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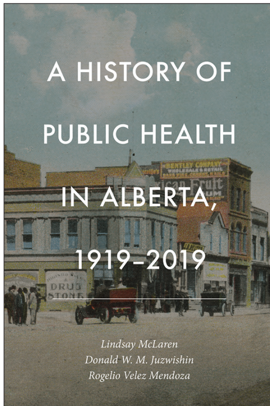

A HISTORY OF PUBLIC HEALTH IN ALBERTA, 1919–2019

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Social Determinants of Health in the Alberta Government: Promising and Pernicious Historical Legacies

Lindsay McLaren

Introduction

Health and well-being are fundamentally shaped by the quality of the circumstances in which we are born, grow, live, work, and age; these are the social determinants of health. Inequitable distribution of the determinants, which reflects inequities in power and resources that are inherent to our political, economic, and colonial systems and structures, creates and perpetuates health inequities, which are unfair and avoidable differences in health between social groups.[1] Health equity occurs when people are not disadvantaged by social, economic, political, and environmental conditions, including how those conditions intersect with social identities based on factors such as ability, age, gender, race, sexuality, and social status.[2]

The social determinants of health and health equity are integral to a broad definition of public health; that is, the art and science of promoting health and preventing illness through organized efforts of society.[3] Yet, the extent to which this knowledge and perspective is embraced in Alberta (and indeed across Canada, and beyond) is limited. The 2008 final report of the World Health Organization Commission on Social Determinants of Health boldly asserted that addressing the social determinants of health required action to improve peoples' daily living conditions; to tackle the inequitable distribution of power, money, and resources;

and to measure and understand the problem and assess the impact of action. Yet, analyses of the report's impact ten years later show a persistent tendency — by researchers, practitioners, and governments — to embrace downstream, depoliticized versions of the social determinants of health that emphasize individual-level, bio-behavioural explanations for, and responses to, health inequities.[4]

One foundation of the social determinants of health concept is that the primary determinants of well-being and health equity reflect public policy decisions in government ministries other than health. A health-in-all-policies approach — and its historical precursor of healthy public policy — that systematically considers the implications for health, well-being, and health equity of policies across government ministries, theoretically provides a way to operationalize this foundation. Anchored in contemporary calls for a health-in-all-policies approach,[5] the objective of this chapter is to consider examples of how the social determinants concept has manifested across Alberta's history in the provincial government, such as how the provincial Department of (Public) Health was organized, and how legislative assembly deliberations that transcended health and other sectors played out. Key sources included annual reports of the provincial department or ministry responsible for public health and the *Alberta Hansard*. We were particularly interested in whether, or the extent to which, an upstream approach that was social justice-oriented and focused on root causes of poor and inequitable health, was evident.

Following some brief historical framing around societal approaches to addressing poverty and need, we first provide some examples of how the administrative lines separating health and social policy domains were (appropriately) blurred during the first half of the twentieth century in Alberta. Next, we consider a period during the 1970s and 1980s when health and social policy were merged into one provincial government ministry and which, on the surface, could embrace consideration of the health implications of social policy decisions and vice versa, in line with a health-in-all-policies approach. Finally, to shed light on more recent discourse, tensions, and opportunities for a broad vision of public health, we examined instances where "social determinants of health" was mentioned in the provincial legislature, including by whom and in what circumstances. Alberta provides an interesting context for this study. The province's recent history, particularly since the 1970s, is largely characterized by a precarious boom-bust economy dominated by fixation on extractive resource revenue and politically conservative leadership which — notwithstanding the range of beliefs within conservatism — tends to be at odds with a social determinants of health approach. Indeed, Alberta's record on public policy, which has almost universally worsened social and economic inequality, poverty, and the quality and

availability of public services and supports, has been highly problematic from the point of view of well-being and health equity.[6]

Conceptual Framing: Societal Responses to Poverty and Need

In his review of milestones in Alberta's public welfare history, social worker and historian Baldwin Reichwein provided examples from ancient history of societies feeling a duty to "help the poor." For most of human history, this sentiment took the form of charity, or voluntary acts of giving, to those deemed "in need" by those with social and economic advantage.[7]

This sentiment, and its underpinnings in classical political conservativism, evolved into different approaches to social policy within organized state administration which, as per the social determinants of health approach, have significant implications for well-being and health equity. The post-WWII development of Canada's welfare state is a relatively recent example; although, as discussed elsewhere in this volume, the welfare state has not prevented a broad array of services and supports from falling to the private and non-profit sectors (Chapter 5), nor has it embodied the inclusivity that it is widely believed to symbolize (Chapters 1 and 7).

A much earlier historical example is England's "poor laws." The poor laws of the sixteenth and seventeenth centuries took the form of a parish-level tax administered locally, which provided relief for the aged, sick, and infant poor, with leftover funds to be used to create jobs for "able-bodied" people, often in workhouses.[8] The poor laws and subsequent versions of them are relevant to this chapter and to public health more generally because some of the tensions embedded in the contemporary social determinants of health discourse have roots in those early activities. For example, having state infrastructure to collect and redistribute public taxes raises pragmatic but value-laden questions about who is and is not eligible for assistance, how much they should receive, and the criteria for evaluating need. Notions of eligibility have long been infused with tensions around deservingness and what constitutes appropriate generosity. For example, a fourteenth-century English statute made a distinction between the "worthy poor" — which included older people, people with disabilities, widows, and dependent children — and the "unworthy poor" — those who were able-bodied but unemployed.[9] A problematic belief that the "able-bodied poor" could and should work for pay has long underpinned a view that the generosity of aid should not exceed a certain limit, to ensure that there is no incentive to remain on public assistance.[10]

In Canada, these tensions have materialized in what Danish welfare state scholar Gøsta Esping-Andersen has called a liberal welfare orientation.

Underlying Esping-Andersen's liberal regime is a key belief, whether implicit or explicit, that the state should only intervene in the economic lives of individuals if the capitalist market fails. Welfare benefits in liberal regimes, according to Esping-Andersen, accordingly tend to be modest, that is low enough that they do not present a disincentive to working for private wages, and/or means-tested where one must prove their eligibility.[11] Alberta's recent historical alignment with this liberal orientation is succinctly conveyed by the subtitle of Reichwein's public welfare review noted above: "history rooted in benevolence, harshness, punitiveness, and stinginess."[12] These styles and modes of governance and approaches to public policy have demonstrable implications for health, well-being, and health equity;[13] they are thus integral rather than peripheral to public health as a field of scholarship and applied practice.

Social Determinants of Health in the Provincial Government: Insights from Alberta's History, 1919–2019

> "As part of its commitment to community health during the early 1900s, the [Edmonton] Board of Health helped administer the limited social service programs offered by the city [including] the distribution of relief funds necessary to tide destitute citizens over the difficult winter months. Efforts were made, starting in 1908, to develop an effective system of assessing relief cases and supplying provisions to citizens who qualified for assistance." — Toward a Healthier City: A History of the Edmonton Board of Health, 1871–1995[14]

The quotation about the Edmonton Board of Health shows that local public health authorities were involved in efforts related to social determinants of health — in this case, poverty relief — during Alberta's earliest years as a province. Although one should not over-interpret this involvement — in the early phases of the province, all government departments had a wide range of responsibilities (see Chapter 4) — it does not seem unreasonable to speculate that officials were attuned to the (likely obvious) health effects of economic destitution, especially during winter in a northern climate.

An administrative connection between health and social policy continued and, perhaps not surprisingly, expanded during the depression years of the late 1920s through the 1930s. Starting in 1926, under the United Farmers of Alberta government, the provincial minister of public health was given responsibility

for the provision of poverty relief in Improvement Districts of the province (relief in urban areas was the responsibility of the individual municipalities). The Social Credit government, elected in 1935, continued to build social welfare infrastructure. They consolidated provincial relief efforts into a Bureau of Public Welfare which, along with the Child Welfare and Mothers' Allowance Branch, was under the authority of the Department of Public Health starting around 1937. This arrangement, with the provincial public health department having responsibility for social welfare, continued until 1944 when the bureau and the branch moved to a newly created provincial Department of Public Welfare.[15]

There are indications that public health authorities of the time were aware that social and economic factors were important for health. One example is Alberta Deputy Minister of Health Dr. Malcolm Bow's 1937 address to the Canadian Public Health Association, of which he was president at the time, where he said, "if our ideal is a full measure of physical and mental health for all, then the housing problem ought to be one of the first to receive attention."[16] Bow identified housing —in particular, unsanitary housing — as the first of "eight major health problems facing us to-day," thus providing an illustration of early attention to what we now call the social determinants of health.

The 1970s and 1980s: The Health and Social Merger Period

> "You will, therefore, be asked to consider legislation to create a new Department of Health and Social Development, laying the foundation for an integrated approach to preventive, as well as active and rehabilitative health and social services at the community level." — 1971 Alberta government throne speech, Harry Strom (SC).[17]

In 1971, as announced in the quotation from the Strom government's throne speech, provincial health and social policy domains were brought together into the Department of Health and Social Development. The arrangement theoretically signified attention to health implications of social policy and vice versa and is thus potentially informative from a contemporary health-in-all-policies perspective. The department was renamed Social Services and Community Health in 1975.[18] To accompany this section, a timeline of key events is provided in Table 12.1.

Table 12.1: Summary of some milestones concerning intersectoral (health and social policy domains) activities and arrangements in the province of Alberta, 1905–2010s.

Year	Event
Early 1900s	The Edmonton Board of Health helped to administer the limited social service programs offered by the city at the time
1926	The Minister of Public Health was made responsible for provision of relief (social assistance) in Improvement Districts of the province
1937	The Bureau of Public Welfare and the Child Welfare and Mothers' Allowance Branch fell under the authority of the Department of Public Health (until 1944)
1966	The provincial *Preventive Social Service* program was introduced as part of a broader Social Credit reform of welfare services. The program aimed to empower local governments to deliver preventive social programs.
1967	The *Preventive Health Services* report, commissioned in 1965, was released. Its mandate was to make recommendations on preventive health services in Alberta including ways to coordinate and integrate preventive health services with other services including social services. With the passing of the *Department of Health Act*, the provincial *Department of Public Health* (est. 1919) was replaced by the *Department of Health*, which was divided into two sections each with its own deputy minister: Health Services, and Hospital Services.
1969	Within a broader context of deinstitutionalization, the *Blair Report* on mental health, commissioned in 1967, was released. One of the report's key recommendations was to integrate social services and health services at the local level.
1971	The provincial *Department of Health and Social Development* was created under the Social Credit government of Harry Strom and unfolded under the Progressive Conservative government of Peter Lougheed, elected in 1971.
1975	The department was re-named *Social Services and Community Health*, and functions related to hospitals and health care insurance were transferred to a separate, newly established provincial *Department of Hospitals and Medical Care*.
1986	*Social Services and Community Health* was dissolved with the creation of the provincial *Department of Community and Occupational Health*, which absorbed the public health programs (but not the social service programs) from the former department.
1989	With the passing of the *Department of Health Act*, the Department of Community and Occupational Health and the Department of Hospitals and Medical Care were dissolved. All of "health" (i.e., public health, medical care, and hospitals) was back together under one ministerial roof, separate from social services (and other social determinants of health).
2012	The provincial *Ministry of Human Services* was created, which consolidated several people-centered departments and programs
2013	Alberta's *Social Policy Framework* was released, one of the main goals of which was to coordinate activities within and between government and ensure that there is policy alignment and consistency. "Social policy" was defined as extending beyond social services, to consider how we work, live, and spend our time, thus showing some alignment with a social determinants of health approach
2014	The *Social Policy Framework* disappeared with the election of Jim Prentice

THE ALBERTA DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT: CONTRIBUTING FACTORS

Although the new department existed almost entirely during Peter Lougheed's Progressive Conservative administration (1971–1985), its foundations were set during the later years of Social Credit leadership (1935–1971).[19] We highlight three intersecting initiatives during the 1960s and early 1970s that contributed to the creation of the merged department: i) the preventive health services report; ii) the Preventive Social Service program; and iii) *Mental Health in Alberta: a Report on the Alberta Mental Health Study, 1968* (the Blair Report). These initiatives, summarized below, occurred within the federal context of the Canada Assistance Plan, which was created in 1966 to support the provision of social programs by provinces, territories, and municipalities.

First, in 1965 a special committee was established by the provincial government to review and produce a report containing recommendations on preventive health services in Alberta. In the context of growing concerns about provincial spending on health care, especially hospitals, the committee was explicitly tasked with finding ways to coordinate and integrate preventive health services with other services, including hospitals and other health services, welfare, and special education.[20]

The 144-page preventive health services report was tabled in 1967 and included 247 recommendations.[21] Described in the news media as "explosive," the report recommended significant re-organization of the provincial health department,[22] including to divide the province into nine health regions. While this did not materialize until the mid-1990s,[23] it is relevant to the present discussion because the health region concept underpinned the report's recommendations concerning coordination of health and social services, including that preventive social services be based on the health region (recommendation #161), that the areas served by welfare workers be made coterminous with health regions and health districts (#162), and that the responsibility for the operation and administration of social services be transferred to the boards of health regions (#163).[24] These recommendations, where coordination between sectors involves the social sector falling to the parameters of the health sector rather than the other way around, may illustrate the notion of "health imperialism," a negative term to describe a tendency of the health sector to presumptively take leadership in any intersectoral arrangement.

Another organizational recommendation of the preventive health services report was to replace the Department of Public Health Act (first passed in 1919) with a new Department of Health Act. Under that act, which passed in 1967, the new department was divided into two sections — one for hospital services

(responsible for activities under hospital and nursing home legislation) and one for health services (responsible for everything else, such as local health services, vital statistics, environmental health), each of which now had a deputy minister.[25] Concern for the state of public health was evident in the report and echoed in the legislature: "there is great need for active steps to improve the image of public health and raise the standards of operation from the provincial point of view. Otherwise, that branch of the health services known as public health will continue to wane."[26] Moreover, by strengthening a distinction between health and hospitals, the 1967 act seems to have set the stage for the more extensive re-organization that followed in the early 1970s.

The second initiative, which concerned the preventive social service domain, began around the same time. As described in an extensive analysis by Professor of Social Work, Leslie Bella, Alberta's Preventive Social Service program was introduced in 1966 as part of a broader Social Credit reform of welfare services.[27] Embodying the government's philosophy of local autonomy, the program aimed to empower municipalities to deliver preventive social programs, with 80 percent of funding to do so provided by the province.[28] Examples of local programs included counselling, day care, home care, information and referral, youth programs, volunteer recruitment, and community programs.

The Preventive Social Service program had four major — and somewhat morally infused — goals: i) to prevent welfare dependence; ii) to prevent marriage breakdown, which was seen to lead to welfare dependence; iii) to reduce child welfare intake; and iv) to promote general social and physical well-being. An important insight from Bella was that the goals were interpreted differently by politicians on the one hand and administrators on the other. The politicians, in line with the Social Credit's ideological orientation, intended the program to reduce dependency on public assistance and thus prevent the welfare state. The administrators, in contrast, saw the program as a way to strengthen social services and thus expand the welfare state.[29]

Although the preventive health services and preventive social services initiatives were important, Social Credit Health Minister James Henderson argued that the main impetus for the creation of the merged provincial department (Department of Health and Social Development) was the 1969 Blair Report on mental health. The report was released just as Premier Harry Strom was taking over following Ernest Manning's twenty-five-year reign. Set against the broader backdrop of the deinstitutionalization movement, which advocated for replacing residential institutions with community-based services for persons with disabilities,[30] as well as growing concerns by the Alberta government (including as expressed in the preventive health services report) about mental health problems

and the costs of treating them,[31] the Blair Commission was asked to make recommendations for a comprehensive and integrated program for diagnosing, treating, caring for, rehabilitating, and preventing mental illness in Alberta.[32] One of the Blair report's key recommendations was to integrate social services and health services at the community level; this was seen as a path to decentralizing mental health services, which were considered to transcend health and social domains. The new provincial Department of Health and Social Development was intended to provide "a common administrative plane" for those community-level services.[33]

CROSS-PARTY OPPOSITION TO THE NEW DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT: PEELING BACK THE LAYERS

The Progressive Conservatives, who formed the official opposition starting in 1967, were opposed to the idea of the merged department. Hugh Horner (PC, Lac St. Anne), for example, said "I am totally and absolutely opposed to the amalgamation," arguing that it — along with the hospital commission created around the same time — was "nothing but a bureaucratic expansion out of proportion to what's required." He also insisted on using the word "welfare" because he did not feel that the government was in fact doing anything about "social development."[34] Presciently, Leonard Werry (PC, Calgary-Bowness) expressed concern about whether the amalgamated department would maintain an intended focus on prevention and rehabilitation, and mental health.[35] Nonetheless, the bill to merge the two departments passed in a forced vote in March 1971, marking one element of what was described in the *Hansard* as "the most extensive re-organization of government departments since 1935."[36] The new Department of Health and Social Development was responsible for almost all social services and health programs and for vital statistics.[37]

The department was thus in place when the Progressive Conservatives, under Peter Lougheed, won the 1971 provincial election. Although they had opposed the legislation, they decided to "carry the experiment forward," in part — according to the minister of the new department, Neil Crawford — to reduce additional disruption among departmental staff.[38] The first session of the new legislature (1972) gives some insights into some of the tensions around the new department, both within and between parties. Within the PCs, Dr. Kenneth Paproski (Edmonton-Kingsway), for example, supported the new department's focus on what he termed "total health care," which included "physical, mental and social needs" and emphasized "health maintenance and not disease orientation only."[39] Ernest Jamison (PC, St. Albert), on the other hand, questioned the value of the new department, considering the "many existing agencies and volunteer bodies available" already to deliver these services. This latter comment illustrates the

blurred and contested lines of sectoral responsibility — including what services and supports should fall to the public, private or non-profit sectors — that is highly pertinent to a broad vision of public health. Moreover, in strong alignment with a social determinants of health perspective, Jamison also commented "that government can help more by providing employment and housing," arguing that looking after those two needs is key to preventing "social difficulties."[40]

Comments from Roy Farran (PC, Calgary-North Hill) illustrate the difficulty, or unwillingness, of legislators to conceptualize an integrated version of health and social domains. After expressing that consolidation of health and social development would take many years to materialize, he segued into a lengthy commentary about the need to rationalize health programs, focusing on hospital beds. Farran's narrow and downstream view of "health" is illustrated by his comments about the appropriate scope of activities for health departments, specifically the Calgary health department: "The City of Calgary is spending a huge amount of money on an expanding health department . . . . They want to build separate little clinics in each corner of the city that go far beyond the original concept of the medical officer of health who went around and sniffed the drains and tested for typhoid and saw whether the kitchens were clean in the restaurants. Nowadays, they've gotten into the whole broad field of social welfare as well as direct health treatment."[41] Such a viewpoint, which trivialized activities that fall outside of a very narrow version of physical sickness, presented a significant challenge to implementing policy that embraced a broad vision of public health.

Comments from members of the Social Credit opposition, in turn, illustrate some of the long-standing tensions around assistance and deservingness of public support noted earlier in this chapter. Raymond Speaker, the minister of the new department when it was created under SC leadership, for example, questioned whether the PC government saw public assistance as a right or a privilege.[42] Douglas Miller (SC, Taber-Warner) said that "with respect to social development and social assistance . . . I feel strongly that costs and abuses will continue to mount until the entire program is decentralized to the local authority to screen service-development-workout-programs convenient for the needy. As I mentioned, for those who can work, there are plenty of things for them to do."[43] This comment also sheds some light on the reasons for the Social Credit's original focus on decentralization, stemming from the Blair report; namely, they saw it as way to help prevent "abuse of the system" by the undeserving "needy," thus illustrating Alberta's historically punitive approach to public assistance noted by social worker and historian Reichwein.

HOW "HEALTH" WAS CONCEPTUALIZED WITHIN THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Focusing on the period 1971–1972 through 1973–1974, when the department was called Health and Social Development, a few observations can be made about its alignment with the contemporary health-in-all-policies concept. First, in 1971–1972, which was the first full year of the new department, Chief Deputy Minister, Bruce S. Rawson (PC) stated in the department's annual report that the major objective of the new department was "to focus on health and social development needs in the province to bring about better planning and program development, priority setting and the integration and coordination of total service delivery."[44] Although one should be cautious about reading too much into a single sentence in a report from the past, it is interesting that "prevention" is absent from that statement, considering the emphasis on prevention that guided the new department in the first place. Second, the PC government almost immediately added new divisions including community care for those with mental illness.[45] Although this represents a more holistic approach compared to hospitals and residential institutions, it is still quite downstream in its emphasis on illness and treatment. Finally, and of potential concern from the perspective of the "public" in public health, is the report's emphasis on "greater involvement of the private sector" in these new divisions.

Further, for those first few years, annual reports show that the health and social domains within the new department appeared to co-exist rather than to be integrated to any great extent. For example, the summary of "preventive social services" in the 1972–1973 and 1973–1974 annual reports illustrate the ideological and moral underpinnings of the government by emphasizing community initiative, volunteer involvement, and reduction of unwanted outcomes such as "family breakdown," with limited explicit reference to health and well-being, even though promoting well-being was one of the stated goals of the program.[46] Meanwhile, the Provincial Board of Health within the department continued to emphasize health protection-style activities focused on physical illness, such as communicable disease control, food safety, and appropriate waste disposal; and the health units, which had become 100 percent provincially funded starting in 1973, continued to provide preventive public health services throughout the province.[47]

In 1975, in the context of national initiatives such as the Lalonde Report, which recognized a broader array of determinants of health, the department was renamed Social Services and Community Health.[48] The same year, functions related to hospitals and health care insurance were transferred to a separate, newly established provincial Department of Hospitals and Medical Care, which was in

place from 1975 to 1988.[49] Conceivably, with downstream, treatment-oriented activities organized separately, this arrangement could permit even more emphasis on social determinants of health by the merged department. Although health and social services appeared to remain organizationally separate during this time, some subtle indications of a shift in overall orientation are apparent in the annual reports. For example, the 1975–1976 report included a section on "prevention":

> In general, preventive services provide support toward developing individual, family and community strengths. These services, provided to all age groups, can touch on the fields of health, education, social welfare, community development, social planning, and even economic development. . . . Most [preventive social services] projects offer services at one or two levels of intervention: primary — where measures are taken to strengthen and support the individual, family and community before any breakdown occurs; [and] secondary — where steps are taken to solve a problem which has just emerged.[50]

Although the program's morally infused focus on "social breakdown" persisted, this description contained words that carry a hint of health promotion (building strengths), intersectoral thinking (health, education, etc.), and universalism (primary prevention).

In the health services section of that same report, the community health section contains the following preamble:

> In contrast with treatment-oriented medicine, community health services are primarily preventive in nature. . . . They are designed to reduce disease and disability, maintain standards of health and promote good health habits. To achieve these goals, community health services must take into account the many factors affecting the health of the individual and the community as a whole [including] . . . the physical and social environment [and] . . . the influences of heredity and lifestyle which may contribute to disease and illness.[51]

In 1977–1978, the preventive social services branch was transferred from the Social Services Division to the Health Services Division of the department. With this transfer, the major preventive programs of the department were grouped together in one division and preventive social services and local health services,

including dental, nutrition, home care, immunization, and regulation of day care facilities, were jointly administered.[52]

Overall, this partial analysis of the 1970s, anchored in contemporary health-in-all-policies discourse, suggests that by putting two previously separate policy or service domains into the same government department, integration can increase over time. Importantly, however, this analysis also makes obvious that such service integration — although theoretically consistent with a broad conceptualization of health — by no means ensures an upstream orientation to addressing the social determinants of health as embraced by a broad vision of public health.

Social Services and Community Health was dissolved in 1986 with the creation of the Department of Community and Occupational Health, which absorbed the public health programs, but not the social service programs, from the merged department. The new Department of Social Services, later renamed the Department of Family and Social Services, absorbed the social service programs. With that 1986 legislation, health and social policy domains were once again administratively separate. A few years later, Community and Occupational Health (est. 1986), and Hospitals and Medical Care (est. 1975), were dissolved with the Department of Health Act of 1989.[53] Thus, starting in 1989, all of "health" — including public health, medical care, and hospitals — was once again together under one ministerial roof, and this was the context for our final section.

Mobilization of "Social Determinants of Health" in the Alberta Government: The 1990s–2010s

BACKDROP: THE PROVINCIAL DEPARTMENT OF HEALTH IN THE 1990S

Annual provincial Department of Health reports from the early 1990s suggest some attention to the social determinants of health, including policy antecedents. For example, among the nine health goals identified in Alberta Health's 1991–1992 annual report was "to include a health perspective in public policy," thus aligning with the concept of healthy public policy that had been recently introduced in the Ottawa Charter for Health Promotion.[54] Subsequent annual reports suggest some modest engagement with this goal. For example, the 1993–1994 report stated that "healthy public policy means taking into account the possible impacts on health of a proposed major policy change. It also means consulting with the groups potentially most affected when a policy is changed. As a result of concerns raised by seniors during review of the proposed Alberta Seniors Benefit several changes to the program were suggested."[55] The Alberta Seniors Benefit, a form of social assistance, is administered by a government department other

than health, and consulting with seniors is one way to gain insight into its implications for health and well-being.

Considering these initiatives, along with the "Klein Revolution," the 1990s and early 2000s provide an interesting context in which to study mobilization of social determinants of health concepts in the Alberta government.[56] To do so, we searched the *Alberta Hansard* for "social determinants of health"; we summarize some key people and events chronologically in the following pages.[57] To help orient the reader, the individual politicians referenced below are listed in Table 12.2.[58]

Table 12.2: List of individuals referenced in our analysis of social determinants of health in Alberta legislative debates, 1990s–2019 (alphabetical by last name).

Name	Party affiliation and constituency (during time period referenced)
Laurie Blakeman	Liberal, MLA for Edmonton-Centre
Heather Forsyth	Progressive Conservative, MLA for Calgary-Fish Creek
Carol Haley	Progressive Conservative, MLA for Airdrie-Chestermere
Dave Hancock	Progressive Conservative, MLA for Edmonton-Whitemud and Minister of Human Services
John Hayden	Progressive Conservative, MLA for Drumheller-Stettler
J.A. Denis Herard	Progressive Conservative, MLA for Calgary-Egmont
Fred Horne	Progressive Conservative, MLA for Edmonton-Rutherford and Minister of Health and Wellness
Ralph Klein	Progressive Conservative, Premier and MLA for Calgary-Elbow
Jim Prentice	Progressive Conservative, Premier and MLA for Calgary-Foothills
Alison Redford	Progressive Conservative, Premier and MA for Calgary-Elbow
Dave Rodney	Progressive Conservative, MLA for Calgary-Lougheed
Linda Sloan	Liberal, MLA for Edmonton Riverview
Ed Stelmach	Progressive Conservative, MLA for Fort Saskatchewan-Vegreville
David Swann	Liberal, MLA for Calgary-Mountain View

SOCIAL DETERMINANTS OF HEALTH IN ALBERTA GOVERNMENT DELIBERATIONS: THE 1990S: EDMONTON-RIVERVIEW MLA, LINDA SLOAN

The first explicit references to "social determinants of health" in the Alberta legislature were made in the late 1990s. Linda Sloan (Liberal; 1997–2001) served as opposition critic for Family and Social Services and stands out as perhaps the

only person making such references during the 1990s based on the *Hansard*.[59] For example, in a 1997 debate on Bill 14: The Appropriation Act, which authorized how funds from General Revenue were to be used for the fiscal year, Sloan identified what she saw as a disproportionately low operating allocation to the Department of Labour, compared to other, service-oriented departments such as health and family and social services. This was problematic, she argued, because of what it implied for social determinants of health, namely working conditions:

> That [inadequate funding to the Department of Labour] is reflective, I think, of . . . the subversive means that are taken . . . to undermine the working conditions of people in this province, and to undermine the . . . unions in this province whose existence is to serve, to advocate, and to represent employees and to promote their socioeconomic status. . . . I speak to it knowing the relationship between the social determinants of health . . . not only being defined singularly by accessing services or working within a particular sector but by being able to afford to eat nutritional foods, being able to live in an adequate house . . .[60]

Sloan's recognition of the connections between labour unions and health, and that health is not reducible to health or social services or private income, are indicative of her strong understanding of the social determinants of health. As another illustration, in 1999, Sloan mobilized the social determinants concept in reference to income inequality:

> We saw really late last month the release of a report surrounding income disparity [including] how the gap between rich and poor in the province of Alberta is growing. When that report was released, the Premier heatedly chastised the institution, the Parkland Institute, that had sponsored the conference at which the report was released and proceeded to subliminally suggest that that institute's funding should somehow be undermined. It struck me how arrogant that that approach would be taken when I have not seen a report from this government about income disparity, about the social determinants of health and how their program policy and budget changes have had an impact on the social determinants of health in this province.[61]

Sloan pointed out that, not only was the Klein government failing to address income inequality nor considering how their government's policies were

contributing to it, but they tried to undermine an organization for demonstrating that the problem existed.[62]

Overall, an analysis of the social determinants of health concept in Alberta must recognize Linda Sloan as being one of the only voices for this concept in provincial government deliberations in the unfriendly environment of the 1990s Klein government.

THE 2000S: LIBERAL MLA LAURIE BLAKEMAN, THE WELLNESS INITIATIVE, AND THE HEALTHY FUTURES ACT

During the first decade of the 2000s, references to the social determinants of health in the Alberta legislature increased modestly. Standing out amid this growing voice was Laurie Blakeman (Liberal, Edmonton-Centre). From 2004 to 2008, Blakeman served as opposition critic for Health and Wellness. Blakeman effectively mobilized the social determinants concept both in social policy debates (for example, questioning whether health was considered in deliberations concerning the Assured Income for the Severely Handicapped program in 2005) and in health debates.[63]

An example of Blakeman's mobilization of the social determinants concept in health debates is seen in the 2006 debate on Bill 1: Alberta Cancer Prevention Legacy Act, which was broadly intended to position Alberta "to attack cancer at every level, from prevention right through to potential cures." Blakeman skillfully drew attention to the act's limited attention to primary prevention and social determinants of health when she said, "I'm always interested in the juxtapositions that I witness in this House, and there are two of them that I'm seeing come with this bill. On the one hand, we have this bill being tabled in the House on one of the same days that . . . coal-bed methane exploration is resulting in contamination of . . . well water to the point where they can set it on fire. You juxtapose that kind of toxicity in someone's life with this grand bill to deal with ending cancer. You've got to put those two things together, folks."[64] Blakeman used the social determinants of health concept to highlight what she saw as the hypocrisy, gently described as "juxtapositions," of the cancer initiative, considering the limited policy attention to environmental carcinogens.

Two other initiatives during the '00s, both led by Blakeman, were Motion 501 concerning a Wellness Initiative, and Bill 214, the Healthy Futures Act. These are informative in part because of the ensuing debate, which sheds light on points of opposition and informs a broad vision of public health that embraces social determinants of health and their socio-political implications.

Blakeman's 2005 Motion 501, Wellness Initiatives proposed that the government use taxes from tobacco sales to create a wellness fund. The fund was envisioned to contribute to a healthier society and cost containment in the health

care system by supporting wellness programs delivered through family and community support services; public health initiatives such as efforts to create healthier environments in schools, hospitals, etc.; and research on how to better integrate social determinants into wellness and health system initiatives.[65]

The motion was defeated (11 for, 31 against). Although some members spoke in favour, commending the motion's focus on investment in the causes of health problems,[66] several others opposed it, drawing on lines of opposition seen in other debates (see Chapters 3 and 8) such as redundancy with existing policies. For example, Carol Haley (PC, Airdrie-Chestermere) argued that she could not support the motion because "there is already a fund dedicated to healthy living initiatives in Alberta. It is called the Department of Health and Wellness. . . . There is another fund. It's . . . called the Alberta Heritage Foundation for Medical Research."[67] These comments reveal a persistent and frustrating conflation of health and health care. Both the Department of Health and Wellness and the Alberta Heritage Foundation for *Medical* Research (italics added) were predominantly focused on biomedical, clinical, and health care-oriented initiatives, which is precisely what the Wellness Initiative was aiming to offset by its broader conceptualization of health and its determinants.

In 2007, Blakeman introduced private member's Bill 214: Healthy Futures Act under the Progressive Conservative Ed Stelmach (2006–2011) government. Recognizing that many important determinants of health have little to do with the health care system, the bill proposed that major policies and funding decisions undergo a health impact assessment, which involves judging the potential health effects of a government initiative with the aim of maximizing the proposal's positive health effects and minimizing its negative effects. The bill, which Blakeman argued aligned with World Health Organization recommendations, would include the appointment of a director of assessment review who would lead and oversee assessment processes.[68]

Although several members voiced support for the bill, several others opposed it, and the bill was defeated at second reading (15 for, 26 against).[69] Once again, opponents argued that the proposed activities were not necessary in light of processes already in place. John Hayden (PC, Drumheller-Stettler), for example, argued that " our government . . . has shown its commitment to continuous improvement in the area of health by creating the Health Quality Council of Alberta. . . . [E]stablishment of a health commissioner [therefore] seems unnecessary."[70] Hayden argued that health impact assessment was not necessary in light of all-party committees and the existing Health Quality Council of Alberta. Importantly, however, the council is entirely focused on the health care system,[71] and thus fundamentally differs in its mandate from the intent of Bill 214, which

was to systematically consider the health implications of decisions outside of the health sector.

A second line of opposition was that the proposal was overly broad and thus, by definition, problematic, as argued by Dave Rodney (PC, Calgary-Lougheed): "one of my main concerns with this bill is that it could effectively bring the decision-making apparatus of the government and this Assembly to a grinding halt."[72] Other PC legislators, such as Heather Forsyth (PC, Calgary-Fish Creek), argued that the bill's breadth gave it the potential to be too subjective when she said that "public health impact assessments have the potential to become a public forum of opinion rather than informed decisions on empirical evidence."[73] Health impact assessments *do* involve public consultation and they *are* evidence-based; the comment thus misunderstands that the two can (and should) go together.[74]

Overall, instances where the social determinants of health concept was mobilized in Alberta government during the '00s reveal important challenges for a broad vision of public health, including the need to articulate and defend upstream policies for well-being and health equity in a way that is less vulnerable to predictable and inaccurate, but unfortunately often effective, opposition comments about redundancy, specificity, and conflation with health care.

THE 2010S: ALBERTA'S MINISTRY OF HUMAN SERVICES AND THE SOCIAL POLICY FRAMEWORK

Our final illustration of the mobilization of social determinants of health concepts in the Alberta government is Alberta's Social Policy Framework, which was developed during the PC government of Alison Redford (2011–2014).

To set some context for the framework, we note some relevant comments from the 2012 legislative assembly discussion of budget estimates for the provincial Department of Health and Wellness. In response to a query from David Swann (Liberal, Calgary-Mountain View) around funding for public health, which is a very small proportion of the health and wellness budget, PC Minister of Health and Wellness Fred Horne stated: "To sum up with respect to public health, the expenditure out of the budget formerly under the public health budget for wellness is about 3 percent, but as hopefully I've been able to describe to my colleagues, wellness is embedded throughout not only my ministry in terms of the primary care system but also through many other ministries, including Justice and Attorney General, Human Services, Education, and others that have a direct role in influencing the social determinants of health."[75] In other words, Minister Horne seemed to be justifying a small budget for public health activities (within the health budget) on the basis that other departments were in fact also responsible for policies and services that support the social determinants of health. While accurate, it could also signify "passing the buck" such that no

ministry would be responsible for social determinants of health unless there was a framework in place to ensure that they did not fall through cracks of discrete ministries. It was in this context that Alberta's Social Policy Framework was released in 2013 under the leadership of Minister of Human Services, Dave Hancock.

The Ministry of Human Services, created in 2012, consolidated several departments, including Child and Family Services, Housing and Urban Affairs, and Employment and Immigration, and programs, such as Assured Income for the Severely Handicapped and Protection for Persons with Developmental Disabilities. Although it brought many "people-centered" activities into one department, there was some trepidation about how this would play out. Indeed, Hancock himself said that his "biggest concern was whether or not we would have the opportunity to look at it from a holistic basis . . . is this just going to be running programs, or is this going to be an opportunity to reshape how we think about our society and how we think about the role of government in supporting individuals to be successful?"[76]

Other comments, moreover, add nuance around some of the underlying orientations. In reference to flipping pancakes during Social Work Week, Hancock stated that he "got into some exciting conversations with individuals there about . . . how they feel about a minister who says that there are two parameters, the Bible on one side and the Criminal Code on the other. It has to be legal, and it has to be ethical and moral. Within that, we expect you to use judgment. Rules are for when brains run out."[77] The context was the ministry's emphasis on "outcome-based services," where front line professionals such as social workers were to be empowered to use their judgment to achieve a positive outcome for the person or family in front of them. However, the Bible and Criminal Code references seem problematic in the light of their misalignment with a social justice orientation that values inclusion (e.g., diverse religious or spiritual affinities) and that is contrary to a punitive, discriminatory, "tough on crime" approach to societal well-being.[78]

Reminiscent of the health and social merger period of the 1970s, there are indications that the Department of Human Services tended, at least initially, toward a partial and downstream focus on persons living in challenging social and economic conditions, as opposed to a more upstream population-level focus. This is illustrated by a line of questioning from David Swann about the ministry of human services' plans for childcare.

> Effective April 1 the household income that qualifies families to receive the maximum childcare subsidy will increase from $35,000 to

> $50,000. This will allow additional low- and middle- income families to receive new or increased funding to offset the cost of accessing childcare, which is a positive development; that is, of course, if they are able to find the childcare space. My understanding is that only about one-fifth of our young parents that are working — that is, about 70 per cent of the mothers that have children of childcare age — can get access to childcare services.[79]

Swann commended the expansion of eligibility for the childcare subsidy but drew attention to the limitations of the current childcare environment for working parents across the population.

Although the health ministry was not part of the new Ministry of Human Services, it was, according to Hancock, integrally involved in the social policy framework itself.[80] Although members could, and did, raise fair questions about what the framework actually meant in practice,[81] the document upon its release in February 2013 showed alignment with a health-in-all-policies approach.[82] For example, included among the main goals was "to coordinate activities within and between government . . . and to ensure that there is policy alignment and consistency." Further, in a section titled "What is social policy," the wording conveys an upstream orientation: "social policy extends beyond a narrow definition of social services and supports: it is about how we work, live, and spend our time, and it helps determine how we come together to meet human needs like housing, employment, education, recreation, leisure, health, safety, and the care of children."[83] Other references to "health" likewise suggest alignment with a social determinants approach; for example, the framework document says that "social, economic, and environmental policies interact and complement each other. For instance . . . land use and development decisions are linked to economic and recreational opportunities at the local level, and the health of the physical environments — from clean air to safe drinking water — is related to the health of the people who live in them."[84]

Overall, these statements illustrate a framework that might have supported an upstream, population-level, social justice-oriented approach to public policy, consistent with a social determinants of health perspective. Unfortunately, we did not get a chance to see whether or to what extent those intentions would have materialized, because the framework disappeared in 2014 with the election of Jim Prentice (PC). This turn was disappointing to many, including Laurie Blakeman, still the Liberal MLA for Edmonton-Centre, who made the following comments in the Prentice throne speech debate in November 2014.

> What I want to talk about is what's not in the throne speech. . . . This throne speech had no reference to the social policy framework. . . . Why would you abandon something that so many people have worked on so hard, that was such a buy-in from so many people?
>
> Today we have over 140,000 people in poverty, children in poverty . . . and what are you doing about it? Where is the social policy framework? . . . Like, how many times do you guys have to be given the studies and the facts and the numbers that show you that an investment in social policy pays off over and over and over again? But, no, you guys want to have more police and more ambulance workers and more prisons, because that's where everybody ends up, when you could be investing on the front end.[85]

Conclusions

Anchored in contemporary calls for a health-in-all-policies approach, which is integral to a broad version of public health, in this chapter we considered examples of how the social determinants of health concept has manifested in provincial governments across Alberta's history, including whether or the extent to which an upstream, social justice-oriented approach is evident.

During the first half of the twentieth century, there are examples where formal health structures, such as local boards of health and the provincial Department of Public Health, participated substantively in social assistance initiatives, thus embedding the notion that health and social factors are connected and suggesting subtle but potentially important ways in which governance arrangements matter. And indeed, when health and social policy domains were deliberately placed together in the 1970s in the provincial Department of Health and Social Development, there are indications that, despite some ongoing examples of "turf wars," health and social services seemed to become somewhat more integrated over time. Importantly, however, integrating (or providing a mechanism to integrate) services or policy domains does not in itself ensure an upstream approach as embraced by a social determinants of health perspective. To ensure that health, rather than a narrow focus on illness, and equity, rather than charity, are emphasized, other factors — such as vision, public engagement, leadership, tools for evaluation, and funding — need to be in place.[86]

In their report titled *Health Equity through Intersectoral Action*, the World Health Organization recommended, among other things using political champions to advocate for intersectoral action.[87] This need for political leadership and vision is perhaps best illustrated by our analysis of the most recent period of the

1990s through the 2010s. There were several individuals in the Alberta government — such as Linda Sloan and Laurie Blakeman — who were highly knowledgeable, articulate, and passionate about the social determinants of health. Perhaps a main comment of regret is that there were too few of them. Building capacity to mobilize around such voices is an important goal for a united public health community in Alberta that can effectively work toward improving health and well-being for everyone.

NOTES

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2 National Collaborating Centre for Determinants of Health (NCCDH), *Let's Talk: Health Equity*, 2nd ed. (Antigonish, NS: NCCDH, St. Francis Xavier University, 2023), https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Health_Equity_EN_June5.pdf.

3 For example, Canadian Public Health Association (CPHA), *Public Health: A Conceptual Framework,* Canadian Public Health Association Working Paper (Ottawa: CPHA, 2017), https://www.cpha.ca/public-health-conceptual-framework; David Butler-Jones, *The Chief Public Health Officer's Report on the State of Public Health in Canada 2008: Addressing Health Inequalities* (Ottawa: Public Health Agency of Canada, 2008), https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/report-on-state-public-health-canada-2008.html); NCCDH, *Alberta Health Services: Establishing a Province-Wide Social Determinants of Health and Health Equity Approach* (Antigonish, NS: NCCDH, St. Francis Xavier University, 2013), http://nccdh.ca/images/uploads/Alberta_Health_Services_Case_Study_Final_En.pdf.

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5 Paul Kershaw, "The Need for Health in All Policies in Canada," *Canadian Medical Association Journal* 190, no. 3 (22 January 2018); Marcello Tonelli, Kwok-Cho Tang and Pierre-Gerlier Forest, "Canada Needs a 'Health in All Policies' Action Plan Now," *Canadian Medical Association Journal* 192, no. 3 (20 January 2020); Evelyne de Leeuw and Carole Clavier, "Healthy Public in All Policies," *Health Promotion International* 26, suppl. 2 (2011).

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Growth Doesn't Trickle Down: The Wage Dimensions of Income Polarization," in Raphael, *Social Determinants of Health: Canadian Perspectives*, 41–60; Nathalie Auger and Carolyne Alix, "Income, Income Distribution, and Health in Canada," in Raphael, *Social Determinants of Health: Canadian Perspectives*; Richard G. Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996); Richard Wilkinson and Kate Pickett, *The Spirit Level: Why Equality is Better for Everyone* (London: Penguin Books, 2009). See also various reports by Parkland Institute (https://www.parklandinstitute.ca).

7 Reichwein, *Benchmarks in Alberta's Public Welfare Services*.

8 "Poor Law – British Legislation," *Encyclopedia Britannica*, accessed 25 November 2020, https://www.britannica.com/event/Poor-Law; Reichwein, *Benchmarks in Alberta's Public Welfare Services*.

9 Robert L. Barker, *The Social Work Dictionary* (Washington, DC: NASW Press, 2003), 474.

10 Reichwein, *Benchmarks in Alberta's Public Welfare Services*. See also Lindsay McLaren, "In Defense of a Population-level Approach to Prevention: Why Public Health Matters Today," *Canadian Journal of Public Health* 110, no. 3 (2019).

11 Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton, NJ: Princeton University Press, 1990); Raphael et al., *Social Determinants of Health: The Canadian Facts*. In this context, liberal refers to classical liberalism and its emphasis on individual liberty and equality.

12 Reichwein, *Benchmarks in Alberta's Public Welfare Services*. The single-term leadership of the provincial NDP (2015–2019) represents somewhat of an exception to this broad statement.

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24 Legislative Assembly of Alberta, *Report of the Special Legislative and Lay Committee*, 109–110.

25 Alberta Department of Public Health, *Annual Report 1967* (Edmonton: Printed by L. S. Wall, Printer to the Queen's Most Excellent Majesty, l969), 10–11; Legislative Assembly of Alberta, *Report of the Special Legislative and Lay Committee*; *The Department of Health Act*, S.P.A. 1967, c. 27.

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29 Bella, "Goal Effectiveness." According to Bella, the program — which was introduced in 1966 — was one of the few to survive into the more fiscally restricted seventies. Further, and based on research by Bella and others, the program was expanded and was renamed Alberta Family and Community Support Services Program.

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41 Alberta. Legislative Assembly of Alberta, 16 March 1972.

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43 Alberta. Legislative Assembly of Alberta, 14 March 1972.

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46 Alberta Health and Social Development, *Annual Report 1972–73* (Edmonton, 1973), and Alberta Health and Social Development, *Annual Report 1973–74* (Edmonton, 1974); Bella, "Goal Effectiveness."

47 Alberta Health and Social Development, *Annual Report 1971–72*; Alberta Health and Social Development, *Annual Report 1972–73*; Alberta Health and Social Development, *Annual Report 1973–74*.

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56 Kevin Taft, *Shredding the Public Interest* (Edmonton: Parkland Institute, 1997).

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58 There are others who spoke up for social determinants of health but whom we did not feature here, including long-serving Liberal MLA (Edmonton Riverview) Kevin Taft, and David Swann. As one example of Taft's mobilization of the social determinants of health concept, in 2002 Taft spoke in favour of Bill 6: Student Financial Assistance Act, highlighting the benefits of fair access to education not only for individuals but also for society as a whole, including reducing societal inequality and contributing to a healthy, functioning democracy (Alberta. Legislative Assembly of Alberta, 7 March 2002), and during Oral Question Period in 2006 when Taft questioned the government's focus on health reform that would involve out-of-pocket payment in the context of a growing gap between rich and poor in the province (Alberta. Legislative Assembly of Alberta, 14 March 2006).

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64 Alberta. Legislative Assembly of Alberta, 2 March 2006.

65 Alberta. Legislative Assembly of Alberta, 7 March 2005.

66 These comments came from Dr. Bruce Miller (Liberal), MLA for Edmonton-Glenora, and Dr. David Swann (Liberal), MLA for Calgary-Mountain View. Alberta. Legislative Assembly of Alberta, 7 March 2005.

67 Alberta. Legislative Assembly of Alberta, 7 March 2005.

68 Alberta. Legislative Assembly of Alberta, 26 November 2007.

69 Members who spoke in support of Bill 214 included Harry Chase, Bridget Pastoor, Jack Flaherty, Craig Cheffins, and David Taylor, all Liberals and all of whom spoke to the bill's emphasis on upstream approaches to the well-being of the collective.

70 Alberta. Legislative Assembly of Alberta, 26 November 2007.

71 Alberta. Legislative Assembly of Alberta, 26 November 2007; "Our Mandate," Health Quality Council of Alberta, accessed 22 November 2020, https://hqca.ca/about/our-mandate/.

72 Alberta. Legislative Assembly of Alberta, 26 November 2007.

73 Alberta. Legislative Assembly of Alberta, 3 December 2007.

74 "Health Impact Assessment," Health Topics, WHO, accessed 22 November 2020, https://www.who.int/health-topics/health-impact-assessment#tab=tab_1.

75 Alberta. Legislative Assembly of Alberta, 7 March 2012 (Fred Horne, Progressive Conservative Minister and MLA for Edmonton-Rutherford).

76 Alberta. Legislative Assembly of Alberta, 13 March 2012.

77 Alberta. Legislative Assembly of Alberta, 13 March 2012.

78 Vicki Chartrand, "Broken System: Why is a Quarter of Canada's Prison Population Indigenous?" *The Conversation*, 18 February 2018, https://theconversation.com/broken-system-why-is-a-quarter-of-canadas-prison-population-indigenous-91562.

79 Alberta. Legislative Assembly of Alberta, 13 March 2012.

80 Alberta. Legislative Assembly of Alberta, 13 March 2012.

81 For example, David Swann (Liberal, Calgary-Mountain View) commented: "With respect to the social policy framework . . . I think it's very timely and important for Albertans to be part of that discussion. The minister references the policy framework in broad, vague terms but has yet to tell Albertans in plain language what it's all supposed to mean. I've heard it referred to as an integrated strategy, a comprehensive review, a public consultation, a transition to outcome-based service delivery, and lots of seemingly disparate issues. Can the minister explain what the social policy framework is, how long

its development is expected to take, and what might happen as a result of the framework?" (Alberta. Legislative Assembly of Alberta, 13 March 2012).

82 Alberta Government, *Alberta's Social Policy Framework* (Edmonton, February 2013), https://open.alberta.ca/publications/6214203.

83 Alberta Government, *Alberta's Social Policy Framework*, 4.

84 Alberta Government, *Alberta's Social Policy Framework*, 4–5. See section titled "What is Social Policy?"

85 Alberta. Legislative Assembly of Alberta, 24 November 2014 (evening).

86 Maria Guglielmin et al., "A Scoping Review of the Implementation of Health in All Policies at the Local Level," *Health Policy* 122, no. 3 (2018); Lindsay McLaren and Daniel J. Dutton, "The Social Determinants of Pandemic Impact: An Opportunity to Rethink What We Mean by 'Public Health Spending,'" editorial, *Canadian Journal of Public Health* 111 (2020).

87 Public Health Agency of Canada and WHO, *Health Equity Through Intersectoral Action*.