1998-1999, pp. 43-50.

²³ Hume / Rushforth, 1998-1999, pp. 43-50.

²⁴ Wilson, 2000, pp. 97-112.

²⁵ McDaniel, 1997, p. 215.

support of this vision, Premier Klein asserted, for example, that 70% of all illnesses are caused by unhealthy lifestyles. Moreover, the possibility that those who have health problems should pay for the care they receive is openly discussed in decision-making and policy-making circles.²⁶

As part of broad governmental efforts to reduce public expenditures, much of the existing public health infrastructures were dismantled in 1994. Several professional expertises (e.g. public health nurses) were wiped out in the process. Before the onset of the regionalization process, every region had its own public health agency and funding. For example, the Edmonton Board of Health had a community development office with specialized personnel who worked in health units in the city's poor neighbourhoods. This structure was abolished with the implementation of regionalization and the specialized employees were laid off (A5, p.10). Moreover, nurses, nutritionists and other public health specialists were working for the provincial ministry. In 1994, the ministry did away with this expertise in public health programming, laid off its professional personnel, and got out of all activities related to service provision (A1, p.7). Public health programs have since then mostly been delivered by external organizations (A5, p.6). Alberta destroyed some of its public health administrative structures as well as its expertise and capacities for interventions.

In a context of sharp expenditure reductions at provincial level, health promotion programs were in a bad position to compete for funding in the new regionalized health care system with curative services as well as with core public health programs such as immunizations. Consequently, they virtually disappeared. A respondent described the state of health promotion after 1994: "Regions were floating with no direction, no guidance, no requirements other than some basic stuff.

²⁶ Consider the following excerpt from an anonymous interview conducted in 2004:

A1: *We're certainly looking at manners in which we can provide people incentives to stay healthy. Now, incentives work more than one way. Largely, we would like to focus on positive incentives. But certainly we've discussed... but this isn't anything that's actually gone to government. A lot of these ideas will be going to our caucus later on. But as a department we would sit there and say, okay, if a person isn't behaving the way they should why is it that we would then say okay, here is free treatment and free all of this stuff when you're doing nothing for yourself? Okay. That's a really different approach than we've ever looked at, and I don't know if it would be acceptable. What would our public think or our population think? I think they would rather say there's a reward for trying to stay healthy rather than a punishment. Because if you start thinking that way, where does it stop? Do you now say because I ski that I'm taking a risk, so therefore maybe I shouldn't get everything, and is me skiing or riding a motorcycle or skydiving different than a person who isn't changing their diet? We're both engaging in an activity that could put our health at risk.*

Nicole F. Bernier: *We are having these discussions right now?*

A1: *In the department, yeah. I don't think we would go that far. But that isn't my decision to make.*

Health promotion was free-for-all, all over the map” (A4, p.6). Remedial action was taken with the implementation of a new governmental program, *Action for Health*, a targeted provincial fund which provided resources to regional authorities to hire health promotion staff and to implement programs dealing for instance with tobacco reduction, injury prevention, and improving nutrition. But the process has not been linear since the rupture in institutional arrangements; the policy has progressed in an uneven manner. In 2003, the number of RHAs was reduced to nine, which, once again, entailed territorial reorganizations of health services, public health services, and population health promotion services. Moreover, the funds allocated to the *Action for Health Program* were merged with budget envelopes transferred to the RHAs, such that, once again, population health promotion programs found themselves in direct competition with medical and hospital services. This engendered a new setback for health promotion.

Ontario's Destabilisation. Mike Harris' Progressive-Conservative government of Ontario adopted even more drastic measures to cut public expenditures in the mid-1990s than Alberta's premier Ralph Klein had done a few years earlier. In Ontario, however, public health policy has not been as hard hit as its counterpart in Alberta. Indeed, Ontario's public health policy was 'destabilized'—as opposed to 'dismantled'—during the 1994-2004 period. But the relative progressiveness of Ontario's policy experienced a significant setback.

In the early 1990s, Ontario's Premier's Council and, later, the provincial government adopted a broad view of health and its determinants as the basis for health policy in Ontario.²⁷ The NDP government, which held office from 1990 to 1995, changed the Premier's Council on Health to the Premier's Council on Health, Well-being and Social Justice. This reflected a growing convergence between social and health policy thinking at this point in time (T2, p.5). However, after the election of the Progressive-Conservatives under Mike Harris in June 1995, several health policy changes occurred. Among such changes, health promotion and diseases and injury prevention became a new priority for healthcare reform, in the context of sharp expenditure reductions. In 1997, new mandatory public health programs and guidelines were introduced. According to Riley, “the healthy lifestyles programs were consolidated into a single chronic disease prevention program, and program standards were made more measurable and prescriptive.”²⁸

²⁷ Pederson / Signal, 1994, pp. 244-261.

²⁸ Riley, 2003, p. 21.

The destabilization of public health policy in Ontario occurred especially on the heels of the municipal amalgamations in 1998, during which public health units (municipal and local authority) were consolidated to serve a new, larger, local territory. This involved integrating different cultures and approaches among public health professionals on one front at the same time as these same professionals had to fight severe government-imposed cuts in expenditures across the government on another front. In 1998, the provincial government transferred 100% of public health costs to municipalities. This meant that public health came into direct competition with municipal services for funding, this at the same time as radical cuts were implemented in all sectors of governmental activities and more responsibilities were devolved to municipalities. A process that had been taking place across Ontario, of making best practices and programs initiated at the local level available across the province, was interrupted. In the end, public health professionals had lost relatively few resources, in Ontario's policy context, as a direct result of the cuts. However, the context in which they had to operate and the increased needs resulting from reforms in social services and social policy put a lot more pressure on public health services at the same time as their capacity to intervene efficiently and coherently was questioned in the midst of municipal amalgamations and budgetary cuts at the provincial level. The municipal amalgamation and severe cuts in all domains of government intervention led Ontario's public health to withdraw into itself, with the result that professionals involved in public health became too concerned with internal matters to introduce new initiatives and further the progressiveness of the provincial public health policy, which remained in a state of relative stagnation during these years.

Québec's consolidation. In Québec, a 1993 administrative reform led to the regionalization of the health care system and the creation of 18 regional health and social services boards to cover the whole province. This regionalization process made it possible for a better integration of public health into the health and social services network's provincial and regional decision-making structures. In the spirit of the orientations advocated by the Rochon Commission of 1988,²⁹ the administrative reform made it possible to refocus public health as a component of the socio-sanitary system. The period following the regionalization of public health was characterized by several integration and coordination problems.³⁰

²⁹ Québec. Commission d'enquête sur les services de santé et les services sociaux. 1988, *Rapport de la Commission d'enquête sur les services de santé et les services sociaux*, Jean Rochon, Québec, 803p.

³⁰ Deschênes, *Rapport sur l'examen des responsabilités respectives du ministère de la Santé et*

Notwithstanding a very ambitious official policy, for some years Québec's approach to health promotion was shaky and ambiguous.³¹

However, when we extend the observation period to 2004, Québec's orientation is characterized by the consolidation of administrative and programmatic foundations. The foundation of Québec's policy was established in 1992 with the *Politique de la santé et du bien-être* (*Health and Well-being Policy*), which had measurable health objectives formulated by taking into account the social determinants of the population's health. This policy marked an important moment in Québec's policy since it sought to ensure that the government dealt with issues related to health and well-being from a broader and more encompassing perspective than one limited to socio-sanitary services.³² It had 19 objectives related to reducing health problems and social problems and had six actions strategies with regard to the determinants of the population's health and well-being. Its very existence was meant to ensure that the health system's policies were guided by health and well-being objectives for the population. In addition to ensuring the best possible access to health services, it was the Policy's intention that the socio-sanitary system play a greater leadership role with regard to the determinants of health and well-being.³³

The policy consolidation was subsequently marked by the adoption of the *Priorités nationales de santé publique 1997-2002* (National Public Health Priorities), which sought more specifically to provide all of Québec's regions with the same public health priorities, and the *Programme national de santé publique 2003-2012* (National Public Health Program) (as discussed above). Like the initial 1992 official policy, these programs adopt a global approach and vision with regard to health and well-being, which take into account the social determinants of the population's health and which are reflected as much in the objectives as in the specified intervention strategies.

The consolidation was also helped by the 1998 creation of the Institut national de la santé publique du Québec (INSPQ) (National Institute of Public Health of Quebec). This Institute is more than a Center for Disease Control in the strictest sense. It is a governmental

des Services sociaux, des Régies régionales et des établissements, 1996, Québec, Ministère de la Santé et des Services sociaux.

³¹ O'Neill / Cardinal, 1998, pp. 19-23.

³² Québec. Conseil de la santé et du bien-être. 2004. *Une banque d'idées pour le Québec Les dix ans du Conseil de la santé et du bien-être*, p. 7. Available online at <http://www.csbe.gouv.qc.ca/site/3.77.0.0.1.0.phtml>, accessed on 2006-07-12.

³³ Québec. Conseil de la santé et du bien-être. 2004. *Une banque d'idées pour le Québec Les dix ans du Conseil de la santé et du bien-être*, p. 9. Available online at <http://www.csbe.gouv.qc.ca/site/3.77.0.0.1.0.phtml>, accessed on 2006-07-12.

agency whose mission is to act as an advisory body for public health to the Ministry of Health and Social Services. Its initial goal was to bring together the various public health expertises available in Québec's regions and to make this expertise accessible across the province. The creation of the INSPQ entailed a shift in the geographical distribution of public health resources and was met with considerable resistance by regional authorities. However, the INSPQ's efforts to integrate public health resources on a provincial basis have been successfully continued since 2002. In addition to being a provincial centre for public health expertise, the INSPQ is actively involved in advocacy for reducing social health inequities.

Lastly, the consolidation was completed with the *Loi sur la santé publique* (Public Health Act), modernized in 2001, which stipulates that "public health actions must be carried out with a view to protecting, maintaining or improving the state of the population's health and wellbeing." In particular, Article 54 of the new *Act* stipulates that the Ministry of Health and Social Services must act as an advisor to the government for all health-related issues and that it must be consulted during the formulation of measures contained in provincial legislation and regulations which might have a significant impact on the health of the population. Since the mid-1990s, the process of institutionalizing public health has continued at the regional and provincial levels and the social determinants of health perspective have been more widely incorporated into the program, administrative and legislative instruments of Québec's health policy. Québec's consolidation process for over a decade is in sharp contrast with the discontinuity and destabilization which characterize Alberta and Ontario respectively.

Discussion

Significant research efforts are currently being devoted to investigating how social inequities and the social determinants of health affect the population's health and what can be done about them. Public health crises in Canada and abroad have focused the attention of policy makers and public managers on public health issues and made it clear that the development of adequate public health infrastructures is a necessary component of health policy, over and above health care. This renewed awareness of the role of the state in protecting the population's health by means other than providing medical treatments and hospital services has represented an opportunity for public health professionals worldwide who are committed to a progressive understanding of their role. The *Ottawa Charter* was a decisive step in catalyzing the progressive

health-sector forces in Canada and abroad. Today, this movement has developed a 'voice' which is heard in national and international health-related policy debates and with which it advocates public interventions on the social determinants of health. This indicates a convergence, within the framework of a specific discourse and by newly organized proponents, of health policy with the not-so-new thinking for improving social conditions via the policies of the welfare state.

Canada has played a significant leadership role in the field. However, this leadership has been displayed largely by the federal government, notwithstanding the fact that provincial governments have a large share of jurisdictional responsibility for health policy matters. The goal of this article was to assess and compare the extent to which the 'new public health' concept has made its way, in 2004, into provincial health policy directly aimed at improving the population's health over the past decade. Briefly stated, with the exception of Québec, this concept has not fared so well. The results presented above show a spectrum of successes for incorporating the 'new public health' concept as part of official health policy. Although the new public health vocabulary was borrowed in certain passages of the Albertan Framework, strategies of interventions on the social determinants of health are non-existent. Although Ontario's *Guidelines* take the social determinants of health into account, the incorporation of the social determinants of health is limited to reducing barriers of access to mandatory public health services, while its health promotion programs focus on a traditional approach consisting in the social marketing of healthy lifestyles. Québec's *Programme national de santé publique* goes further than Ontario's *Guidelines*, showing a greater and broader commitment to reducing social health inequalities as such, instead of barriers of access, and a more diversified, structural approach. The new public health ideas are thus most fully incorporated in Québec's policy.

Results for Ontario and Alberta are partly consistent with observations found in the public health literature, which show that despite the existence of the *Ottawa Charter's* principles and their endorsement by 27 countries, actual health promotion practices in most countries continue to focus on social marketing strategies aimed at individuals and at promoting healthy lifestyles.³⁴ There is also a gap between the scientific observations establishing links between the determinants of health and population health outcomes on the one hand and the political actions related to such observations on the other. Research results clearly show the detrimental effect of social inequities on health outcomes, but have not been conducive to policy development to

³⁴ Kickbush, 2003, pp. 383-388.

effectively reduce such inequities.³⁵ In other words, gaps can be observed between advocacy content, research results and the necessary commitment of resources to develop policy relevant initiatives.³⁶

The implications of the results for Alberta and Ontario are numerous and will need to be further explored. But what appears as the most significant implication for the new public health movement is the following. If the new public health ideas failed to enter the health sector's policies aimed directly at improving the population's health, the envisioned multi-sectoral approach on the social determinants of health, the most essential component of the new public health approach, is an elusive goal. Why would the new public health vision be influential with the Treasury Board or the Finance Department or any other sector of government intervention not under the purview of health ministries, when it fails to be incorporated into the policies of the health sector itself, where it can be most influential? Similarly, how could the new public health vision be more successful in other countries, when it fails to create a policy impact in a country which is still considered among the world leaders in this field?

It is undeniable that multi-sectoral initiatives have taken place, such as with childhood issues being dealt with in a concerted effort between departments responsible for education, social services and income security. However, it is worth asking whether such initiatives are designed primarily to address the social determinants of health. Are multi-sectoral initiatives really developing, consistent with the new public health vision, 'upstream' government interventions to maximize the children's health and well-being? Or are they designed in a 'downstream' fashion, that is, to counter the most negative effects of existing unequal social arrangements on some of Canada's most vulnerable individuals? The existence of multi-sectoral initiatives is clearly a necessary, though insufficient indication that a province or country is committed to address the socially determined health inequities. The *Health Initiative* in Alberta and *Framework for a Healthy Alberta*, the ensuing multi-sectoral initiative is an eloquent example. It illustrates how the new public health language, disconnected from its objectives, can simply be a commodity used by authorities to pursue right-wing policy goals formulated in progressive terms.

In addition, when considering the Québec 'exception' or 'model', we must bear in mind that Québec's official policy, despite its great potential, still faces important limitations and implementation

³⁵ Glouberman / Millar, 2003, p. 390.

³⁶ Sutcliffe/ Deber et al., 1997, pp. 246-248.

challenges.³⁷ Alberta's and Ontario's experience with the policy process over a decade indicate that Québec's favourable results must be considered in the perspective of an unfolding policy process. In particular, Alberta's policy process was dismantled, re-started and then re-organized again. The peaks and valleys approach to health promotion followed during the period of observation has not been conducive to a greater degree of uniformity between regions and there was no linear process leading to a better institutionalization of population health promotion. For its part, Ontario was at a relatively advanced starting point at the beginning of the period but was 'destabilized' by radical provincial politics leading to severe cuts from the central government, downloading of responsibilities to the municipal level without corresponding resources, and municipal amalgamations in the late mid-1990s. These policy orientations indicate that the institutionalization of public health functions and incorporation of the social determinants of health into health policy is not a linear process in a given direction: it can actually move backwards. Québec's process has so far been characterized by continuity and the progressive consolidation of its infrastructure. It has pursued a path of institutionalization leading toward greater incorporation of the social determinants of health into its public health programming through a series of successive steps in defining official policy and provincial legislation.

The institutionalization of public health has been greater in Québec than in the two other provinces. However, the present study has indicated that in the Canadian context, the insertion of the new public health concept is related to broader provincial policies and the general political agenda pursued by provincial governments and that the ideology pursued by elected officials has a significant impact on the orientation of public health. As such, the 2003 election of a new, business-oriented Liberal government in Québec poses new challenges for progressive health and social welfare policy in the coming years.

Whereas the search for 'best practices' and 'models of organization' is very common in health policy research, public health appears here not as a stand-alone structure that can be imagined and modelled according to an efficiency model, but as part of much broader political pursuits.

³⁷ For a discussion on this issue, see Bernier, "Québec's Approach to Population Health: An Overview of Policy Content and Organization", in *Journal of Public Health Policy*, (in press, 2006). Available online at <http://www.palgrave-journals.com/jphp/journal/v27/n1/pdf/3200057a.pdf>, accessed on 2006-07-13.

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