

Promoting Health
and Addressing the Social Determinants of Health under Fiscal Austerity :
The 'New Public Health' in Ontario and Quebec, 1994-2004

A Paper Presented to
The 2005 Canadian Political Science Association Annual Conference
June 2-4, 2005
University of Western Ontario in London, Canada

Nicole F. Bernier, PhD
Groupe de recherche interdisciplinaire en santé (GRIS) and
Department of Social and Preventative Medicine
Faculty of Medicine
Université de Montréal
C.P. 6128, Succ. CV
Montréal, Québec H3C 3J7
Tel. 514 343 6135
e-mail : nf.bernier@umontreal.ca

Work on this project has been supported by a CIHR/CHSRF fellowship (PDA-1047-05) and by the Chaire Approches communautaires et inégalités de santé at Université de Montréal.

Health has stood very high on the Canadian political agenda in the past few years, as it has in other advanced democracies. The political attention devoted to health policy has been focused primarily on Canada's biomedical treatment system, but political leaders and public managers are increasingly aware that health policy cannot simply be equated to healthcare policy. Tragedies such as the *E.coli* contamination of the Walkerton water supply in the year 2000, the cases of "mad cow disease" (Bovine Spongiform Encephalopathy) and the "SARS outbreak" (Severe Acute Respiratory Syndrome) in 2003, have reminded Canadians that public health services, when neglected or inadequately organized, can have devastating consequences and deadly outcomes. SARS in particular "underscored for many, the need for an effective, responsive, and well-resourced public health infrastructure across Canada" (Ontario Expert Panel on SARS and Infectious Disease Control 2003). Significant policy initiatives to improve Canada's public health infrastructure have been undertaken in the recent years and indicate that state interventions to prevent diseases and injuries and to protect and improve the health of the whole population are in the process of being better institutionalized as a fundamental component of Canada's health policy. Among such initiatives at the national level are the creation, in 2004, of the Public Health Agency of Canada (PAHC) and the appointment Canada's first Chief Public Health Officer and first Secretary of State for Public Health.¹

¹ For instance, see two of a series of comprehensive governmental reports following the SARS crisis, referred to as the Naylor and Kirby reports, which gave an impulsion to a series of policy responses across Canada. 1) Canada. Health Canada (2003). Learning from SARS : Renewal in Public Health in Canada. Ottawa, National Advisory Committee on SARS and Public Health,, Canada. The Standing Senate Committee on Social Affairs, S. a. T. (2003). Reforming health protection and promotion in Canada: time to act. M. Kirby. Ottawa.

Traditional public health approaches focus on improving the population's health through health protection (such as food and water safety), surveillance and prevention of disease and the management of epidemics. This is where the main efforts of public health are directed. This being said, contemporary efforts undertaken since the mid-1980s in Canada and abroad go well beyond population health risks management. They comprise a broader view of health, inclusive of well-being, and refer to a certain understanding of the ways in which lifestyles, living conditions and health outcomes are interconnected (Kickbusch 2003). In addition to the core functions of public health, 'new public health' approaches seek not only to promote healthy lifestyles and prevent injuries and diseases, but also to create environments that are supportive of health and well-being. They entail that everything that governments do or do not do affect the population's health and well-being and that public health professionals should seek to influence other governmental sectors (Canada. Health Canada 2003).

'New public health' approaches are sometimes considered a form of 'health imperialism' or 'social engineering', when not simply naïve and unrealistic. Proponents of the 'new public health', who are mostly professionals working in the health sector, aim to improve general policies, programs and services which create, maintain and protect health and well-being. Their interventions can be focused on helping to attain better income security programs, a good education system, a clean environment, adequate social housing and community services (Canadian Public Health Association 2001). Although its embrace is probably too ambitious for what it can achieve, the 'new public health' should not be dismissed too easily. It was strongly advocated by Canada's public health professionals in the 1986 *Ottawa Charter for Health Promotion* and is now

supported by a solid research infrastructure and an international professional movement, in which Canada demonstrated significant leadership (Kickbusch 2003). Consistent with this professional movement, the influential report issued in 1997 by the National Forum on Health Care, which had been appointed three years earlier by the federal Liberal government to “develop a new vision for Canada’s health system for the 21st century”, went beyond the health care field. It embraced a line of analysis consistent with the new public health approach, focussing on the ‘social determinants of health’. It argued for “a broad, integrated child and family strategy consisting of both programs and income support” (Tuohy 1999, p.96). This new public health approach has subsequently made its way into Canada’s research infrastructure. In 1999, the *Canadian Population Health Initiative* was launched, to “foster a better understanding of factors that affect the health of individuals and communities and to contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians”. The social determinants of health, as a key component of the ‘new public health’ concept, are a legitimate theme for research sponsorship by the Canadian Institutes for Health Research (CIHR) (Evans 2003). In the same vein outside Canada, the World Health Organization launched, in 2004, a Commission on the Social Determinants of Health, whose purpose is “to enable countries worldwide to tackle the root causes of disease and health inequalities and to intervene on the social conditions in which people live and work”.

Although it is too often neglected by both health policy and social policy research, public health is an important sphere of the welfare state: it plays an essential

and vital role ensuring the basic conditions for the conduct of human activity². The policies associated to the 'new public health' are relevant to the 'two worlds of welfare research', that is, social and health policy, as they connect these two worlds at nexus. They are also relevant to the study of policies associated to fiscal austerity, for the fact that they offer puzzling anomalies from a rational choice perspective. Indeed, public health is a strategically vulnerable sector in periods of budgetary controls, but was not affected by fiscal austerity measures to the extent that could be expected from a theoretical standpoint. The results of empirical observations of both Ontario's and Quebec's public health approaches over the last decade will show below that the 'new public health' approach was even consolidated and further developed in Quebec.

In Canada, there is not a national public health policy as such, since public health is a sphere of mixed jurisdiction between the federal and provincial governments. As in several other policy fields in the Canadian federation, each province defines its own policy, so there exists several policy approaches to public health in this field among provinces (Frank and Di Ruggiero 2003; Colin 2004). The observations for this paper on Canada's public health policy thus focus not on 'national' policy as such but on policies pursued by Canada's two largest provinces. The purpose is, first, to show the relative success of the new public health agenda in Ontario and Quebec, between 1994 and 2004 in a context of fiscal austerity; and, second, to advance an interpretation for such relative success. The empirical observations are based on the relevant (but scarce) peer-reviewed literature found mostly in public health journals. They also rely heavily on primary sources comprising official publications as well as 18 anonymous, semi-structured

² In budgetary terms, this sector represents only about 2% to 3% of total health expenditures.

interviews conducted with provincial and regional policy-makers as well as academics in Canada in 2004. The documentary-type interviews were used as background information to complete the basic elements of observation not available otherwise to help approach the little explored public health policy domain with a framework of analysis drawn from the political science literature. Respondents were selected on the basis of their familiarity with one of the province's policy.

Federal-Provincial Fiscal Relations, Rational Choice and Public Health

Traditionally, the federal government has used its spending power to intervene in social and health policy, two spheres under the formal jurisdiction of the provinces. From the inception of Canada's modern welfare in the late 1960s to early 1970s, the federal government has set basic national principles for the provinces' social assistance and health insurance programs to meet as requirements to qualify for federal transfer payments. Starting in the late 1970s, the federal government has sought to reduce its health and social transfers to the provinces in an expenditure-control strategy while retaining the leverage necessary to ensure provincial compliance with basic national principles (Bernier 2003, p.129; Tuohy 1999, p.92; Vaillancourt 1996, p.282-283). Starting with the establishment of the *Established Programs Financing* (EPF) in 1977, the federal government converted previous arrangements made on a shared-cost basis of funding (50%-50% between the federal government and the provinces) to a block grant system for health care. The block grant program contributed to reduce the federal government's share of expenditures with the provinces over time, but especially from the mid-1980s, when the Conservatives held the rate of increase of EPF transfer payments below that of nominal GDP and froze them from 1990 onward (Tuohy 1999, p.92; Bernier 1992). As a

result of this first wave of reforms, the federal government paid a share of 30.6% of health expenditures in 1980, as compared to only 21.5 in 1996 (Naylor 1999). This withdrawal process was pursued and even intensified in the mid-1990s. Under the banner of deficit reduction, along with budget cuts, reduction of the civil service and the deregulation of certain sectors, the federal government restructured almost every policy area and accelerated the schedule for reduction payments transfers to the provinces over time (Bernier 2003b, p.52, Clark 2002). A new *Canada Health and Social Transfer* was created in 1996, replacing both the cost-shared *Canada Assistance Plan (CAP)* (for social assistance) and the EPF (for health care and postsecondary education). The federal government sharply reduced its already eroded transfers to the provinces by 9.4% between 1995-96 and 1996-97, and by 6.7% the following year (Bernier 2003, p.138).

In addition to adjusting to reduced transfer payments from the federal government, the provinces had to deal with several economic challenges of their own including the effects of prolonged economic stagnation such as declining taxation revenues and low employment levels, at the same time as reduced eligibility for (federal) unemployment benefits were contributing to sharp increases in (provincial) welfare rolls. In the mid-1990s, mounting deficits and debt accumulation had become “the most pressing political issues at all levels of Canadian governments” (Hanlon and Rosenberg 1998, p.561). In Ontario, the Progressive-Conservative government was elected in 1995 under Mike Harris with four goals: to reduce the public sector staff by 15%, to simplify the government, to improve the province’s competitiveness and to restore the province’s fiscal balance (Graham & Phillips 1998). To face its economic challenges, the provincial government downloaded responsibilities for social housing,

social assistance, public health and child services to the municipal level, and 'uploaded' or centralized the responsibility for education to the provincial level. The 'Common Sense Revolution' translated in a greater emphasis "on smaller government and greater reliance on market forces in public decision making and resource allocation" (Brandford, 2003, p.1017). In Quebec, deficit elimination through reducing public expenditures was introduced only in 1996 on the governmental agenda, which is later than every other Canadian province (Matthews 1998). Nevertheless, budgetary controls introduced then led to what was described as the Quebec government's 'most important budgetary reform since the 1970s and perhaps even since its creation' (Rouillard, 1999, p.57).

Early rational-choice, neo-institutional interpretations of welfare state reform under fiscal austerity have emphasized the irreversible character of welfare state arrangements, arguing that welfare state programs have created political constituencies of beneficiaries, service providers and civil servants able to mobilize against radical reforms. As a consequence, incremental reform is more likely to occur than radical reform, such that the continuity of arrangements and resilience of welfare state programs is to be observed (Pierson 1994; Brown 1988). Empirical observations have since then showed that the cumulative effect of reversed incremental adjustments over the years can have profound consequences on the status quo (Bernier 2003; Cox 1998; Daly 1997). In addition, successful radical reforms undertaken in countries such as New Zealand offered empirical contradictions. There is now recognition that substantial changes to welfare state programs can occur (Castles 1996; Pierson 2001). This can be understood in part by the fact that the success of political leaders, which can and do

develop effective strategies of division, obfuscation and compensation over time to minimize electoral opposition, was underestimated in the early works (Bernier 2003).

A rational choice interpretation of welfare state reform under fiscal austerity indicates that public health will be a vulnerable element of welfare state reform. From a theoretical perspective, programs that offer tangible benefits to specific groups (old age pensions for instance) will fare better than programs that offer diffuse benefits to diffuse groups (such as environmental protection) (Klein 1988). Province-wide public health programs procure diffuse benefits to the general population, or to large population groups such as low-income, socially vulnerable groups, ethnic minorities, or age categories such as children, adults or the elderly. Whereas programs with strong electoral constituencies are considered more difficult to reform than others, the beneficiaries of public health programs are mostly statistical, abstract categories, as opposed to electoral groups or social communities susceptible to organize, coalesce and mobilize against a program's reform. The constituencies of the public health sector are generally limited to public health professionals working in the health sector and a few professional, loose and at times ambiguous alliances in other sectors such as education, agriculture, environment and social policy. Public health programs are generally not visible to the general public so their curtailment does not entail electoral retaliation. This implies that the need for political leaders to use sophisticated division, obfuscation and compensation strategies for imposing losses (see Pierson 1994) is minimal. Public health programs solicit direct budgetary expenditures: decision-makers have to impose concrete losses and concentrated costs in the form of taxation or reducing other budgetary items. However the traceability of benefits is weak since it is difficult for a

voter to link a specific health outcome (for instance 'suffering less' from type 2 diabetes or obesity, or not having died from a given epidemics, 10 years from now) to a specific preventive public health program. In addition to being diffuse and intangible, eventual benefits can occur in a time horizon of several years, while the cost for setting up a program is immediate. Last but not least, public health programs are often in direct competition for budgets with sectors which are much more strategic and requiring concrete actions on specific and already manifest problems, that is, acute care services.

Clearly, provincial public health programs are not at an advantage from an electoral calculus standpoint and are associated to a set of conditions favourable to minimalist government interventions. From a rational choice perspective, the public health sector should be strongly affected by fiscal austerity measures since it meets very few, if any, of the conditions which would make its policies irreversible. Yet, it was not overly affected by Ontario's and Quebec's reforms. Although the new public health was largely destabilized by Ontario's sweeping reforms from the mid-1990s, its central tenets, which were incorporated into Ontario's health policy at the beginning of the 1990s, survived the 'Common Sense Revolution'. In Quebec, the new public health even progressed towards a better consolidation and diversification as a fundamental component of Quebec's health policy over the past decade.

The relative success of the New Public Health

Before we undertake to look at what contributed to this relative success, we will analyze it in more detail to show what it consisted of. For each of the two provinces, the administrative organization of public health, the incorporation of the new public health

ideas into provincial health policy, and the evolution of the new public health between 1994 and 2004 is analyzed in the three sub-sections below.

Table 1

**Organization of public health and health promotion
in Ontario and Quebec (2004)**

Province and characteristic	Central authority (role)	Intermediate authority	Main tension for budgets	Coordination and representation agents (provincial level)
Ontario: Institutional Pluralism	Ministry of Health and Long-Term Care (moderate)	Public Health Units (37) (municipal, local)	Competition with municipal services	-Ontario Health Promotion Resource System -Ontario Public Health Association (active but not reinforced by a social movement)
Québec : Statism	Ministère de la Santé et des Services sociaux (strong)	Regional public health boards (18) (regional)	Competition with hospital services/ curative	-INSPQ -CSBE -Quebec association of public health

Ontario's institutional pluralism. Table 1 shows that Ontario's public health infrastructure corresponds to an institutional pluralism model. Such model entails that it is a decentralized system, with a moderate level of leadership from the provincial government (as compared to Quebec's), and a number of government-led administrative entities which are involved in public health policy at the provincial level. The central government 'governs by proxy' in certain areas, providing financial resources to the non-governmental sector to facilitate policy coordination. Ontario's 'institutional-

pluralist model' is different from a pluralist model such as Alberta's, for instance, where the government's role is very weak and the provincial policy coordination functions are found outside of the governmental structures, led by a few mobilized public health professionals including some government representatives who are only one among several other players.³

Ontario is the only Canadian province where regionalization of the health services has not occurred. This is also where the local-municipal level plays the greatest role. Ontario's public health system is the most decentralized, dispersed and fragmented system in Canada. No other province has devolved so much public health responsibilities (including financial responsibilities) to the municipal level (Ontario 2004), and no other province has a comparable tradition of cost-sharing the financing of its public health programs with municipal authorities (Ontario Expert Panel on SARS and Infectious Disease Control 2003). The financing structure of public health is one of cost-sharing between the Ministry and the municipalities. The sharing formula has varied in the past, the province's share ranging from 40% to 100% of the cost depending on the program. In 1998, the funding and responsibility for the delivery of mandatory public health programs and services was transferred to municipalities (Kothari and Edwards 2003; Ontario Expert Panel on SARS and Infectious Disease Control 2003). Since 1999, the Ministry has generally funded 50% of each local unit's cost (Annual Report of the Office of the Provincial Auditor of Ontario, 2003:220).

³ For a fuller discussion on the provincial models including Alberta's, see the author's paper to be presented at the European Phoenix Thematic Network Conference on Health and Social Welfare Policy in Catania, Italy in June 2005.

In this province where municipalities play a key role in public health services delivery, the public health system and the healthcare system are two separate entities working in relative isolation; this means that public health jurisdictions are divided between these two separate entities (Ontario Expert Panel on SARS and Infectious Disease Control 2003). The modernized, 1983 *Public Health Act* as well as the 1990 *Health Protection and Promotion Act* provide the legislative framework for the current administrative and programmatic arrangements.

At the provincial level, Ontario's public health is under the official provincial leadership of the Ministry of Health and Long-Term Care. The Public Health Division within that Ministry oversees activities relating to Ontario's public health system in general and is led by a Chief Medical Officer of Health (CMOH), who is also Assistant Deputy Minister since 2002. The CMOH officially monitors the organization and delivery of public health programs and services across the province. Until 2002, the Public Health Division was only a Branch of the ministry, but it was restructured and expanded since then. Population health promotion as such is covered by the new *Chronic Disease Prevention & Health Promotion Branch*, which is under the authority of the Public Health Division and the CMOH.

The backbone of Ontario's public health system is at the local level. Indeed, 37 public health units carry out health promotion and disease prevention programs. Each unit serves a population ranging in size from about 37 000 to 2.5 million residents and is administered by a medical officer of health, who reports to the local board of health. The board of health may be an autonomous corporation made up of elected representatives from the local municipal councils or it may be part of a regional municipality. The

board's representatives are accountable in large part to local and regional municipal councils (Ontario 2004). The board of health is responsible for the administration and delivery of public health services and programs at the local level, in partnership with other sectors, agencies and volunteer community groups/coalitions. It provides leadership in identifying issues and developing services that are adapted to effectively address local needs (1997 MHPSG). At the very base of the structure there are also a growing number of community health centers. The first CHCs were created from the end of the 1960's. Their role is to provide the most vulnerable groups of Ontario with a point of access to health services. CHCs are actively engaged in health promotion and prevention.

The role of the central authority, the ministry of Health & Long-Term Care, is moderate. Although remedial action has been undertaken, the 2004 Campbell Report found that the Public Health Branch (which was expanded to a division since then) is considered dysfunctional, providing inadequate coordination at the provincial level, lacking central expertise. In addition, it does not convey much respect from the local health units (p.75). This being said, there exists mandatory public health programs for the province. Ontario's central programmatic instrument in public health is the 1997 *Mandatory Health Programs and Services Guidelines* (see below). This document sets minimum standards for public health to the boards of health across the province in three specified areas, namely chronic diseases and injuries, family health and infectious diseases. In addition, to Ontario's official public health structures, the Chronic Disease Prevention and Health Promotion Branch of the Ministry of Health and Long Term Care provides funds to the 22 organizations that are part of the *Ontario Health Promotion*

Resource System. This System provides training, consultation, print and electronic resources, network building opportunities and referrals to people and organizations who want to increase their capacity to promotion health in Ontario. Consequently, important coordination activities occur outside of the governmental structures, although they are directly sponsored by the Ministry of Health and Long-Term Care.

The Ontario Public Health Association has played an active role in commenting and advocating in favour of public health issues over the years of observation. However, from the election of the Progressive-Conservatives in 1995, it has not been widely supported by the socioeconomic groups which saw their funding drastically cut and the channels of representations closed to Ontario's trade unions, social and community groups (Brandford 2003).

Quebec's statism. Table 1 also shows that Quebec's public health sector corresponds to a statist model of organization. This means that the central government plays a key, strong leadership role, and that the coordination and representation functions are an integral part of the governmental administrative structures. Since the creation of its modern welfare state in the 1960s, Quebec has pursued a tradition of integrating the various components of health and social policy into a unified approach. The architects of Quebec's welfare state wanted to group social security, health services and social services under a single department of Social Affairs. Consistent with this traditional philosophy, Quebec has also actively sought for about two decades, with a good degree of success, to integrate public health as an integral component of the province's socio-sanitary system at all administrative levels, as opposed to creating parallel structures for public health.

In Quebec, the central authority responsible for public health is the ministère de la Santé et des Services sociaux, which groups together health and social services, a unique feature in the Canadian health system. A general public health directorate (direction générale de santé publique) was created at the ministerial level during Quebec's regionalization process for health care in 1993. With the creation of this directorate, public health effectively became a full component of the socio-sanitary system at the provincial level. It has facilitated the planning of prevention-promotion activities on a provincial basis and the integration of these activities into the health services at the ministerial level (INSPQ 2002). Today the General Public Health Directorate is responsible for three (sub)-directorates: well-being and health promotion; public health protection; public health program. The well-being and health promotion directorate is responsible for traditional activities in health promotion such as education and social marketing about healthy lifestyles, and detecting risks of cancer. But its mandate is far broader than that. It is indeed responsible for conceiving approaches and strategies relative to the reduction of well-being and health inequalities, healthy public policy, healthy community development, developing healthy and secure health environments.

The role of the MSSS is supported by a separate governmental agency dedicated to public health and created in 1998: the Institut national de santé publique (INSPQ). This agency plays an important role at coordinating provincial public health efforts as its mission is to act as an advisory body attached directly to the Ministry of Health and Social Services. Initially, this Institute was created in order to integrate existing regional centers of public health expertise, particularly in Montreal and Quebec City, the

province's two largest cities, to consolidate and develop Quebec public health expertise, and to ensure improved accessibility (MSSS 1998). It supports the Ministry and regional authorities by contributing to the development of public health research, by disseminating and transferring knowledge, and by developing international exchanges (INSPQ 2004).

At the regional level, 18 Public Health directorates (Directions de la santé publique) were created in 1992 as part of the Régies régionales de la Santé et des Services sociaux (which lately became les Agences régionales locales as part of a far-reaching reform of the organization of health services in the province that was initiated by the new Liberal government). The 18 regional Public Health Directorates replaced the 32 community health departments that were under the responsibility of regional hospitals. Since 1992, then, the regional public health directorates have been responsible for informing the population about its health, developing interventions strategies in public health. But again their mission is not limited to more traditional public health and population health promotion: consistent with official policy, their mission also includes contributing to social development in their respective regions. At the local level, the establishment, in the early 1970s, of CLSCs (Centre locaux de services communautaires), provided an integrated access point to healthcare, public health and social services at the local level (until their very recent reform).

The policy coordination and policy advocacy are largely assumed by the INSPQ, which is actively involved in promoting health and wellbeing, among vulnerable groups in particular. It provides support for social and community development and informs the Minister about public policy impacts on the population's health and wellbeing

(INSPQ 2002). The INSPQ is actively involved in the promotion of new public health concepts. It focuses on individual and community social development, the socioeconomic determinants of health and wellbeing, and providing support for policy, orientations and programs. Not only does the INSPQ explicitly acknowledge the link between health, poverty and social inequalities, it also advocates commitment by ministerial, regional and local authorities in multisectoral interventions in the war against poverty and the reduction of social health inequalities. In addition, the *Conseil de la santé et du bien-être* (Health and Wellbeing Council), another government agency, plays a representational role. Its mission is “to contribute to improving the population’s health and wellbeing by providing advice to the Minister of Health and Social Services, informing the public, fostering debate, and creating partnerships” (CSBE 2004, p.8). While operating at arms length from ministerial power and within official structures, the Council serves to give expression to the points of view of socioeconomic groups and to mobilize the social sector, and represents a vision that advocates respect for the individual and dignity (CSBE, p.9). Its action supports and complements that of the new public health.

To sum up the content of Table 1, Ontario’s approach is very decentralized and dispersed and several public institutions are involved in public health. The dispersion creates meaningful local variations and several local initiatives which do not necessarily reflect a “central” or common vision for the whole province. The coordination functions are weak and for health promotion largely external to the governmental structures. However, Ontario’s institutional pluralism entails that the ministry plays a leading role in its functioning, among which providing the necessary resources, and is more

characteristic of a 'government by proxy' than an absolutely weak government leadership. Quebec's mode of organization is described as statist for several reasons. Its public health program and its recent legislation are directive and comprehensive, and its public health functions are an integral component of the socio-sanitary system at all administrative levels. Contrary to Ontario's infrastructure, Quebec has integrated the coordination functions for population health promotion as part of the governmental structures. Finally, some of Quebec's central advocacy and mobilization functions for the new public health and social policy (the latter being a support to the values and principles advocated by the new public health), have also been integrated in government.

The 'new public health'. The new public health entered provincial policy in a specific manner in each province and to a different degree. As Table 2 indicates, Ontario's main provincial program in public health is the *Mandatory Health Programs and Services Guidelines* (1997-). This document sets minimum standards for public health to the boards of health across the province in three specified areas, namely chronic diseases and injuries, family health and infectious diseases. Its 17 mandated programs focus on prevention, early detection of cancer and control of infectious diseases. The Guidelines are described as a "chronic disease prevention" instrument (Elliott et al.2000). They emphasize risk-factors and stipulate that health promotion efforts by the boards of health shall be dedicated to "community development, social marketing, mass communication and media, health education, adult education, peer education and behaviour change education" (MHPSPG p.5). Ontario's guidelines seek to provide *Equal Access* of all Ontarians to public health programs by reducing educational, social and

environmental barriers to accessing mandatory public health programs. Such barriers are explicitly described: literacy level, language, culture, geography, social factors, education, economic circumstance, and mental and physical ability (p.6).

Table 2

Incorporation of determinants into the policy framework

Province and Program	Type of incorporation
Ontario :	
Mandatory Programs and Services Guidelines (1997+)	Reduction of access barriers
Quebec :	
National public health program 2003-2012	Health and welfare grouped together Reduction of social health inequalities

Whereas the Ontario Guidelines reflect a public concern for reducing the existing barriers of access to mandatory public health services, the incorporation of the social determinants of health into policy is limited. Firstly, Ontario's policy does not ensure an equitable geographical distribution of public health services. The Guidelines have not been fully enforced because the Ministry has, in a period of five years between 1998 and 2003, conducted no regular assessments of local health units to determine whether they were complying with these guidelines (Auditor General p.219). Estimated compliance levels with the MHPSPG are at around 75% (Ontario 2004). This is attributable to the fact

that the boards of health have seen their responsibilities increase since the 1990s without corresponding budgets (Elliott, Taylor et al. 2000; O'Connor 2002). In other words, the downloading of public health (and other) responsibilities to municipal governments from the mid-1990s without the necessary budgets implied that there are great variations among the local units in the amounts spent for mandatory health programs and services. While the provincial average was at \$37 per capita in 2002, the amounts spent by the 37 local units ranged between \$23 per capita and \$64 per capita (Auditor General Report p.219). These variations may reflect the concerns of local politicians (Elliott, Taylor et al. 2000). Partial compliance with the Guidelines also denotes a fundamental, well-documented seizure between Ontario's central and local authorities, which became very apparent during the recent SARS crisis.

Secondly, in population health promotion as such, Ontario's two key provincial programs focus on a more traditional approach to health promotion which leaves little room for action on the broader determinants of health. Indeed, the *Focus Community Program*, is a 5-year, \$12 million program which aims to prevent alcohol and other drug abuse and that focuses in particular on children and youth. The numerous components of this program are implemented by 21 of the 37 local agencies in partnership with community groups. All of the components are based on social marketing and education approaches and/or providing community support. The other key program, the *Heart Health Program*, is a 5-year, \$17 million initiative which aims to prevent cardiovascular disease. It seeks to "raise public awareness of the three key lifestyle factors linked to a reduced risk of cardiovascular disease and cancer". The program is delivered through public health units and their local partners across the province. It provides funding for

the external organizations such as the Heart Health Resource Centre at the Ontario Public Health Association.

In addition to these two key initiatives, the province is involved in other population health promotion activities, mainly via programs and strategies such as reducing tobacco use, promoting physical activity, protecting children, and nutrition. A recent, 2004 initiative launched by the new McGuinty government remain in line with the ones already in place. ACTIVE2010 is a strategy to increase participation in sport and physical activity throughout Ontario. It consists of a partnership between the Ministry of Health and Long-Term Care and the Ministry of Tourism and Recreation which aims to increase the physical activity of Ontarians to 55 % by the year 2010. "Removing barriers" is a theme in the program, formulated this time as to facilitate the participation of challenged individuals and families (in particular low-income households, seniors and people with disabilities) in sport and physical activity. Intervention on what is called the "health environment" in public health circles is sought as the program will help local and not-for-profit organizations provide and enhance opportunities for physical activity and community sport and recreation (News Release 2005/01/06).

Quebec's provincial policy regarding population health promotion is contained in a ten-year, comprehensive public health program, the *Programme national de santé publique 2003-2012*. Consistent with the new public health approach, the Quebec government's official program adopts a very broad definition of 'population health' that also comprises 'population well-being'. It aims to improve not only the population's health in a narrow sense as such but also, more generally, the population's well-being, in recognition that health and wellbeing statuses are interconnected and interdependent.

The program comprises but goes far beyond promoting healthy lifestyles and social marketing campaigns, and even beyond that of reducing the barriers of access to public health services as in Ontario. It seeks to reduce health and wellbeing inequalities as such, which is a goal that transcends all domains of governmental intervention on the population's health. The attainment of this goal relies on broad strategies that extend beyond the health sector and beyond individuals; it relies on comprehensive, structural interventions on the social determinants of health: strengthening individual potential, supporting community development, participating in intersectoral actions fostering health and wellbeing, providing support for vulnerable groups, and encouraging effective preventive clinical practices (MSSS 2003). Also, in addition to the four core functions of public health (surveillance, health and wellbeing promotion, prevention of illnesses, psychosocial problems and traumas, and health protection) the Program acknowledges three public-health support functions (support for regulations; support for legislation and public policy having an effect on health; and support for research, innovation and skills development).

The Program is an outcome of the 2001 *Public Health Act*. In addition to concentrating the essential functions of public health, the new *Act* provides support for all dimensions of public health interventions. It supports not only the core functions of health protection as such, but also the health surveillance mandate, as well as the prevention and promotion mandate. It acknowledges that the laws and regulations emerging from various government sectors can influence population health and wellbeing. It empowers the Ministry of Health and Social Services (MHSS) to initiate intersectoral action in support of developing public policy

favourable to health. Decision-making processes in all areas of government activity must take into account the potential impacts of all legislative and regulatory initiatives on the population's health and wellbeing. All Ministries and agencies are required by virtue of the *Act* to consult the Minister of Health and Social Services when they are formulating laws or regulations which could have a significant impact on health and wellbeing. It is then incumbent upon the Ministry to advise the government.

In a nutshell, Ontario's public health policy emphasizes social marketing, chronic diseases, prevention of risks, reducing healthcare costs and changing lifestyles, which is more consistent with a traditional approach to public health. However, official policy has adopted a broader definition of health at the beginning of the 1990s. In addition, the provincial guidelines recognize and seek to act upon the influence of the determinants of health (income, social status, education, etc.), which "have as much or more to do about influencing health than does the presence of health care practitioners and facilities"⁴. Ontario's incorporation of the determinants of health is mostly defined in terms of reducing barriers of access to mandatory public health services. It is not fully incorporated into health promotion programs, which continue to focus on social marketing of healthy lifestyles. Quebec's *Programme national de santé publique* (2003-2012) goes further than Ontario's Guidelines, showing a greater and broader commitment to reducing social health inequalities as such, instead of barriers of access. They are most fully incorporated in Quebec's policy, supported by Quebec's recent legislation, which

⁴ (www.health.gov.on.ca/english/public/program/pubhealth/public_mn.html, accessed on 2005-02-07)

consists in a comprehensive public health approach not restricted to health sector interventions.

Public health trajectories 1994-2004. As Table 3 shows, Ontario's public health policy stagnated and was destabilized mostly by the sweeping reforms that occurred in Ontario's public sector during this period, but did not experience a sustained frontal assault as such. At the same time, Quebec's policy pursued a path consistent with the new public health policy it had developed at the beginning of the decade as it consolidated its public health infrastructure.

Ontario's 'external' destabilization of public health policy occurred in particular following the municipal amalgamations in 1998, during which public health units, which are under municipal and local authority, were amalgamated together to serve a new, larger, local territory. This involved integrating different cultures and approaches among public health professionals on one front at the same time as these professionals had to fight the governmental budgets imposing severe cuts in expenditures across the government on the other front. In addition, in 1998, the provincial government transferred 100% of public health costs (among other costs) to municipalities. This meant that public health was now competing directly with municipal services for funding, at the same time as radical cuts were implemented in all sectors of governmental activities and more responsibilities being devolved to municipalities. Public health professionals gathered the available epidemiological data, mobilized and engaged in difficult negotiations to preserve their resources. The share-cost basis of provincial-municipal expenditures for public health was re-instated only a year later, in 1999, but only to the 50% level. Most health authorities were thus dealing with only 2/3 of their former

budgets. In addition, sweeping reforms in most of Ontario’s social policy created unprecedented pressures on public health, which was called upon to deal with problems such as increased levels of homelessness, mental health problems and family violence as an ultimate social safety net.

Table 3

**Orientation of provincial public health policy
in Ontario and Quebec, ≈ 1994-2004**

	Ontario	Quebec
Dominant features of policy evolution	Stagnation and external destabilization	Continuity
Institutionalization of public health (regional, provincial)	Interruption	Increase
Incorporation of determinants into public health policy	Preservation	Consolidation and diversification

Whereas the relative progressiveness of Ontario’s policy relative to other provinces experienced a setback, important gains made earlier in terms of a new public health approach were preserved. At the beginning of the 1990s, Ontario’s Premier’s Council and, later, the provincial government had adopted a broad view of health and its determinants as the basis for health policy in Ontario (Pederson and Signal 1994). The NDP government, which was in place between 1990 and 1995, changed the Premier’s Council on Health to the Premier’s Council on Health, Wellbeing and Social Justice. As noted by a respondent, this reflected a growing convergence between social and health policy thinking at this point in time (interview with T2). However after the election of

the Progressive-Conservatives, several health policy changes occurred. A process that had been taking place across Ontario, of making best practices and programs initiated at the local level available across the province, was interrupted. At the same time, health promotion and diseases and injury prevention became a new stated priority for healthcare reform. Improving the population's health, and especially reducing the very costly chronic diseases, became perceived and used as instrumental to cost containment for the health care. According to Riley (2003), "the healthy lifestyles programs were consolidated into a single chronic disease prevention program, and program standards were made more measurable and prescriptive" (p.21). The 1997 mandatory guidelines continued to adopt a broader definition of health and to emphasize the reduction of barriers of access to the mandatory public health services and programs.

In the end, public health funding had been reduced at the same time as health policy was experiencing new pressures to expand its scope of intervention to the 'social' sphere as a result of Ontario's social policy reform. This financial restructuring intensified the tensions between local needs and the provincially mandated services (Kothari & Edward 2003). This being said, the public health sector lost few resources when compared to the community and social policy sector (interview with T1, T2, T5). The new public health approach was indirectly affected by the context in which public health professionals had to operate, in particular the increased needs resulting from radical reforms in social services and social policy. Their capacity to intervene efficiently and coherently was also questioned in the midst of municipal amalgamations and budgetary cuts at the provincial level (interview with T5). The municipal amalgamation and severe cuts in all domains of governmental intervention induced a 'repli sur soi' of

Ontario's public health: public health professionals were too preoccupied with internal and survival concerns to introduce new initiatives and further advance the provincial public health policy. Therefore, while the new public health preserved some of its important assets in Ontario's provincial framework for public health, it remained in a state of relative stagnation during those years.

Québec's consolidation. In Quebec, in 1992, the administrative reform led to the regionalization of the health care system and the creation of 18 regional health and social services boards to cover the whole province. As discussed above, in Quebec, the regionalization of the health care system made it possible for a better integration of public health into the health and social services network's provincial and regional decision structures (INSPQ 2002). In the spirit of the orientations advocated by the Rochon Commission (Rochon, 1988), the administrative reform made it possible to refocus public health as a component of the socio-sanitary system. The period following the regionalization of public health was characterized by several integration and coordination problems (Deschênes, 1996). Notwithstanding a very ambitious official policy, for some years Quebec's approach to health promotion was shaky and ambiguous (O'Neill and Cardinal 1998). However, when we extend the observation period to 2004, Quebec's orientation is characterized by the consolidation of administrative and programmatic foundations. Since the early 1990s, the process of institutionalizing public health has continued at the regional and provincial levels and the social determinants of health perspective has been more widely incorporated into the program, administrative and legislative instruments of Quebec's health policy.

The foundation of Quebec policy was established in 1992 with the *Politique de la santé et du bien-être (Health and Wellbeing Policy)*, which had measurable health objectives formulated by taking into account the social determinants of the population's health. This policy marked an important moment in Quebec policy since it sought to ensure that the government dealt with issues related to health and wellbeing from a broader and more encompassing perspective than one limited to socio-sanitary services (CSBE 2004, p.7). It has 19 objectives related to reducing health problems and social problems and has six actions strategies with regard to the determinants of the population's health and wellbeing. Its very existence is meant to ensure that the health system's policies are guided by health and wellbeing objectives for the population (Morais 2003). In addition to ensuring the best possible access to health services, it is the Policy's intention that the socio-sanitary system plays a greater leadership role with regard to undertaking actions in the area of determinants of health and wellbeing (CSBE 2004, p.9).

The policy consolidation was subsequently marked by the adoption of the *Priorités nationales de santé publique 1997-2002 (National Public Health Priorities)*, which sought more specifically to provide all of Quebec's regions with the same public health priorities, and the *Programme national de santé publique 2003-2012 (National Public Health Program)* (as discussed above). Like the initial 1992 official policy, these programs adopt a global approach and vision to health and wellbeing, which take into account the social determinants of the population's health and which is reflected as much in the objectives as in the specified intervention strategies. The consolidation was also helped by the 1998 creation of the *Institut national de la santé publique du Québec (INSPQ) (National Institute of Public Health of Quebec)*, the initial goal of which was to integrate regional

centres of public health expertise at the provincial level and to improve accessibility (MSSS 1998). Although, this integration-consolidation met with considerable resistance by regional authorities, its efforts have been successfully continued since 2002. Lastly, the consolidation was completed with the *Loi sur la santé publique* (Public Health Act), modernized in 2001, which stipulates that “public health actions must be carried out with a view to protecting, maintaining or improving the state of the population’s health and wellbeing” (topo p.3). In particular, Article 54 of the new act stipulates that the Ministry of Health and Social Services must act as an advisor to the government for all health-related issues and that it must be consulted during the formulation of measures contained in provincial legislation and regulations which might have a significant impact on the health of the population.

To sum up, policy processes and orientations in public health were not negatively affected to the extent that can be predicted from a theoretical perspective in the two provinces. Ontario, ‘destabilized’ by radical provincial politics leading to severe cuts from the central government, downloading of responsibilities to the municipal level without corresponding resources and municipal amalgamations in the late mid-1990s. The policy orientations have not been conducive to a greater incorporation of the new public health principles into health policy. This being said, in the midst of the ‘Common Sense Revolution’ and drastic cuts made in the public sector, some of the central gains made at the beginning of the 1990s, that is, adopting a broader definition of health and dealing with barriers of access to mandatory public health services, were maintained (although not reinforced) in the 1997 Guidelines. Quebec’s process was characterized by continuity and the progressive consolidation of its infrastructure at the regional and

provincial levels. Quebec's policy pursued a path of consolidation and greater institutionalization at the regional and provincial levels. This led toward greater incorporation of the social determinants of health into health policy, through a series of successive steps defining official policy and provincial legislation and setting up regional and provincial public health infrastructures.

This interpretation does not at all suggest that public health has made sufficient progress or is optimally organized. Recent crises have shown that Ontario's public health services were largely deficient and neglected. In particular the 2002 O'Connor report showed that the Walkerton contamination of the water supply tragedy cannot be dissociated from neo-liberal policies pursued under the Harris government, and in particular from the sudden privatization of the remaining water quality testing that was done in government labs. Mary Powell's paper shows evidence of the marginalization of public health in Ontario during those years and even argues that public health has been in dismal shape in Ontario for most of the last 125 years (2005, unpublished). This being said, the new public health was 'relatively' successful, even in Ontario, because public health in general and the new public health in particular were not as negatively affected as could be predicted from a theoretical, rational choice perspective in Ontario and, contrary to what could be expected, was even further developed in Quebec.

Understanding the New Public Health's Relative Success:

Institutions and Policy Preferences

The relative success of the new public health, especially in Quebec, must be understood in the larger context of overall health policy orientation in Canada. It is

undeniable that health policy experienced several tensions and problems in the 1990s as a result of mounting fiscal pressures. In Ontario, for instance, Mike Harris' government attempted to reduce the hospitals' budgets by \$1.3 billions in 1995, from about \$7.3 billions. The government-appointed *Health Services Restructuring Commission*, based on Ontario's 1996 *Saving and Restructuring Act*, scrutinized hospital services, made recommendations from a cost-reduction perspective and hospital funding was revised (Hanlon and Rosenberg 1998). Nevertheless, as Tuohy (1999) observed in her comparative study of the dynamic of change in the health care arena in the U.S., Britain and Canada, the Canadian health care system experienced a relative structural and institutional stability during this period. Contrary to the other two countries, Canada did not attempt to change the policy parameters governing the institutional mix (market, hierarchy and collegiality) and the structural balance of the system between the state, health care professionals (particularly the medical profession) and private financial interests (p.245). During this period of fiscal austerity, the provincial governments did not withdraw from health policy, but even asserted their role: with the exception of Ontario, they brought some horizontal and vertical integration in the hospital sector while creating regional authorities for health. They had great latitude to redefine the organization of health care delivery and to rebalance the influence between state actors, the private sector and the medical profession, but restricted their role to adopting "blunt budget instruments to slow the growth of the health care budget and to reallocate within it" (p.245).

Whereas all national income security programs and federal transfer payments to the provinces underwent fundamental changes as a consequence of the federal

government's restrictive policies, there was no frontal challenge to the Canadian medicare model. This can be attributed in part to health care being a great national symbol in Canada and, by the mid-1990s, media attention and polls across the country showing a growing public concern that medicare was in jeopardy (Maioni 1998; Tuohy 1999). This was reflected in the revision of the federal-provincial fiscal framework in the mid-1990s. On the one hand, it eliminated the obligation for provinces to provide social assistance benefits on a needs basis, which opened the door to conditional benefits at the provincial level.⁵ On the other hand, and consistent with the Canadian public agenda focused on health care, the five principles of the Canada Health Act were maintained in the new fiscal framework. The amalgamated block funding for social and health transfer program thus entailed that federal requirements contributed to protect health care budgets relatively to social assistance. The relative success of the new public health can be understood as part of the fiscal framework and as part of the broader success of Canadian health and health care policy.

But as mentioned earlier, public health is at a disadvantage when competing for resources and budgets with the medical treatment system: acute care services deal with concrete, specific and immediate problems, contrary to public health services such as injury and disease prevention and health promotion which generally deal with diffuse and abstract, and long-term concerns. Taking the larger health policy context into consideration therefore appears as a necessary but insufficient condition. Another useful dimension is the fact that public health fulfills one of the essential welfare state's functions and represents a basic condition for the state's legitimacy. Whereas public

⁵ Receiving benefits could now be legally conditional to looking for employment, participating in a workfare program or sending one's children to school.

health programs are normally not visible to the public, they do become very visible when not adequately performing their expected roles and when public health problems surface as a result of inadequate government provision. The malfunctioning or inadequacy of public health programs (such as immunization and ensuring basic sanitary conditions in all sectors of human activity) exposes government leaders to potentially very strong electoral retaliation, and could even lead to questioning the essence of governmental institutions. The Walkerton E.coli contamination of the water supply and the Toronto-area SARS crisis indicated that public health does become visible when it cannot provide for basic sanitary conditions to prevent the occurrence of large-scale disasters, when it cannot not adequately protect the population's health from epidemics and other public health tragedies, and when it is not ready to react to threatening events in an efficient, coordinated manner.

In many respects, public health programs are similar to social assistance programs, in that they are among the state's essential functions. Such programs can be kept to a minimal level of intervention, however. Pierson (1994) pointed out that it can be difficult for mean programs to become meaner during budgetary cuts. But in retrospect, after many years of neo-liberal policies, this argument appears as merely rhetorical: empirical evidence showed that mean social assistance programs can become even meaner. In Canada some provincial governments showed their ability and willingness to sharply reduce social assistance benefits, impose strict conditions for receiving benefits including for beneficiaries to participate in a workfare program, and even deny benefits to the 'undeserving' poor (such as drug or alcohol dependents or beneficiaries unable to show they are looking for employment) or after a time limit.

Among a series of such drastic measures, Ontario under the Harris government reduced social assistance benefits by over 21.6% in 1996.

Whereas social assistance programs were shaken by three decades of neo-liberalism in Canada, they also proved resilient to it. This can be an indication that political leaders see a strategic advantage for government policy to at least appear to be dealing with the basic needs of the most vulnerable citizens. Similarly, there might be an advantage for governments to appear to the middle classes to be providing a basic social safety net to 'deserving' citizens in case things go wrong. From a rational perspective, political leaders may have an interest, in the same train of thoughts, to preserve the basic conditions to at least entertain the idea that their government is doing enough of what is do-able to protect the population's health. Like social assistance programs, the resilience of public health appears from this perspective not as much as resulting from 'strategic' considerations as it being a pre-requisite for government.

Now, this is still insufficient to explain why the central tenets of the 'new' public health vision were preserved in Ontario and further developed in Quebec. If the above interpretation is valid, why were public health interventions not reduced to their lowest single common denominator (that is, going back to public health's essential functions). Why did the Ontario government preserve, and Quebec even further develop, broader notions of health and public health interventions? The answer varies for each province. For Ontario, the answer lies in good part in the fact that the new public health is consistent with the ideology of the government in place during most of the period under observation. The new public health corresponds to a paradigm for social policy-making that is consistent with neo-liberal policies: protection against social risks, emphasis on

the (liberal) notion of equality of opportunity and future chances, and corresponds to a 'social investment model' of social policy-making (Jenson and Saint-Martin 2002). The social investment paradigm for social policy was developed in OECD countries from the early 1980s but accelerated in the 1990s. It can be contrasted to the Keynesian 'consumption model' by which governments provided passive benefits in case of need instead of investing in 'active' benefits such as education for children, professional training for unemployed workers and workfare or learnfare programs for social assistance beneficiaries. The social investment model of social policy-making seeks not simply to compensate beneficiaries for lost revenues resulting from massive social risks such as illness or unemployment. It emphasizes the development of specific programs and policies that are focussed on the most vulnerable individuals and groups in society. It seeks to control or prevent the occurrence of individual problems where they are most likely to occur, be it in socio-economic groups, ethnic groups, age groups or geographical areas.

Consistent with the neo-liberal, social investment paradigm of social policymaking was the line of argumentation which was actively pursued by public professionals in Ontario from the mid-1990s. Public health professionals directed their efforts to persuade the Harris government that cutting in certain public health expenditures was detrimental to the province's finances and health care in the long term. The line of argumentation, well supported by epidemiological studies, was largely organized around the idea that public health problems not being dealt with now (such as immunization, prevention of chronic diseases) would be much more costly to the public purse later (interview with T5). As mentioned earlier, the Common Sense

Revolution coincided with a renewed emphasis on the promotion of healthy lifestyles and chronic disease prevention. Whereas channels of representation were closed to socioeconomic groups after the election of the Harris government, the public health sector's counter-offensive discourse could be articulated in terms that were compatible to a certain extent with the pursuit of the 'Common Sense Revolution' and was at least heard by the Harris government.⁶ This helps explain their success relative to social policy representatives.

If we accept the idea that the relative success of the new public health in Ontario is due in part to the fact it was compatible with the neo-liberal policy orientations pursued by the Harris government, this challenges explaining the Quebec experience. Quebec is, among Canada's four largest provinces (Ontario, Alberta and British Columbia) the most distinctive one from the Canadian 'liberal' welfare state model, the United States and the Esping-Andersen's liberal welfare state model (Bernard and Saint-Arnaud, p.222,228). Social democratic traditions are stronger in Quebec than in the other provinces (Baer et al. 1993; Grabb et al. 1999 and 2000, Clarke 2002). Quebec's experience with fiscal austerity in the past decade or so has been described as a 'deviant case' compared to other provinces. This province, while adopting certain economic policies influenced by neo-liberalism, has largely resisted a neo-liberal model of development during the period under observation (Lévesque, Bourque & Vaillancourt 1999; Vaillancourt, Aubry et al.2000; Clark 2002).

⁶ This interpretation is based on elements of information collected during interviews with T2, T5.

While the 'progressiveness' Quebec's policy can be challenged,⁷ especially since the election of the Liberal government in 2003, it is a fact that Quebec's approach to reform its health and social services sector and its social assistance programs has been less drastic than elsewhere in the past decade. In the late 1990s Quebec has insisted on developing social economy enterprises instead of privatizing health-related services, and has put a much less coercive and less punitive emphasis on imposing new conditions to beneficiaries for receiving social assistance benefits (Bernier 2003b; Boismenu and Bernier 2000). Similarly, Quebec's social policy went in a direction different from other provinces with the implementation of its progressive family policy starting in 1996, which comprised income-tested family allowances, the setting up of a universal, highly subsidized provincial day care system and attempts to improve the provincial work legislation which became successful in 2002 (Jenson 2002). As for the 'new public health', the importance accorded to children/family-related policies in Quebec's social policy from the mid-1990s indicates that the social investment model of social policymaking also permeated in Quebec. Preventing child poverty, providing opportunities for early childhood development via a network of regulated daycares that ensures a basic curriculum and staff competences, setting up a social infrastructure that can detect a child's individual or family difficulties in their very early years and that is accessible to all social classes including recipients of social assistance benefits, and providing the basic conditions for working parents to be legally enabled to provide essential care for their children, are all consistent with a social investment model for social policy-making.

⁷ See for instance Graefe, 2001; Groulx, 1998; Lamoureux, 1998.

The social investment model of policy making facilitated the relative success of Ontario's new public health because it was compatible with the neo-liberal orientations pursued by the Harris government, but it is for different reasons that this paradigm fared differently, in a more progressive version, in Quebec. The case of the 'new public health' must be understood as an element of Quebec's social policy. Social policy has historically been an instrument of negotiation between the Quebec government and Ottawa, and has been used as an instrument for Quebec's national affirmation in its relation with Ottawa and the rest of Canada (Bernier 2003, Jenson 2002, Théret 1999). This is exemplified for instance by Quebec's refusal to ratify the Victoria accord in 1971, because it entailed an insufficient decentralization of social policy responsibilities. Typically in Canada's postwar history until this day, Quebec has designed relatively generous provincial social policy programs such as a family allowance program (1970, 1999) or a postsecondary bursary program (1998) and Ottawa has counter-reacted with an overlapping, equally generous national program, in a process of competitive nation-building. A similar dynamic can be observed in the case of public health, especially during the Parti Québécois government between 1994 and 2003. While all provinces agreed on the importance to coordinate their efforts to ensure the basic functions of public health, Quebec's representatives strongly disagreed in the past couple years on the idea that the newly created federal organizations for public health would adopt a broader definition of their mandate, that is, a 'new public health' approach (interview with Q1, A3). As for other social policy areas, Quebec's progressive 'new public health' approach can be seen as a way to pre-empt the expansion of federal powers into that sensible sphere of intervention.

The very progressive character of Quebec's public health and social policies more generally, in the Canadian context, indicates that the social investment paradigm did not permeate Quebec's social policy *in spite of* its distinctive social democratic tradition and policy orientations. Rather, it did so *as a particular form of expression* of the social investment paradigm which is reflective of such traditions and broader policy orientations pursued by the Quebec government. The new public health's growing convergence with Quebec's social policy during the 1990s and early 2000s is one among many forms of expression of a historic rivalry between Quebec and Ottawa for affirming their national identities.

Conclusion

A series of public health crises in Canada and abroad have brought the attention of policy-makers and public managers on public health issues and made it clear that the development of adequate public health infrastructures is a necessary component of health policy, beyond health care. This new awareness of the role of the state in the protection of the population's health by means other than providing medical treatments and hospital services has represented an opportunity for health professionals worldwide who are committed to a progressive understanding of their role and that of the state in improving the health and well-being of its population and to protect the most vulnerable groups in society. The Ottawa Charter in 1986 was a decisive step in first catalyzing the health sector progressive forces in Canada and abroad. Nowadays, this movement has developed a 'voice' which is heard in national and international health-related policy debates, with which it does advocate in favour of public interventions on the social determinants of health. This clearly means that advocacy for public

interventions in several policy areas outside the health sector as such is being made by health professionals and that efforts are dedicated to improve social conditions through health interventions in other administrative sectors such as income security. The new public health represents a convergence, under a specific form of health discourse articulated by newly organized proponents, with the not-so-new thinking for improving social conditions and the social policies of the welfare state.

Canada has played a significant leadership role in the field, but this leadership was undertaken mostly by the federal government, while the provincial governments are responsible significantly for health policy matters. Also, multisectoral interventions on the population's health and well-being entail shifts in power and resources that make the 'new public health' concept ambitious and idealistic from a political standpoint. This paper showed not only that the new public health fare differently in Ontario and Quebec in the context of fiscal austerity from the mid-1990s, but also some of the reasons why it has been relatively successful in the two provinces, from an electoral calculus, theoretical standpoint. The interpretation developed in this paper indicates that, in the Canadian context, the insertion of the new public health concept is closely connected to broader provincial policies and the general political agenda pursued by provincial governments.

ACKNOWLEDGEMENTS

1. B.Hansen, S.Lewis, E.Murphy, P.O'Hara, C.Price, K.Raine, 2 other anonymous respondents (interviews in Alberta)
2. C.Acker, M.Cushing, M.Herrera, J.Lee, D.Patychuk (interviews in Ontario)
3. M. Boucher, C.Colin, R. Massé, H.Morais, J. Rochon (interviews in Quebec)
4. Christine Colin, Louise Potvin, Sabina Stan, Jean Rochon (comments on the Quebec article)
5. Geneviève C. Guindon (research assistance)
6. CIHR/CHRSF (2003-2005 fellowship), Chaire Approches communautaires et inégalités de santé (resources)

REFERENCES (to be completed)

Canada. Health Canada (2003). Learning from SARS : Renewal in Public Health in Canada. Ottawa, National Advisory Committee on SARS and Public Health,.

Canada. The Standing Senate Committee on Social Affairs, S. a. T. (2003). Reforming health protection and promotion in Canada: time to act. M. Kirby. Ottawa.

Canadian Public Health Association (2001). The Future of Public Health in Canada, Canadian Public Health Association: 10p.

Colin, C. (2004). "La santé publique au Québec à l'aube du XXI e siècle." Santé publique **16**(2): 185-195.

Elliott, S. J., S. M. Taylor, et al. (2000). "Restructuring Public Health in Ontario: Implications for Heart Health Promotion." Canadian Journal of Public Health / Revue Canadienne de Santé Publique **91**(2): 94-97.

Frank, J. and E. Di Ruggiero (2003). "Public health in Canada: what are the real issues?" Canadian Journal of Public Health **Revue Canadienne de Sante Publique**. **94**(3): 190-2.

INSPQ (2002). La santé des communautés, perspectives pour la contribution de la santé publique au développement social et au développement des communautés. Québec, Institut national de Santé publique du Québec.

INSPQ (2004). Electronic Source www.inspq.qc.ca. Quebec, Institut National de Santé publique. 2004.

Kickbusch, I. (2003). "The contribution of the World Health Organization to a new public health and health promotion." American Journal of Public Health. **93**(3): 383-8.

Kothari, A. and N. Edwards (2003). "Who Is Protecting the Canadian Public Health System?" Home Health Care Management & Practice **15**(5): 391-398.

MSSS (1998). Priorités nationales de santé publique 1997-2002, Ministère de la Santé et des Services sociaux.

MSSS (2003). Programme national de santé publique 2003-2012. Québec, Ministère de la Santé et des Services sociaux.

O'Connor, M. J. D. (2002). Part Two: Report of the Walkerton Inquiry. Toronto.

Ontario, C. t. I. t. I. a. S. o. S. i. O. (2004). The SARS Commission Interim Report: SARS and Public Health in Ontario. The Honourable Mr. Justice Archie Campbell. Toronto: 222 pages.

Ontario Expert Panel on SARS and Infectious Disease Control (2003). For the Public's Health. Initial Report. Toronto, Ministry of Health and Long-Term Care,; 216 pages.

Ontario Expert Panel on SARS and Infectious Disease Control (2003). For the Public's Health: Initial Report - Executive Summary and Recommendations: 43 pages.

Pederson, A. and L. Signal (1994). The Health Promotion Movement in Ontario:
Mobilizing to Broaden the Definition of Health. Health Promotion in
Canada -- Provincial, National & International Perspectives. A. Pederson,
M. O'Neill and I. Rootman. Toronto, W.B. Saunders Canada: 244-261.