

# Health promotion policy in Canada: lessons forgotten, lessons still to learn<sup>†</sup>

JACQUELINE LOW\* and LUC THÉRIAULT

Department of Sociology, University of New Brunswick, PO Box 4400, Fredericton, New Brunswick, Canada E3B 5A3

\*Corresponding author. E-mail: jlow@unb.ca

<sup>†</sup>Based on a paper presented at the 2nd Atlantic Networks for Prevention Research (ANPR) Conference, St John's, Newfoundland & Labrador, Canada, 4–6 July 2007.

---

## SUMMARY

In this paper, we analyse Canadian health promotion discourse past and present, in the context of selected federal and provincial government policy initiatives. Principally, we examine the health promotion discourse articulated in *A New Perspective on the Health of Canadians*, *Achieving Health for All: A Framework for Health Promotion*, the *Ottawa Charter for Health Promotion*, *Improving the Health of Canadians*, and *Canada Health Action: Building on the Legacy—Volume II—Synthesis reports and Issue papers*. We argue that the

health promotion lessons of the past 30 years contained within these reports have largely been forgotten, overlooked or disregarded in policy implementation. We conclude, as have many before us, that successful health promotion policy needs to reflect a collectivist rather than individualist ethos where responsibility for the health of Canadians is concerned. Moreover, it needs to be one that addresses the social determinants of health, including inequity, via the coordination of healthy public policy.

**Key words:** health promotion; health policy; social determinants of health

---

## INTRODUCTION

In this paper, we analyse Canadian health promotion discourse in the context of selected federal and provincial government policy initiatives. Principally, we examine the health promotion discourse articulated in *A New Perspective on the Health of Canadians* (Lalonde, 1974), *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986), the *Ottawa Charter for Health Promotion* (WHO, 1986), *Improving the Health of Canadians* (CPHI, 2004) and *Canada Health Action: Building on the Legacy—Volume II—Synthesis reports and Issue papers* (Health Canada, 2004). We argue that the health promotion lessons of the past 30 years contained

within these reports have largely been forgotten, overlooked, or disregarded in policy implementation. We conclude, as have many before us, that successful health promotion policy needs to reflect a collectivist rather than individualist ethos where responsibility for the health of Canadians is concerned. Moreover, it needs to be one that addresses the social determinants of health, including inequity, via the coordination of healthy public policy.

## CANADIAN HEALTH PROMOTION MODELS: LESSONS FORGOTTEN

The contemporary notion of health promotion emerged over 60 years ago when, in 1946, the

World Health Organization (WHO) introduced a new definition of health meant to address the limitations of a biomedical understanding of health as the absence of disease (WHO, 1946). This definition of health ushered in a new era in health policy and influenced what has become a long history of interest in health promotion in Canada. Canada's championing of the health promotion model began in 1974, when then liberal Minister of National Health and Welfare, Marc Lalonde, tabled his report: *A New Perspective on the Health of Canadians*. In it he argued that to improve the health of Canadians, Canada's federal health policy had to reflect the fact that illness, disease and disability were national problems that could only be successfully addressed through attention to lifestyles; the state of the environment and the organization of health care services; in addition, of course, to human biology. At the time his was a radical position aimed at revolutionizing Canadian health policy.

A little more than 10 years later, another Minister of National Health and Welfare, conservative Jake Epp (Epp, 1986), presented his model of health promotion in the report, *Achieving Health for All: A Framework for Health Promotion*. His health promotion model built on the legacy of Lalonde's (Lalonde, 1974) and shares with it a concern with self care, or the lifestyle choices people make; and the organization of health care services, in Epp's (Epp, 1986) case recommending a greater role for community health care. However, his model also differs from Lalonde's (Lalonde, 1974) in important ways; most notably in that Epp (Epp, 1986) identifies reducing inequity as the first, and thus most significant, of health challenges facing Canadians. He writes: 'there is disturbing evidence which shows that despite Canada's superior health services system, people's health remains directly related to their economic status' (Epp, 1986, p. 3). Reducing inequity is fundamental to health promotion as it is a social determinant of health that is systemically woven into the large scale structures of society; thus impacting at the level of population health (Navarro, 2007).

Ever after, health promotion discourse in Canada has reflected a multi-factor approach to understanding the determinants of health introduced by Lalonde (Lalonde, 1974) and, following Epp (Epp, 1986), has emphasized that inequality is a major determinant of health. To

illustrate, 'social justice and equity' are seen as pre-requisites for health in the Ottawa Charter for Health Promotion (WHO, 1986, p. 1). This lesson is later reinforced in the report, *Canada Health Action: Building on the Legacy*, in which Health Canada (Health Canada, 2004, section 1.1.1) clearly states that 'social, economic, and cultural determinants of health, just as genetics and health services are determinants.' Likewise, in the Canadian Institute of Health Information (CPHI, 2004, p. 23) report, *Improving the Health of Canadians*, the point is squarely made that 'better social and economic conditions mean better overall health'.

Recognizing the positive relationship between inequality and ill-health has remained an enduring health promotion lesson in Canada, even in the face of political and cultural discourses that have become dominant over the past 30 years and that have emphasized individual rather than collectivist responsibility for health. For instance, Health Canada (Health Canada, 2004, section 2, emphasis ours) concludes:

While we must take responsibility for the way we eat, exercise, drink or use drugs ... these actions alone cannot protect us from the broader environment. *We know that these practices are very much influenced by the social and economic environments in which people live and work. Thus, they involve less of an individual choice than was once thought.*

What is abundantly clear is that the overarching health promotion lesson of the past 30 years is that promoting the health of Canadians requires more than a narrow focus on individual biology and acute interventions, it also requires attention to the type and organization of health care; the physical and social environment; individual coping strategies and lifestyle choices; and, of particular importance, addressing the social determinants of health; the chief of which is reducing inequity (Lalonde, 1974; CPHA, 1996; Epp, 1986; WHO, 1986; CPHI, 2004; Health Canada, 2004).

These things in turn require a preventative approach to health care provision. What McKinlay (McKinlay, 1986, p. 503) styles 'upstream' endeavours. However, most health care services, and we can count Canadian health care among these, are organized to provide curative interventions aimed at acute conditions. Following Zola (Zola, 1970), McKinlay (McKinlay, 1986) argues that this is akin to standing downstream and pulling people

out of the river after they have fallen in. In contrast, health promotion approaches are those which stress preventative health care and take into account how social structure produces ill health and how structural factors, such as the economic framework of a society, shape lifestyle choices (McKinlay, 1986). They are thus analogous to upstream activities where people are prevented from falling into the river in the first place.

In turn, the successful implementation of a health promotion approach stressing preventative strategies, and addressing the social determinants of health, rests on the coordination of healthy public policy. This particular health promotion lesson was highlighted over 20 years ago in *Achieving Health for All* (Epp, 1986) and in the *Ottawa Charter for Health Promotion* (WHO, 1986). It was stressed again, a decade later by the Canadian Public Health Association (CPHA, 1996). Finally, what coordinating healthy public policy requires is a collectivist rather than individualist ethos; as collectivist approaches are, by nature, concerned with the social determinants of population health.

### **CANADIAN HEALTH PROMOTION INITIATIVES: LESSONS STILL TO LEARN**

Notwithstanding the reiterative uniformity of health promotion lessons over the last 30 years, when the record of Canadian policy initiatives is examined, they remain lessons still to be learned by policy makers. To illustrate, much lip service has been paid to health promotion in Canada; however, the health care system in Canada has remained largely hospital-centred and focused on acute health care. Furthermore, the Canada Health Act itself limits the pursuit of preventative health care policy initiatives that address the social determinants of health (Vaillancourt and Thériault, 1997). For example, the Canada Health Act legislation was originally enacted to support curative interventions delivered in hospital or by doctors in medical clinics, rather than in community or family-based settings, and thus the act introduces a hospital-centred bias into the system (Health Canada, 2002). While we do not argue that such services are not an important part of our national health policy, they are not the only

ones necessary to a true health promotion model of health care delivery.

Likewise, the conditions governing federal transfer payments to the provinces, such as the Canadian Assistance Plan (CAP, 1966) and the Canadian Health and Social Transfer (CHST), have played a role in the maintenance of a hospital-centred view of health care, as little incentives were offered to the provinces to truly move away from an institutional approach to health care delivery. As a mechanism for moving federal funding for health care to the provinces, CAP was replaced in 1996 by the CHST, which was replaced in turn by the Canadian Health Transfer (CHT) in 2004. Again, neither the CHST nor the CHT include provisions to ensure that public monies are used for preventative or other health promotion services (Veldhuis and Clemens, 2003). Moreover, with the funding cuts inaugurated with the CHST little new money has been available to experiment with delivery mechanisms that are more in-line with a true health promotion model.

Further, despite the need for policies that address what are socially produced, and therefore collective health challenges, the bulk of health promotion activity has been, and continues to be, aimed at the level of the individual (Raphael and Bryant, 2006). For example, progressive funding cuts have meant that school boards across Canada have had to economize. In response to these cuts, many have chosen to eliminate regular physical education programmes. For instance, a survey by the *Globe and Mail* shows that in 2006 only 26% of school boards in Canada had daily physical education and only 20% reported having intramural sports programmes (Picard and Alphonso, 2007). As always in Canada, there is significant regional variation with '100% of Quebec and Newfoundland boards reporting employing physical-education instructors with an applicable post secondary degree, compared with 20% in British Columbia, 25% Ontario, and 30% in Alberta' (Picard and Alphonso, 2007, p. A6). In the face of this reality, and the reality of growing obesity rates among Canadian children, the recent federal government policy response has been to provide a tax credit of up to \$500 to *individual* families who enrol their children in fitness activities (CBC, 2007). This individualist policy initiative is only of benefit to those families that can afford to pay for such

activities in the first place. The current federal government has chosen this policy route rather than one which would result in increased funding to schools, such that physical education programmes could be put back into curricula nationally, thus helping to promote the health of all Canadian children.

The problem is not that providing tax incentives to encourage individuals to enrol their children in sports does not promote the health of *individual* children, rather, it is that policy initiatives aimed solely at the individual do little to address the social determinants of health, and thus fail to promote the health of all Canadians. Further, when the vast majority of health promotion initiatives are aimed at the individual it fosters the illusion that a person's health status is entirely under his or her control. As a result, responsibility for what are population health problems, and thus our collective responsibility, is assigned solely to the individual; effectively blaming the victim of ill health for what are socially produced health problems (Low, 2002).

As well as illustrating the reductionist effects of over-emphasizing individual approaches to promoting health, the cases cited above demonstrate a failure on the part of government to coordinate healthy public policy. That policy makers have not taken up this particular health promotion lesson is particularly troubling as we know, from the health promotion lessons of the past 30 years, that problems of ill health are not caused by single factors; meaning that solutions to population health problems involve action on several policy fronts. Take again the case of rising rates of childhood obesity. In addition to elimination of regular physical education, the presence of sugar and fat laden foods in schools is a factor contributing to this health problem. Unhealthy foods are in schools largely because many school boards have seen fit to make deals with private corporations in order to make up for shortfalls in government funding for education. For example, as of spring 2006, guidelines to ensure that 'only 100% juices, bottled water, no-fat and low fat milk [would] be sold in elementary and middle schools' were still being debated (Oziewicz, 1996, p. A16). Moreover, as of winter 2007, '50% of Canadian school boards have contracts with either Coke or Pepsi' (Picard and Alphonso, 2007, p. A6). An exception here concerns Nova Scotia where school boards report that 'their schools serve

no pop, chips or candy bars' (Picard and Alphonso, 2007, p. A6). Other factors contributing to the problem of childhood obesity include suburban sprawl and a lack public transportation, the consequences of which is that children no longer walk significant distances with any regularity (OCFP, 2005). This particular matrix of health denying factors has also resulted in further degradation of air quality, through increased automobile emissions, which contributes to the incidence of respiratory disease in Canada. Meaningfully addressing these health problems requires coordination of, at least, policy to do with transportation, housing, education, and the food industry, in addition to what is traditionally understood as health policy.

Similarly, the policy record on the environment falls short of a true health promotion spirit, reflecting again a reductionist approach and a failure to coordinate healthy public policy. For instance, one of the most popular government programmes aimed at promoting healthy environments is blue box recycling. However, such recycling programmes have been plagued by problems including: a 'lack of markets, low material revenues, and low recovery rates' all of which increase the costs of these programmes at the same time as they serve to decrease the effectiveness of them (AMO-AMRC, 2006, p. 12). Further, they are again policy initiatives that are aimed at the level of the individual rather than ones that represent a serious attempt to change the manner in which goods and services are produced, packaged, and distributed in Canada. The latter approach would affect structural changes that would go much farther in improving air and water quality in Canada, which in turn would promote the health of all Canadians.

A particularly illustrative case here concerns the *E. coli* outbreak in Walkerton, Ontario. In the spring of 2000 people in Walkerton began experiencing a variety of adverse gastro intestinal symptoms such as vomiting and bloody diarrhea. By the time the outbreak concluded seven people had died and well over 2000 people became sick as a result of drinking water contaminated by *E. coli* bacteria (Ali, 2004). The results of the inquiry into the Walkerton tragedy demonstrate that, under conservative Premier Mike Harris, the provincial government's 'policy of downsizing and privatization' meant that the Ministry of the Environment

conducted radically fewer monitoring activities (Ali, 2004, p. 2607). Moreover, as Ali (Ali, 2004) points out, those conducting the inquiry itself failed to examine factory farming, a structural element, as a causal factor in the Walkerton case. The memory of Walkerton makes the current federal conservative government's decision to reduce the number of advisory groups to agriculture and Agri-food Canada alarming to say the least (TBS, 2006).

The policy record on reducing inequities, another key health promotion lesson, is likewise unimpressive. Perhaps most representative of the failure of policy makers to recognize the imperative of reducing inequities for promoting health, is that over the past decade they have done little to counter, and in some cases have actively supported, calls for the privatization of the Canadian health care system (Armstrong and Armstrong, 2003). A notorious example concerns the former premier of Alberta, Ralph Klein for whom the championing of the privatization of health care in Alberta became something of an obsession. More generally, the results of a 2002 audit show that 'virtually every province is breaking the Canada Health Act' (Laghi, 2002, p. A1). Privatizing Medicare would be among the most retrograde of steps in reducing inequities in Canada as Medicare is one of the core institutions making up Canada's social safety net and thus promotes equality. We do well to remember that in the USA, a country with a private health care system, millions go bankrupt annually due to the cost of medical care (Wordsworth, 2000).

Further, reducing inequities obviously has to do with more than health policy alone and the recent policy record here is equally problematic. For example, the Harper conservatives have made cuts to programmes and services meant to support the most vulnerable in Canadian society such as: literacy programmes and social development partnership programmes, as well as to groups involved in advocacy activities such as the Status of Women Canada (TBS, 2006). They have eliminated funding for the First Nations and Inuit Tobacco Control Strategy (TBS, 2006), and while they restored it after a public outcry, they initially scrapped the student summer jobs programme (Taber, 2007). Further, rather than funding a national day care strategy that would enhance the standard of living of all Canadians, Harper's conservatives rolled out a monthly \$100 taxable benefit to families to off-set

the cost of childcare, an amount that is negligible in contrast to its real costs and is thus only of minor benefit to those families already able to afford childcare (CLC, 2006).

That so little policy meaningfully addresses reducing inequality bodes particularly badly for promoting the health of Canadians, particularly as poverty is on the rise in Canada and the gap between the rich and poor is also growing (CPHA, 1996; Raphael, 2001). This is significant as populations are less healthy in countries with a large gap between the rich and the poor, even in cases of 'wealthy' countries such as the USA (Wilkinson, 1996).

## DISCUSSION

What emerges from even a cursory policy review is that health promotion policy-making in Canada reflects a 'déjà vu discourse' where we seem compelled to continually rediscover the same health promotion lessons over and over again (Prince, 2004, p. 66). Therefore, the question becomes: how do we account for the continued failure of government to take up the health promotion lessons of the past 30 years? A large part of the explanation is to be found in the structure of Canadian society, including the socio-political and economic context that informs it.

A major structural constraint on health promotion in Canada is the structural division between the federal and provincial orders of government where the federal government funds and the provincial governments administer health and social services. With the implementation of the CHST in 1996, the provinces gained 'even greater flexibility over their spending priorities' (Veldhuis and Clemens, 2003, p. 3). This means that not only is there considerable variation in the nature and type of health care services available across Canada, but also, no matter how much public money the federal government transfers to the provinces, they can extract no guarantee from provincial governments that those monies will be spent on health promotion initiatives. Furthermore, fines are the only means by which the federal government is able to sanction provinces that violate the Canada Health Act. The levying of fines itself is problematic as successive federal governments have complained that the incidence of violations outstrips their capacity to effectively monitor provincial compliance with the act (Laghi, 2002).

Moreover, the current federal government has all but abdicated its role as the keepers of the Canada Health Act, fining only one province in 2006, despite 'the proliferation of private clinics across the country' (Priest, 2007, p. A7).

Furthermore, addressing the social determinants of health is easier in social democratic states that 'emphasize universal welfare rights and provide generous benefits and entitlements' (Raphael and Bryant, 2006, p. 239). In contrast, the Canadian welfare state is grounded in a 'liberal Anglo-Saxon economy where government provide[s] only modest benefits and step[s] in only when the market fails to provide adequate support' (Raphael and Bryant, 2006, p. 239). Such a social context does not foster the political will to undertake the structural changes that promoting the health of Canadians requires, and as we have argued in this paper, there is little if any evidence that the current federal government of Canada is moving in the direction of coordinating healthy public policy that addresses the social determinants of health. Nor is there any indication they have any commitment to evidence-based policy-making as they have eliminated funding for both the Health Canada Policy Research Programme and for Canadian Policy Research Networks (TBS, 2006).

Even if the political will did exist, the fact remains that it is infinitely easier to focus on the individual than to write policy that addresses structural change. Thus, in an economic climate of tax cuts concomitant with cuts in government funding, it is expedient for governments to reduce population health problems to the individual, as it turns attention away from the social production of health. Moreover, it enables government to use the lifestyle rhetoric of health promotion as an ideological justification for their failure to address the social determinants of health (Bercovitz, 1998).

Therefore, if Canadian policy-making today reflects a legacy of health promotion lessons forgotten and lessons still to be learned, what then does the future hold for health promotion in Canada? The recommendations of Health Promotion Ontario (Health Promotion Ontario, 2007, p. 11) give us an indication of the current state of applied thinking on health promotion when they assert that all 'Health Promoters' in Canada should count among their skills the:

ability ... to analyse the nature of a health issue or problem and provide expert analysis and advice on

how to address it through the appropriate mix of health promotion strategies, including community mobilization, social marketing, health education, advocacy, policy development and organizational change.

Yet the kind of social change envisioned by Health Promotion Ontario reaches only to the level of the community. While this is a positive step away from an individualist perspective on health promotion, it still falls short of fully addressing the social determinants of health at the level of large-scale social structure. Unless government policy makers begin to use the lessons of health promotion as a lens through which to filter social and economic policies before they are implemented, they will remain health promotion lessons still to be learned.

## REFERENCES

- Ali, H.S. (2004) A socio-ecological autopsy of the E. coli O157:H7 outbreak in Walkerton, Ontario, Canada. *Social Science and Medicine*, **58**, 2601–2612.
- AMO-AMRC. (2006) *Improving the Efficiency of the Blue Box Program: An AMO-AMRC Position Paper*. (Association of Municipalities of Ontario and the Association of Municipal Recycling Coordinators, Waste Management Task Force publication) [internet]. Association of Municipalities of Ontario and the Association of Municipal Recycling Coordinators, Ontario, (Published 12 August 2006). [Http://www.amo.on.ca/.../CM/ContentDisplay.cfm&ContentID=86723](http://www.amo.on.ca/.../CM/ContentDisplay.cfm&ContentID=86723) (last accessed 2 July 2007).
- Armstrong, P. and Armstrong, H. (2003) *Wasting Away: The Undermining of Canadian Health Care*, 2nd edition. Oxford University Press, Oxford.
- Bercovitz, K.L. (1998) Canada's active living policy: a critical analysis. *Health Promotion International*, **13**, 319–328.
- CAP. (1966) Canadian Assistance Plan Statute. RSC.C.C-1,S.1 1985 (Canadian Social Research document) [online]. (Updated 1985). [Http://www.canadiansocialresearch.net/cap\\_statute.htm](http://www.canadiansocialresearch.net/cap_statute.htm) (last accessed 19 June 2007).
- CBC. (2007) Fitness Tax Credits for Children. (CBC News in Depth: Health article) [internet]. 3 January. [Http://www.cbc.ca/news/background/health/obese-nation.html](http://www.cbc.ca/news/background/health/obese-nation.html) (last accessed 11 February 2007).
- CLC. (2006) Analysis of the 2006 Federal Budget: a disappointment for ordinary working families. (Canadian Labour Congress article) [online]. 2 May 2006. [Http://www.canadianlabour.ca/index.php/Budget\\_Analysis/914](http://www.canadianlabour.ca/index.php/Budget_Analysis/914) (last accessed 24 June 2007).
- CPHA. (1996) Action statement for health promotion in Canada. (Canadian Public Health Association article) [online]. [Http://www.cpha.ca/](http://www.cpha.ca/) (last accessed 2 October 2007).
- CPHI. (2004) *Improving the Health of Canadians*. Canadian Population Health Initiative, Ottawa; Canadian Institute of Health Information, Ottawa.

- Epp, J. (1986) *Achieving Health for All: A Framework for Health Promotion*. (Focus Research Centre Publication) [internet]. Health and Welfare Canada, Ottawa. [Http://www.frcentre.net/library/AchievingHealthForAll.pdf](http://www.frcentre.net/library/AchievingHealthForAll.pdf) (last accessed 2 February 2007).
- Health Canada. (2002) *Canada Health Act Overview*. (Health Canada document) [online]. 25 November 2002. [Http://www.hc-sc.gc.ca/](http://www.hc-sc.gc.ca/) (last accessed 23 June 2007).
- Health Canada. (2004) *Canada Health Action: Building on the Legacy—Volume II—Synthesis Reports and Issue Papers*. (Health Canada publication) [internet]. 28 May 2004. [Http://www.hc-sc.gc.ca/](http://www.hc-sc.gc.ca/) (last accessed 11 February 2007).
- Health Promotion Ontario. (2007) *Towards Development of Competencies for Health Promoters in Canada: A Discussion Paper*. Health Promotion Ontario, Ontario. [Http://www.hpoteblog.squarespace.com/hpo-resources/](http://www.hpoteblog.squarespace.com/hpo-resources/) (last accessed 19 June 2007).
- Laghi, B. (2002) Audit finds widespread medicare violations. *Globe and Mail*, 9 October, p. A1.
- Lalonde, M. (1974) *A New Perspective on the Health of Canadians: A Working Paper*. Minister of Supply and Services Canada, Ottawa.
- Low, J. (2002) *The Dangers of a Personal Responsibility Approach to Reforming Medicare. Testimony before the Romanow Commission on the Future of Health Care in Canada*. Fredericton, New Brunswick.
- McKinlay, J.B. (1986) A case for refocusing upstream: the political economy of illness. In Conrad, P. and Kern, R. (eds), *The Sociology of Health and Illness: Critical Perspectives*, 2nd edition. St Martin's press, New York, pp. 502–517.
- Navarro, V. (2007) What is national health policy? *International Journal of Health Services*, **37**, 1–14.
- OCFP. (2005) *The Health Impacts of Urban Sprawl Information Series, Vol. 3*. (Ontario College of Family Physicians Publications) [internet]. OCFP, Ontario. [Http://www.ocfp.on.ca/](http://www.ocfp.on.ca/) (last accessed 26 June 2007).
- Oziewicz, E. (1996) Canada moving slowly on banning the bubbles. *The Globe and Mail*, 4 May, p. A16.
- Picard, A. and Alphonso, C. (2007) Canada's schools fail the health test. *Globe and Mail*, 20 January, pp. A6–A7.
- Priest, L. (2007) B.C. only province fined for violating health act. *Globe and Mail*, 7 June, p. A7.
- Prince, M.J. (2004) Canadian disability policy: still a hit and miss affair. *Canadian Journal of Sociology*, **29**, 59–82.
- Raphael, D. (2001) From increasing poverty to social disintegration: the effects of economic inequality on the health of individuals and communities. In Armstrong, P., Armstrong, H. and Conrad, D.(eds), *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Oxford University Press, Oxford, pp. 223–246.
- Raphael, D. and Bryant, T. (2006) Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. *IUHPE Promotion and Education*, **13**, 236–242.
- Taber, J. (2007) Cabinet minister stoked criticism of jobs program: tory infighting highlights Solberg's plight. *Globe and Mail*, 2 June, p. A9.
- TBS. (2006) *Backgrounder—Effective Spending*. (Treasury Board of Canada Secretariat News Release) [online]. [Http://www.tbs.sct.gc.ca/media/nr-cp/2006/0925](http://www.tbs.sct.gc.ca/media/nr-cp/2006/0925) (last accessed 16 June 2007).
- Vaillancourt, Y. and Thériault, L. (1997) Transfert Canadien en matière de santé et de programmes sociaux (TCSPS/CHST): Enjeux pour le Québec, *Cahiers du LAREPPS*, no. 97-07, UQAM, October, 1997.
- Veldhuis, N. and Clemens, J., (2003) Clarifying the federal government's contribution to health care. *Fraser Forum*, 3–5 February.
- WHO. (1946) *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference*, New York, 19–22 June 1946, Official Records of the World Health Organization, no. 2, p. 100, World Health Organization, Geneva.
- WHO. (1986) *The Ottawa Charter for Health Promotion*.(World Health Organization publication) [internet]. Canadian Public Health Association, Health and Welfare Canada and WHO, Ottawa (published 1986). [Http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf) (last accessed 15 January 2007).
- Wilkinson, R.G. (1996) *Unhealthy Societies: The Afflictions of Inequality*. Routledge, London.
- Wordsworth, A. (2000). Medical bills main culprit in bankruptcies: U.S. study: Americans are 'one illness away' from financial collapse. *National Post*, 27 April, p. A1.
- Zola, I.K. (1970) *Helping-does it matter: the problems and prospects of mutual aid group*. Addressed to the United Ostomy Association.