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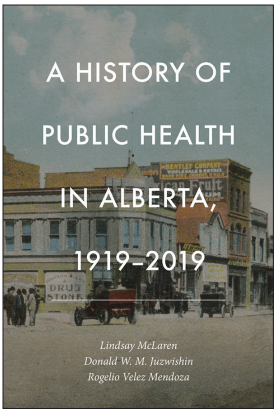

A HISTORY OF PUBLIC HEALTH IN ALBERTA, 1919–2019

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Conclusion

Lindsay McLaren

> *"History does not lie in the material alone, but in the identification, selection, organization and shaping of that information into some kind of product"*
>
> —Heritage Note Series: Conducting Historical Research, Alberta Historical Resources Foundation[1]

Our overall objective for this volume was to commemorate, critique, and learn from Alberta's public health history. This objective was informed and prompted by our concerns about the limited contemporary coherence and visibility, and thus impact, of a broad public health perspective, which has only been confirmed by the COVID-19 pandemic. That broad perspective is conveyed by our working definition of public health as the science and art of preventing sickness and promoting health through organized efforts of society, where health refers to well-being and health equity in populations and their structural causes. Dedicating focused attention to the field's history in Alberta, we reasoned, offered one way to illustrate public health's enduring core features and unique contributions to society. Doing so, in turn, allows us to think about a version of public health — as a field of applied policy, practice, and scholarly inquiry — that maintains its historical strengths while also adapting to contemporary health challenges and their structural causes. This is imperative if public health is to remain an important and relevant societal institution.

With respect to the opening quotation to this chapter, this volume's objective and positioning as described above strongly influenced our "identification, selection, organization and shaping" of materials, from which we now draw several concluding points.

Governance Arrangements Matter, Even if [or When] the Extent is Unknown

As an institution with a strong state element, a historical study of public health demands careful attention to government and governance. This includes the ways in which government administrative arrangements have supported or hindered a broad version of public health that is fundamentally concerned with upstream determinants of well-being and health equity in populations.

To this end, we framed some chapters using a health-in-all-policies perspective, which foregrounds the fundamental understanding that key determinants of well-being and health equity reflect policy decisions outside of the formal health sector.[2] Chapter 8 and Chapter 12, for example, highlight historical circumstances in Alberta where public health was administratively coupled with other policy domains — environment and social services respectively — within provincial government departments. Such administrative coupling offers one mechanism for breaking the entrenched conflation of health and health care, and working toward an intersectoral approach to supporting the public's health by improving social and ecological determinants of health.[3] By studying these examples in their socio-historical contexts, however, the importance of ideological and political economic factors becomes clear: supportive administrative structure is insufficient to offset dominant, indeed hegemonic, narratives that privilege physical dimensions of disease, reductive and downstream solutions to health problems, and inadequate attention to root causes of social and health inequity including the regime of obstruction created by the intersection of mainstream economics and colonial, extractive industry.[4]

Concerning legislative elements, our historical tracking of the provincial Public Health Act (see Chapter 4) provided a different kind of window onto public health practice over time, including its scope and lines of authority.[5] The origins of the act in communicable disease control and health protection / environmental health activities are not unique to Alberta, and they make sense in the light of the early twentieth century disease context (see Chapter 3). They present, however, a challenging legacy for our field. This is despite decades of efforts — dating at least to the Ottawa Charter for Health Promotion of 1986 — to advance a broader version of public health that emphasizes well-being; health equity; and upstream, intersectoral thinking about root causes of health problems. From

this perspective, although the act provides an important foundation for certain organized efforts of society (a phrase contained in many definitions of public health), it also presents — through its contents and its omissions — an institutionalized barrier that constrains how we, as a society, think about and operationalize public health.

Notwithstanding this legacy, there have been shifts over time in the Public Health Act that potentially shed some light on the who, what, and how of public health today. One example is a 1970 amendment that removed the provincial medical officer of health as chair of the Provincial Board of Health and replaced it with deputy minister of health. From the perspective of the COVID-19 pandemic, where the legislative versus political elements of the provincial chief medical officers of health's role and authority have been vigorously debated,[6] this early change seems — in hindsight — potentially significant to understanding the diffuse and poorly understood version of public health seen today. Moreover, the 1984 rewrite of the Public Health Act instituted many changes, including the elimination of the Provincial Board of Health, which had existed since 1907, and — in the context of evolving human rights legislation — its replacement with a board that was advisory in nature and focused on appeals; the removal of topics such as milk pasteurization and community water fluoridation, which were moved to other pieces of legislation; and the relaxing of parameters around the membership of local boards of health, such that having members from municipal government was no longer required. We found limited if any specific commentary on these changes in the public domain, and thus it is difficult to judge their meaning and significance. However, from our contemporary vantage point, where public health is lacking in coherence and unity, one can speculate how a succession of seemingly innocuous changes to a key piece of provincial legislation could have contributed to the weak and narrow version of public health that we have today.

Downstream Drift Is Insidious

A persistent and significant challenge for public health is downstream drift, or the tendency of policy and practice to focus on individual-level behavioural or clinical/biomedical factors, rather than an upstream approach, which embraces root causes of poor health and health inequity that lie in harmful and inequitable social, economic, political, and colonial systems and structures.[7]

The reasons for downstream drift are multiple, complex, and insidious. A historical perspective can shed light on the drift, including when and in what circumstances it occurred. In Chapter 2, we sought such insights via an analysis of one hundred years of provincial government throne speeches. By considering

references to "health," "public health," and "prevention" in the speeches, we showed subtle but important changes over the course of the twentieth and early twenty-first century. First, policy attention to public health activities of prevention and health protection declined, while attention to downstream disease treatment and management increased. Second, we observed that references to "prevention" shifted from primary prevention in whole populations toward greater emphasis on secondary prevention for those deemed "high-risk" or "vulnerable," which often, although not necessarily, have a more downstream orientation. Third, references to "public health" changed over time, a shift that was especially apparent during the lengthy period of Social Credit government under Ernest Manning (1943-1968). Starting in the late 1950s, this government's use of "public health" appeared to drift from a broad concept that included primary prevention in populations, toward a narrower emphasis on treatment, management, diagnostics, and rehabilitation activities within the context of health care. This narrower version of public health largely continued, with the occasional exception and nuance, in subsequent Alberta governments. Because this narrow version is not aligned with public health's stated goals of providing conditions for population well-being and health equity, these shifts over time in the meaning of key terms and concepts seem significant.

Social Justice and Health Equity: One Step Forward, Two Steps Back

Public health communities have long voiced concern about unfair social and economic conditions and their relation to unequal health outcomes, yet substantive efforts to redress inequities including their structural, social, political, economic, ecologic, and colonial determinants have not been forthcoming.

A historical lens can illuminate areas of progress, setbacks, and inactivity in Alberta in this regard. On the one hand, we have repealed some forms of egregiously discriminatory legislation such as the Sexual Sterilization Act (see Chapter 1); although this took us until 1972 and has not eliminated involuntary sterilization.[8] There has been some important recent progress in data infrastructure, including strengthening data ownership and control and facilitating disaggregated data (e.g., data broken down by race or ethnicity) to show inequities in health outcomes like COVID-19 infection and mortality by social and economic identities and circumstances.[9] However, while better approaches to data collection and analysis can illuminate inequities, they are insufficient on their own. For example, despite extensive statistical documentation of health inequities and their root causes in neoliberal, extractive and colonial systems and structures; those systems and structures persist and public health communities

– on the whole – do not engage deeply toward dismantling them. Instead, we continue to accept and perpetuate what can only be described as unacceptable social and economic conditions and health outcomes, for many Indigenous communities in Alberta (Chapter 7). We also, with very few exceptions, continue to elect, and thus shift power to, neoliberally-oriented provincial governments that mobilize a market justice rather than a social justice orientation to health and well-being (Chapter 8 and Chapter 12). And finally, also with few exceptions, we do not engage substantively with climate justice and ecological determinants of health including their political and economic drivers, despite these representing enormously significant threats to health equity (see Chapter 6 and Chapter 8). Connecting the dots between these issues, and strengthening critical engagement around them, are urgent tasks for public health communities.

Points of Opposition to Healthy Public Policy Are Consistent and Predictable

In several chapters we examined the nature of contention and debate around public health policy, including how these manifested in provincial government deliberations.[10] This included seatbelt legislation (Chapter 3), tobacco control, community water fluoridation, and workers' health (Chapter 9), climate change (Chapter 8), and social determinants of health (Chapter 12).

Across these debates we observed some consistency in terms of key points and strategies of opposition. For seatbelt legislation and community water fluoridation, which represent relatively discrete, although not simple, preventive policies, opponents consistently and often effectively mobilized several arguments. These included 1) skepticism about policy effectiveness; for example, questioning or raising doubts about whether or not seat belts saved lives; 2) concern about possible harms; for example, drawing on personal stories where someone was injured by a seatbelt; and 3) agreement with the goal of the policy but not with the mechanism; for example, accepting that seat belts were beneficial but opposing the use of mandates, instead preferring an educational approach to encourage voluntary use.

Consistent points and strategies of opposition were also apparent for more complex policies that transcend sectors, such as those to address climate change (Chapter 8) and to strengthen workers' health (Chapter 9) and social determinants of health (Chapter 12); all of which are obstructed by mobilization of powerful capitalist and colonial interests. One point of opposition was to express concern about the administrative burden associated with complex policy; for example, a proposal to implement health impact assessment of policy in sectors other than health was considered unacceptable because it would "bring the decision-making

apparatus of the government to a grinding halt." Another strategy was to (mis) characterize a policy as redundant or as duplicating policies or activities already in place in a way that obscured or glossed over the substantive differences between the weak legislation that was already in place and the stronger and more upstream legislation that was being proposed. A third point of opposition mobilized the isolated nature of government departments; for example, opponents to climate change legislation asserted that the health impacts of climate change fall outside of the purview of the health ministry. This latter point reflects and perpetuates the significant challenge for public health noted earlier; namely, a hegemonic narrative that conflates health and medical care. Working to decouple the two is fundamental to a broad vision of public health.[11]

Although the capitalist and colonial barriers to healthy public policy are immense, we may perhaps see some way forward around the consistency of these specific points of opposition — which we observed repeatedly, at different points in time and for different policies — and thus their predictability. With respect to representational advocacy, or strategies for generating support for public health goals among broader publics,[12] these points present an opportunity for public health communities to mobilize around articulating and advancing concise and compelling counter-narratives. Provincial/territorial and national public health associations (see Chapter 5) offer a platform for this.[13] From the perspective of a broad vision of public health, which is concerned with root causes of population well-being and health equity, it is essential to also include facilitational advocacy; that is, listening to and working with members of publics who are most affected by these decisions and whose voices are under-represented in policy debates.[14] As discussed in Chapter 6, there is a significant need and opportunity to embed all of these issues, and most importantly critical thinking around them, within public health education programs.

Crises Can Prompt Deep and Substantive Change for the Better

This volume was submitted, and in fact much of the research and writing completed, during the global COVID-19 pandemic, which offered many privileged academics, including the authors of this volume, the gift of time. With respect to our concerns about the state of public health, including its visibility and impact, the pandemic has indeed prompted important changes. It has, for example, placed public health in the spotlight, with one early example being chief public health / medical officers — who are usually mostly invisible to the public — attaining the status of household names across the country. On the other hand, and significantly, the pandemic has reinforced a narrow, reductive, and medicalized

version of public health that is focused on communicable disease control and the health care system, led by certain kinds of scientists and health care professionals, such as physicians, epidemiologists, and virologists.[15]

As articulated in a growing amount of thoughtful commentary,[16] the pandemic has unambiguously demonstrated the need for a broad and coherent version of public health that gives voice to a much broader range of experts in collective well-being and health equity, including those communities who are most affected, and social science and humanities scholars who are experts in critically contextualizing societal institutions and their underlying dimensions of power. The pandemic has shown us, in no uncertain terms, that health cannot be separated from the economy, nor from any other aspects of our lives, identities, and contexts. It has magnified inequities along axes such as income, employment circumstances, gender, race, ethnicity, and ability, which are in no sense natural or inevitable divides — rather they are "the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics."[17] The COVID-19 pandemic, moreover, is only one example of a much broader, deeper, and intersecting set of threats to the integrity of our collective well-being, ecosystems, and democracies.

What might a coherent alternative look like, at this important crossroads? We humbly conclude with a few thoughts about this, which place Alberta in its broader national and international context.[18]

An Integrated, Coherent Version of Public Health

In the light of our concerns that the field of public health lacks coherence and thus vision, a key goal of this volume has been to characterize, or articulate the contours of, a broad version of public health. In fact, in some ways this is the easy part since several visions have already been articulated. Three have appeared throughout this book.[19] The first is the Ottawa Charter for Health Promotion of 1986, which was ahead of its time in characterizing health as a resource for everyday life, and for identifying prerequisites for health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Strengthening health and health equity, according to the charter, requires efforts to build healthy public policy; create supportive environments for health; strengthen community action, including from under-represented voices; develop personal skills to make choices conducive to health; and reorient health services so they are more attuned to prevention and health promotion.

A second vision occurred more than twenty years later when the World Health Organization Commission on Social Determinants of Health identified three overarching recommendations to improve population health and health

equity, a goal it described as "closing the gap in a generation."[20] Those overarching recommendations were to improve daily living conditions; tackle the inequitable distribution of money, power, and resources; and measure the problem (of health inequity) and assess the impact of action.

In 2015, a third vision appeared when the Truth and Reconciliation Commission released its final report and recommendations following a multi-year process of information gathering and public discussions concerning Canadian government policies of cultural genocide, which have caused unacceptable social and economic conditions for Indigenous Peoples in Canada. The social and ensuing health inequities that continue,[21] which provide a dramatic example of the social determinants of health, may only be addressed through a foundation of reconciliation, defined as commitment by *all* Canadians to an ongoing process of establishing and maintaining respectful relationships. Canada must fully implement and work toward substantive realization of the United Nations Declaration on the Rights of Indigenous Peoples.[22]

Although leadership within the health sector is critical,[23] it goes without saying that the goals expressed in these three visions go well beyond the scope and mandate of the health sector. Moreover, the health sector in practice frequently refers to a narrow set of professional actors with a largely biomedical orientation, which serves to obstruct meaningful efforts to support well-being and health equity for all. One potential way to operationalize the fundamental understanding that the primary determinants of well-being and health equity reflect public policy decisions outside of the health sector, within government, is a health-in-all-policies approach, which we have referenced throughout this volume.[24] Indeed, such an approach has been implemented in Canadian jurisdictions. Importantly, however, critical commentary has identified that intersectoral collaboration may come at the expense of a sustained and meaningful focus on upstream determinants of injustices.[25]

Another framework is a well-being economy, or an economy that pursues human and ecological well-being rather than a narrow version of economic growth. A well-being economy — which is not a new idea but is gaining recent national and international momentum — begins with the recognition that our current economic system of neoliberal capitalism does not support the health and well-being of all people and the planet. The benefits of economic growth accrue mostly to the wealthiest individuals and corporations, while incomes at the bottom have stagnated or declined. A narrow focus on economic growth, moreover, underpins activities that permit and encourage destruction of our ecosystems, such as subsidies to polluting industries. There are several examples of an alternative vision offered by a well-being economy, such as the Wellbeing Economy

Alliance, a global collaboration of organizations, alliances, movements, and individuals working to transform the economic system into one that delivers social justice for a healthy planet; New Zealand's well-being budget, which is based on recognition that "just because a country is doing well economically does not mean all of its people are"; Wales's Wellbeing of Future Generations legislation and commissioner, which enshrines long-term thinking in government; and important work toward an alternative to the GDP in British Columbia that centres First Nations concepts of well-being.[26]

Although health-in-all-policies and a well-being economy are being advanced by different communities, sectors, and disciplines, they potentially have important common ground which, when coupled with a strong critical perspective, offer exciting opportunities for thinking about a broader vision of the public's health.

Coordinating a Wider Public Health Vision Across Political Jurisdictions

Having identified contours of an integrated vision for public health, a second step is to find ways for governments to coordinate their leadership. This requires engaging with Canadian federalism as well as the inherent jurisdictions and authority of Indigenous Peoples.

The Canadian federal government's economic support mobilization during the COVID-19 pandemic was significant. Massive amounts of money were invested in people, and some jurisdictional boundaries were overcome to do so. The challenge is to transition those activities from a singular emergency protection response to one element of an integrated, longer-term approach to coherent investment in the broader determinants of health. There are some modest hints of a shift in that direction. The federal government's structural supports shifted, in some cases, into medium-term solutions such as a more flexible and inclusive system of employment insurance. In its 2021 federal budget, the Trudeau government announced significant support for a national childcare system with emphasis on quality and affordability.[27] Stemming from a supply and confidence agreement with the NDP, the federal government has committed to working toward redressing the historical omission of dental care from our national health care system. These signals follow the federal government's 2019 mandate letters, which referenced well-being budgeting, that is, finding ways to ensure that program spending and taxation decisions support people's well-being (rather than private profit accumulation).[28] While potentially promising, the extent to which these initiatives meaningfully work to redress the inequities in power and resources which constitute root causes of health inequities in Canada remains to be seen.[29]

In our federated country, coordinated leadership demands provincial cooperation, the absence of which has been clear in the pandemic. However, for some elements of public health, there is a working guide to better coordination, in the form of the Declaration on Promotion and Prevention, which was signed by Canada's federal, provincial, and territorial health ministers in 2010.[30] As discussed throughout this volume, health portfolios across the country are overwhelmingly focused on treatment-oriented medical care. In this declaration, however, ministers from different political parties committed to principles of prevention, health promotion, and social determinants of health. Imagine how different the COVID-19 pandemic experience might have been had the potential of that declaration been translated into robust governance structures and public policy that is guided by the well-being of all people (for example, generous, accessible, and ongoing social protections like paid sick days, a living wage, and alternative sources of income for essential workers such as grocery store workers) rather than the interests of a privileged minority (for example, the food retail corporations that profited amid the suffering).[31]

Creating supportive governance for well-being and health equity does not stop with Canadian federalism, however. A future that is healthy and just for all people and the planet demands that Canada meet its government-to-government agreements with First Nations and the Métis and Inuit. Although the federal government has endorsed and is implementing the United Nations Declaration on the Rights of Indigenous Peoples, this action will not be effective until or unless Canada concedes that the Inherent Rights of Indigenous Peoples, including the rights to self-determination and free, prior, and informed consent before adopting and implementing legislative or administrative measures that may affect them, are not subordinate to the Canadian constitution, and that colonial sovereignty and authority are not superior to Indigenous sovereignty and authority. As described by Cree and Saulteaux scholar Gina Starblanket and published in important work by Cree scholar Angele Alook and colleagues, a framework for dual governance and shared control is laid out in the historic treaties; it generally involves the establishment of separate governments and jurisdictions in distinct spaces and dual governance and jurisdiction in shared spaces and matters of mutual concern.[32]

Health Uncoupled from Health Care

Underpinning the success of the first two steps, a third step is to work from the ground up to break down the pernicious and entrenched conflation, especially in colonial society, of health, health care, and public health — and to help people to embrace a broad vision of health as well-being that is fundamentally shaped

by the circumstances in which we are born, grow, live, work, and age; including the quality and integrity of our natural environments and our relationships therewith. Popular discourse about health is dominated by a focus on medical care and individual lifestyle behaviours.[33] This conflation is also pervasive — as shown throughout this volume — within our key decision-making structures, both within and outside of the health sector. We need to find better ways to broaden our vision, integrate sectors and government departments around that broader vision, and connect the dots between health and its broader social determinants on a large scale.

Inward Vision

An important challenge that we encountered in writing this volume stems from the observation that public health is a multi-faceted field that includes applied practice and policy, scholarly inquiry, and community activism. However, these different aspects of public health are not on equal footing. Power and politics result in some elements and perspectives rising to the top and becoming the visible face of our field. This was well illustrated during the pandemic, as noted earlier in this chapter.

One way of organizing our thinking about public health is in terms of mainstream and critical perspectives. In general, mainstream perspectives are those that privilege dominant ways of thinking that focus on behavioural and biomedical perspectives; knowing, which are the "scientific" and mostly reductive quantitative approaches anchored in epidemiology and biostatistics; and doing, or top-down, expert driven approaches, which tend to underpin much practice and policy. In contrast, critical perspectives are those which challenge the status quo by situating it within political and historical contexts and making visible the embedded but often hidden elements of power. Critical approaches look outward, illuminating the health-damaging effects of social structures. At the same time, they look inward, asking difficult questions about successes and failures in public health and to expose and question assumptions in our field.[34]

Both perspectives have strengths and weaknesses. Critical perspectives are essential for uncovering root causes of poor health and health inequities because they illuminate structures and processes of power and exclusion that obstruct a just world. A drawback is that they sometimes critique or criticize elements of public health without necessarily articulating constructive alternatives.[35] Because mainstream approaches tend to be depoliticized and ahistorical, they have the considerable drawback of obscuring root causes and thereby perpetuating downstream individualized approaches to solving problems. However, they are more likely than critical scholarship to be solution-focused, and this should

be mobilized to good purpose. Underpinning our work in this volume, and toward a broad vision of public health focused on population well-being and health equity and their root causes in systems and structures, is a desire to try to bring together the best of both perspectives. As a way forward, we humbly conclude with the following two, related thoughts.

First, we see value in public health communities coming together to envision and work toward, a social democratic public health framework. In a recent paper published in the *European Journal of Social Policy*, author Sylvia Walby considers the question of social theory as it relates to public health, specifically in the context of the COVID-19 pandemic.[36] She identifies that, among the political philosophies that have been mobilized to explain the relationship between the individual and society in the context of the pandemic, social democracy has been "curiously absent." This is a problem, she argues, for at least two reasons. First, public health and social democracy are, at least theoretically, aligned; as Walby says, "social democracy is the model of society that informs the public health project, in which 'if one is sick, we are all potentially sick.'. . . [Moreover] it is a social model which insists that justice and efficiency are linked together, rather than being opposed in a zero-sum trade-off."[37]

Another reason why it is problematic to omit social democracy is because it provides a strong counter-philosophy to neoliberalism. In Walby's words, "interventionist social democratic practices can be contrasted with neoliberal policies that pursue more minimal intervention to (mistakenly) reduce damage to the economy."[38] Walby's social democratic public health is highly consistent with the broad vision of public health that we embrace in this volume. Its interventionist orientation, underpinned by social democratic visions of justice and inclusion, aligns with strengths of some historical (mainstream) public health policy and practice. And its underpinnings in political philosophy and robust social theory respect the essential contributions of critical perspectives, which are considerably more recent as applied to public health.

Second, and toward a social democratic public health, we suggest that public health communities find ways to overcome tensions between practice and scholarly communities, by working toward what health sociologist Mykhalovskiy and colleagues call "critical social science *with* public health," where public health refers to applied (mainstream) policy and practice.[39] These authors distinguish between critical social science *in*, *of*, and *with* public health (see Table 14.1). Briefly, while critical perspectives *in* and *of* public health relationships are common and have strengths, they also have drawbacks that are emblematic of the tensions found between scholarship and practice in the field. One common example is the

situation where critical perspectives are positioned outside of, and thus secondary to, the aims of mainstream public health.

To bring the best of mainstream/applied and critical perspectives together, as per critical social science *with* public health, the power and epistemological tensions between scholarship and practice cannot be ignored or avoided but rather must become a site of productive inquiry for which time and effort are carved out. It requires deep epistemic, disciplinary, and sectoral humility by all.[40] In our view, attention to these issues could present an exciting and truly collective and justice-oriented post-pandemic era of public health that is for, and in the interest of, the public's health.

Table 14.1: Critical perspectives in, of, and with public health practice.

Type of relationship	Description	Opportunities	Drawbacks
Critical perspectives *in* public health	Critical scholars work within the institutional and discursive spaces of public health (e.g., within a university School of Public Health or a public health department in the health care system).	Can provide a way for critical scholars to contribute to applied concerns in public health.	Can erode the unique analytic contributions and scholarly autonomy of critical scholars, because social science theories, concepts, and methods are used in service of public health aims.
Critical perspectives *of* public health	Critical scholars are situated outside of public health, which becomes an object of critical inquiry (e.g., illuminating a tendency to overlook fundamental causes of poor health).	Can identify and yield significant insights into built-in and implicit flaws of public health practices, forms of reasoning, politics, concerns, modes of organization, etc.	Can turn into an entirely negative critique, which points out the failings of public health but does not pursue constructive alternatives.
Critical perspectives *with* public health	A relationship between critical perspectives and public health practice that recognizes sources of difference and tension and works productively with those differences and tensions.	Begins to address inadequacies of *in* and *of* orientations; may permit productive channelling of conflict towards tackling key problems such as politics of austerity.	Risk of devolving into a superficial and uncomplicated space of shared interests. Requires commitment to reflexivity on both sides (rare), and ongoing engagement.

Source: adapted from Eric Mykhalovskiy et al., "Critical Social Science with Public Health: Agonism, Critique and Engagement," *Critical Public Health* 29, no. 5 (October 20, 2019), https://doi.org/10.1080/09581596.2018.1474174.

NOTES

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