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Towards a Health in All Policies Approach for Canada's Federal, Provincial and Territorial Jurisdictions?

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About the National Collaborating Centre for Healthy Public Policy

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six Centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. The NCCHPP is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

"Faced with the many complex existing and emerging challenges to health and well-being in countries and globally, including rapid urbanization, climate change, pandemic threats and the proliferation of unhealthy commodities, practical responses are urgently needed."

Adelaide Statement II on Health in All Policies

(World Health Organization & Government of Australia, 2019)

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Summary

Health in All Policies (HiAP) is formally defined as: "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity" (World Health Organization [WHO] & Finland Ministry of Social Affairs and Health, 2014, p. 7, 2014, p. 7). This approach comes with unique goals and mandates dependent on the specific national and subnational policy contexts in which it is developed.

As an outgrowth of the interest in HiAP expressed by participants at a pan-Canadian event organized by the National Collaborating Centre for Healthy Public Policy in the fall of 2019, this paper is intended for public health professionals involved in health promotion and prevention across Canada, analysts and managers of health and social policy in federal, provincial and territorial (FPT) governments and in regional health authorities, as well as their intersectoral and community partners. It seeks to develop a better understanding of HiAP and to clarify what can be expected (or not) of a HiAP approach in Canada's policy context. It explores some of the unique roles and opportunities for FPT governments with regard to adopting or reinforcing HiAP in their jurisdictions, and covers three main facets: 1) what is HiAP?; 2) an overview of HiAP implementation in Canada's provinces; and 3) unique opportunities for FPT governments.

The analysis shows that HiAP as a concept is expansive and potentially radical; however at the empirical level, it is implemented in a limited, adaptable way to foster change from within existing government structures. Based on the experience of two provinces, the analysis suggests that HiAP in Canada's policy context can be seen as a policy instrument which articulates a broad vision with multiple dimensions of health prevention and promotion extending beyond health care, and which supports coordinated action across sectors to improve the social determinants of health. As such, FPT governments could adopt or reinforce HiAP as an overarching policy framework to:

- Ensure the macro-social determinants of health and positive health outcomes receive more systematic consideration from policymakers across sectors;
- Influence policy development in relevant areas;
- Support action at the local level across sectors;
- Support decision makers in proactively responding in a health-equity-informed manner to the COVID-19 pandemic recovery;
- Foster a more systematic integration of the social determinants of health and health equity into planning to face future collective crises;
- Serve as a vigilant reminder, in policymaking processes across sectors, of the impacts of all policymaking on population health; and
- Guide incremental decisions on resource allocation and government priorities over time.

In light of these findings, it is not suggested that HiAP represents a stand-alone policy solution able to ensure population health. Nevertheless, FPT governments might want to consider designing a HiAP strategy primarily as an additional policy lever to facilitate the governance of population health, with a view to improving the synergy between pre-existing public policies and programs. They may also want to incorporate tools and processes as part of a HiAP strategy, to draw more systematic attention to the effects on population health of policymaking by non-health sectors.

For HiAP to be appropriate, respectful and relevant for Indigenous peoples living in Canada, there is a need to work with First Nations, Métis and Inuit communities to identify whether the implementation of HiAP could support their priorities. A culturally sensitive approach would need to proceed from the recognition by all parties that different health paradigms exist, and that they reflect differences between western and First Nations, Métis and Inuit views and beliefs about health and its determinants.

1 Introduction

Many factors influence the health of the population other than genetics, lifestyle choices and health care access and are not administered by the health sector. The Ottawa Charter for Health Promotion (World Health Organization et al., 1986) identified healthy public policy[1] across administrative sectors as a key strategy for promoting health. Since then, the World Health Organization (WHO) has developed action frameworks to support population health promotion, prevention and equity beyond healthcare and lifestyle issues, which "promote intersectoral work and social participation in public policy-making to address a broad range of [health] determinants" (Valentine et al., 2017, p. 12)[2]. One of the action frameworks is more specifically designed for Health in All Policies (HiAP), which is formally defined as:

> an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government (WHO & Finland Ministry of Social Affairs and Health, 2014, p. 7).

A HiAP approach has been adopted by national and subnational governments including those of South Australia, Finland, California, Wales, and Québec (Lin & Kickbusch, 2017). The empirical forms of HiAP are bound to be accompanied by unique goals and mandates that are dependent on the specific national and subnational policy contexts in which they are developed (Shankardass et al., 2015, p. 464). This paper explores some of the possible empirical forms and roles of HiAP in Canada's policy context at the federal, provincial and territorial levels.

1.1 Context

In 2017, during the 70th Annual Meeting of the World Health Organization, representatives from Sudan, Finland, Thailand, the Province of Québec and the State of South Australia launched a Global Network for Health in All Policies (GNHiAP)[3]. Two years later, the GNHiAP held an invitational event in Québec City, Canada during which leaders, experts and fellow practitioners from diverse countries identified strategies and tools for HiAP, addressed practical implementation issues, and reflected on how intersectoral relationships can be developed and strengthened.

This event was followed by the Pan-Canadian Meeting on Health in All Policies, an invitational event organized by the National Collaborating Centre for Healthy Public Policy (NCCHPP) in partnership with the Public Health Agency of Canada (PHAC) and the *ministère de la Santé et des Services sociaux du Québec* (Québec's department of health and social services). The Pan-Canadian Meeting sought to support networking among Canadian stakeholders with an interest in HiAP. Its 25 participants were affiliated with federal and provincial governments, regional health authorities, Indigenous organizations, and universities from across Canada. They shared experiences, discussed

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1 A healthy public policy is a public policy which potentially enhances the health of populations by having a positive impact on the social, economic, and environmental determinants of health.

2 As an example of a social determinants of health framework, we can point to the Government of Canada's identification of 12 main determinants of health that are associated with individual and population health outcomes: income and social status; employment and working conditions; education and literacy; childhood experiences; physical environments; social supports and coping skills; healthy behaviours; access to health services; biology and genetic endowment; gender; culture; and race/racism (Government of Canada, 2022).

3 The GNHiAP supports the implementation of the Sustainable Development Goals adopted by all United Nations Member States in 2015 as part of the 2030 Agenda for Sustainable Development. It also supports Universal Health Coverage.

the status of HiAP in Canada, including in Indigenous contexts, and explored pathways for supporting its practice in Canada. During the one-day event, participants identified HiAP as an essential approach which merits broader recognition, a shared understanding and better uptake by governments in Canada. Among the next steps envisioned by participants were the creation of a Canadian network for HiAP as well as the fostering of a better understanding of implementation prospects for HiAP in Canadian contexts (National Collaborating Centre for Healthy Public Policy, 2020).

The PHAC provided funding to the NCCHPP to follow up on the needs and interests expressed during this event, and this paper is one of the NCCHPP's responses. It seeks to help develop a better understanding of the HiAP concept among public health professionals and their intersectoral and community partners across Canada, and to clarify what can be expected (or not) of a HiAP approach in Canada's policy context.

1.2 Objectives

This paper starts by observing that there are significant gaps between the concept of HiAP (in principle) and its implementation (in practice). It explores the idea that, given their unique roles and opportunities with regard to adopting or reinforcing HiAP, federal, provincial and territorial (FPT) jurisdictions might want to consider designing a HiAP strategy in a pragmatic way, which does not raise an expectation of bringing about radical change. It covers three main facets:

- What is HiAP?
- Overview of HiAP implementation in Canada's provinces;
- Unique opportunities for FPT governments.

The paper focuses on the perspective of FPT governments, that have unique roles with regard to HiAP. There is no question that all jurisdictional levels – local, regional, FPT – matter when it comes to implementing a HiAP strategy, but FPT governments are specifically endowed with powers and responsibilities to enact legislation, formulate regulations, carve out budgets and adjust public programs in areas of public policy that are critical for the macro-social determinants, or root causes, of population health (Lithwick, 2015; Dahlgren & Whitehead, 2007)[4, 5]. Poverty reduction, education, agriculture and food production, unemployment, health care, housing and child care are examples of policy spheres in which public health professionals and community organizations are often very active, but that cannot be addressed exclusively at the local level.

[4] On the division of federal and provincial powers in Sections 91 and 92 of Canada's Constitution Act, 1867, see (Lithwick, 2015).

[5] Dhalgren and Whitehead (2007) conceptualized a well-known and widely used model of the main determinants of health for the whole population. This model presented a spectrum of health determinants, comprising but not limited to factors tied to lifestyle and health care access. Their rainbow model comprised five categories of health determinants: age, sex and constitutional factors; individual lifestyles factors; social and community networks; living and working conditions; as well as general socio-economic, cultural and environmental conditions (or macro-social determinants of health).

1.3 Methods

The analysis is based for the most part on a review of secondary data drawn from textual sources, which comprise selected peer-reviewed articles, monographs, as well as official publications from government organizations and NGOs. The documentary research consisted in an iterative process alternating between potentially useful sources and problem definition and refinement. The process was informed by authoritative sources circulating among NCCHPP researchers and collaborators who are already involved in policy research and activities related to different aspects of HiAP and Canadian public policy. It entailed carrying out internet searches on the official websites of governments and civil society organizations and retrieving peer-reviewed sources referenced within articles and by other sources, to gather details about the topics addressed.

Some of the information related to the implementation of HiAP in Canada's provinces is drawn from primary sources (internally circulated government documents or phone and email conversations), which were used as complementary sources. Data collection supporting the analysis of HiAP as it relates to Indigenous contexts was also supported by complementary sources. These consisted of in-depth, semi-structured personal interviews with three Canadian scholars with expertise in Indigenous studies, conducted in February and March of 2022.

2 What is HiAP?

The scientific literature discussed in this section shows that a comprehensive HiAP approach has three main components: processes and tools to influence policymaking; intersectoral collaborations and multidimensional solutions; and an overarching government-endorsed strategy. Based on this finding, we suggest that a comprehensive HiAP approach may be defined as a government-endorsed strategy intended to influence policymaking in non-health sectors, with the aim of positively impacting the social determinants of the population's health and health equity or, at a minimum, of minimizing the negative health impacts of policymaking[6].

2.1 Three main components

Processes and tools to influence policymaking. A HiAP strategy considers how policies developed by non-health administrative sectors are likely to impact a whole range of social determinants of health and health equity outcomes. It involves setting up administrative processes to facilitate intersectoral collaborations that support healthy public policy development. It also involves using prospective assessment tools such as Health Impact Assessment (HIA) to systematically appraise the anticipated impacts of policy proposals and projects from other sectors on health equity and on the social determinants of health, with a view to influencing policymaking (Baum et al., 2014; Shankardass et al., 2015).

Intersectoral collaborations and multidimensional solutions. HiAP involves collaborations between policymakers and civil servants from the health sector and those from other administrative sectors. It aims to develop synergies to create multidimensional solutions to complex problems relevant to population health (de Leeuw, 2022, p. 207). While HiAP may involve collaborations with community and business organizations as well as other partners from civil society (Shankardass et al., 2015), it was, according to the view of some, "never meant to refer to the involvement of all sectors of society. It was instead meant to refer to the involvement and prioritization of health in all sectors of government" (Godziewski, 2022, p. 186).

An overarching, government-endorsed strategy. HiAP is neither an intervention plan driven by the health sector that incorporates solutions from across multiple sectors to address a specific public health issue (e.g., a whole-of-government approach to tackling tobacco use), nor a disease-focused, multisectoral intervention driven by health authorities (e.g., a whole-of-government approach to tackling chronic diseases). It is an overarching strategy endorsed by the government intended to broadly address the social determinants of health in policymaking across sectors (Green et al., 2021; National Collaborating Centre for Healthy Public Policy, 2018).

[6] HiAP processes and tools might, for instance, facilitate the assessment of anticipated negative impacts of a policy measure proposed by the department of transportation on certain more vulnerable groups of the population, as well as the proposal of mitigation measures to this department.

2.2 Implementation gaps

What the HiAP concept entails in principle and how the concept translates into practice are two different stories. HiAP has been qualified as an "abstract concept with rhetorical ideas," and its conversion into practice is considered challenging (Huang et al., 2019, p. 2). A qualitative systematic review of lessons derived from HiAP in the scientific literature, produced by British researchers, led the authors to make the following concluding remark:

> The dominant narrative of HiAP *in theory* does not correspond to the meaning of HiAP *in practice*. The former is an ambitious strategy to address the social determinants of health with radical policy change across multiple sectors, facilitated by intersectoral action and high strategic commitment to produce support for better policies. The latter is an ambitious strategy on paper only, representing moderate policy change at best and a negative commitment at worst (…) (Cairney et al., 2021, p. 28).

In principle, HiAP would involve all administrative sectors and governance levels, given that "public policies in all sectors and at different levels of governance can have a significant impact on population health and health equity" (WHO & Finland Ministry of Social Affairs and Health, 2014, p. 7). This would comprise not only the more socially or service-oriented sectors, such as those responsible for housing, education, transportation, environment, culture and immigration, but also productivity- and commercially oriented ones that are responsible for innovation, monetary policy, fiscal policy and international trade, and less obvious sectors such as defence. In practice, the health sector in many countries where HiAP has been implemented typically works not with the whole spectrum of possible intersectoral partners, but primarily with education and social sectors (Valentine et al., 2017, p. 17).

In principle, HiAP requires a long-term commitment, vision and action plan at the government level[7],given the fact that aligning all of the sectors' activities to effectively deliver healthy public policies necessitates high-level political support and a good degree of coordination. In practice, there exists tension between this requirement and short-term electoral mandates. The experience of South Australia indicates that even in jurisdictions where a government has committed to HiAP, priorities may shift when the economy becomes less buoyant or when a new government takes office (Baugh Littlejohns et al., 2019; Baum et al., 2017; van Eyk et al., 2017).

In principle, HiAP would be global and address a broad range of issues affecting the social determinants of health. In practice, initiatives labelled as examples of HiAP may focus on a specific issue (e.g., improving nutrition, addressing chronic diseases). One example of a single-issue HiAP initiative in a Canadian context is the Mental Health in All Policies Framework, which seeks to advance "upstream investment through policies that promote equity and mental health among infants, children, and youth in Atlantic Canada and beyond" (Atlantic Summer Institute on Healthy and Safe Communities & A Way Home Canada, 2022, p. ii).

In principle, HiAP could foster radical transformations in redistributive policies, welfare systems, public spending, and economic development, which are associated with the macro-social determinants of health. In practice, governments implement a HiAP strategy not with the expectation of bringing about radical change but, more likely, to foster change from within existing government structures and processes. According to Godziewski (2022), HiAP-like ideas are more analogous to "an endogenous, gradual and slow process of evolution than [to] a radical game-changer" (p. 178).

[7] In Canada, this would encompass involving central agencies (the Privy Council Office, the Treasury Board Secretariat, and the Department of Finance at the federal level, or their provincial and territorial counterparts).

In a nutshell, a HiAP approach, in principle, involves intersectoral collaborations among all administrative sectors, a long-term government commitment, a broad range of issues relevant to population health, and radical transformations in policymaking. In reality, HiAP may involve collaborations among only a few administrative sectors, not benefit from a sustained government commitment, address specific public health issues, and foster change within existing boundaries. While keeping in mind that on-the-ground limitations are bound to exist when HiAP practice is compared to the expansive, adaptable HiAP concept, we will now see that, designed in a pragmatic way, HiAP can nevertheless play a valuable role in Canada's FPT jurisdictions.

3 Overview of HiAP implementation in Canada's provinces

Several Canadian FPT jurisdictions have already implemented HiAP, at least in part. In the 1990s, British Columbia was considered a leader nationally, having adopted not HiAP as a whole but one of its three components. British Columbia indeed developed a HIA tool and implemented a HIA process at the government level to identify health risks as well as the prospective impacts of policy initiatives from sectors other than health on the broader determinants of health, and to influence policymaking across sectors. This HIA process and tool had become part of analyzing all new government policies and programs submitted at the cabinet level before the government-level HIA process was dismantled in 1999 (Shandro & Jokinen, 2018; Banken, 2001). More recently, in 2019, the provincial health officer's annual report's first recommendation was to re-"[e]stablish a legislated health in all policies approach in BC, utilizing a health impact assessment model" (Henry, 2019, p. 214-215).

Other examples include Ontario which, in 2012, developed a Health Equity Impact Assessment Tool (HEAT) to be applied to all policy decisions. While observers don't dispute the fact that HEAT has been implemented with limited success, the Ontario Ministry of Health is currently moving forward with a "refresh initiative" to revive it (Simpson, 2022). Alberta began applying a voluntary Health Lens for Public Policy in 2010 (St-Pierre, 2013). Nova Scotia, through its People Assessing Their Health (PATH) program which began in 1996, engaged communities in the process of developing their own Community Health Impact Assessment Tool (CHIAT) to assess policies proposed by governments, institutions and community groups (Eaton & St-Pierre, 2009). Below, two HiAP strategies are discussed in more detail, to illustrate the more comprehensive forms that HiAP may take when going beyond some form of Health Impact Assessment.

3.1 Québec

The province of Québec's strategy for HiAP consists of a governmental program and a legislative instrument which are described below.

A government-level program. Québec's 2016-2025 *Politique gouvernementale de prévention en santé* (PGPS) (government health prevention policy) is considered emblematic of a HiAP initiative in Canada. The PGPS represents the culmination of a long tradition of relatively progressive practices in social policy, including with regard to health promotion, addressing the social determinants of health and developing healthy public policies, that previously laid the foundation for a comprehensive health prevention policy in the province (St-Pierre et al., 2017; Bernier, 2006).

The PGPS covers a ten-year period starting in 2016 (Ministère de la Santé et des Services sociaux du Québec [MSSS], 2016). It aims to improve the health status and quality of life of the population and to reduce health inequalities. As an inter-departmental government policy under the leadership of the *ministère de la Santé et des Services sociaux* (MSSS) (department of health and social services), the PGPS covers a wide spectrum of public policies and sectors, encompasses two cross-cutting issues (sociodemographic changes; poverty and social health inequalities) and pursues four orientations:

1. Developing people's capacities from an early age;
2. Developing healthy and safe communities and territories;
3. Improving living conditions that promote health;
4. Strengthening preventive actions in the health and social services system.

The PGPS was not devised by the Québec government as a stand-alone solution intended to address the social determinants of health by itself. Rather, it complements other government strategies and a web of sectoral policies affecting the social determinants of health (Bernier, 2022)[8]. One of its raisons d'être is to strengthen coherence and complementarity among the various governmental actions touching on factors that affect health (Ministère de la Santé et des Services sociaux du Québec [MSSS],2022b, p. 61). As such, it represents an additional policy lever that can help address problems that would not otherwise be addressed by existing policies and programs.

The governance of the PGPS and its action plans are supported by an interdepartmental committee of assistant deputy ministers, an interdepartmental committee of directors and an interdepartmental network of professional staff. The *Bureau de coordination et de soutien* (office of coordination and support) supports the work of these governmental bodies and facilitates the implementation of the PGPS and its action plans (MSSS, 2022b, p. 62).

The first *Plan d'action interministériel* (PAI) (interdepartmental action plan) of the PGPS covered the period 2017-2021 and was subsequently extended to 2022 (MSSS, 2022b, 2018). It defined the actions to be carried out, the work schedule, the sharing of roles and their associated investments. The first PAI mobilized 16 departments and close to 80 non-governmental organizations and municipal governments as initial partners involved in policy development and implementation. The first PAI contained 28 departmental commitments with a view to addressing complex issues that fall outside of traditional sectoral boundaries, comprised five areas of research, and came with an initial budget of $20 million per year.

Supporting Health Impact Assessments at the Local Level in Québec

Several HIAs have been conducted at the local level, with the first of these being carried out beginning in 2010 in the Québec region of Montérégie, and with others following in Québec City (Diallo & Freeman, 2020). Measure 2.6 of the PGPS seeks to further expand the use of HIAs to all of Québec's regions, especially to municipal contexts, to ensure better integration of health criteria into urban planning processes across the province. The PGPS explicitly aims to "equip the municipal sector to more systematically integrate the analysis of potential health effects into land use planning and development processes" (MSSS, 2016, p.38). Partnerships developed under the PGPS and its two PAIs ensure provision of support to enable this (MSSS, 2018, 2022b).

The second PAI, covering the period 2022-2025, now enables 27 government departments and agencies to break down silos, work as partners, take coordinated actions and support 80 non-governmental and municipal partners in all regions (MSSS, 2022b). The budget has been doubled, and now represents $40 million per year until 2025. It comprises 100 actions, each of which is associated with implementation measures in the form of training programs, professional workshops, intervention tools, pilot projects, knowledge transfer activities and many more initiatives.

[8] Examples of other government strategies and sectoral policies include the 2017-2023 *Stratégie de lutte contre la pauvreté et l'exclusion sociale* ([Québec's] National Strategy to Combat Poverty and Social Exclusion); the 2017-2023 *Plan d'action gouvernemental pour l'inclusion économique et la participation sociale* (Government Action Plan to Foster Economic Inclusion and Social Participation); the 2015-2020 *Stratégie gouvernementale de développement durable (*Government Sustainable Development Strategy); the 2018-2022 *Stratégie gouvernementale pour assurer l'occupation et la vitalité des territoires* (Government Strategy to Ensure the Occupancy and Vitality of Territories); the *Stratégie gouvernementale pour l'égalité entre les femmes et les hommes vers 2021 – Ensemble pour l'égalité* (Government Strategy for Gender Equality Toward 2021 – Together for Equality); the *Stratégie 0-8 ans – Tout pour nos enfants* (Strategy for Children From Birth to Age 8 – It's All About the Children); and the 2017–2022 *Plan d'action gouvernemental pour le développement social et culturel des Premières Nations et des Inuits* (Government Action Plan for the Social and Cultural Development of the First Nations and Inuit: Do More, Do Better) (Bernier, 2022).

Cross-Sectoral Initiatives Developed as Part of
Québec's Government Health Prevention Policy*

Three interdepartmental initiatives illustrate some of the ways the PGPS's contribution has taken form.

Example #1

Providing financial support to companies wishing to formalize their policies facilitating work-life balance, launched in 2018 (partnership between the *ministère de la Famille* [department of family] and the *ministère du Travail, de l'Emploi et de la Solidarité sociale* [department of labour, employment and social solidarity]):

- Implementation of a lighter summer work schedule, customized work hours and voluntary remote work at the *Ordre des comptables professionnels agréés du Québec;*
- Creation of a health and wellness committee at *Culture Trois-Rivières;*
- Setting up of an emergency babysitting service for workers of a small or medium enterprise;
- Creation of good practice guides (Government of Québec, 2021a).

Example #2

Promoting access to sports and recreation for certain more vulnerable populations (partnership between the MSSS and the *ministère de l'Éducation* [department of education]):

- Purchase of rackets so that children from an underprivileged neighborhood can play badminton;
- Loan of all-terrain wheelchairs to offer people with reduced mobility the opportunity to go hiking in the forest (Government of Québec, 2021b).

Example #3

Improving the living conditions of Indigenous populations (partnership between the Nunavik Regional Board of Health and Social Services and the Native Friendship Centres):

- Adoption of a food security policy in Nunavik;
- Inter-school games;
- Training program to improve understanding of cultural realities for health, social services and community organizations;
- Improvement of certain services, such as the Breakfast Club in Cree and Inuit territory (Government of Québec, 2021c).

*The contents of this box are taken from sheets available here:
https://publications.msss.gouv.qc.ca/msss/fichiers/2021/21-297-12W.pdf

A legislative instrument. Part of the Québec government's HiAP strategy, which extends beyond the PGPS, is a legislative instrument that supports the establishment of a government-level HIA process. Section 54 of Québec's 2001 public health legislation acknowledges that various laws and regulations can affect population health and wellbeing, and empowers the MSSS to undertake intersectoral action to support healthy public policy development (Bernier, 2021; St-Pierre et al., 2017). Under Section 54, all government sectors are required to consider the potential impacts on the population's health of their legislative and regulatory actions. The health minister acts as the advisor to the government on any public health issue, is mandated to give the other ministers discretionary advice on health promotion and the adoption of policies which may foster the enhancement of the health and welfare of the population, and is to be consulted whenever measures are developed "that could have a significant impact on the health of the population" (Québec Official Publisher, 2022, p. 11).

Section 54 has relied for the most part on an intra-governmental mechanism through which the MSSS produces advice concerning government projects submitted to Cabinet for decision. Examples of government projects include bills, draft regulations, decrees, and policy documents, including policies, strategies, action plans, programs, and directives. When submitting a "decision file" to the *ministère du Conseil exécutif* (MCE) (i.e., at the Cabinet level), departments and agencies that sponsor a project need to complete a confidential summary which describes the project, the overall status of the situation, the proposed solution, the consultations that have been carried out, the financial implications and the expected timeline (Bernier, 2021; Boulanger, 2018). Attached to the summary document is an integrated impact assessment brief which reviews anticipated social, environmental and governance effects. The anticipated effects of the project on the health of the population, as well as the segments of the population potentially concerned, are part of the brief. The MCE sends the relevant decision files to the MSSS, which may opt to produce an advisory document with indications on how the proposed measure can be improved. The MSSS's advisory documents are produced under strict confidentiality within a few days. In 2020-2021, the MSSS received 283 requests for advice. It produced 14 advisory documents and had no comments for 269 requests (Commission de la Santé et des Services sociaux, 2022, p. 194). It is the responsibility of each department or agency promoting the projects to ensure the necessary follow-ups occur. The Minister of Health also initiates the production of discretionary advisory documents outside of the process that has just been described.

3.2 Newfoundland and Labrador

In 2017, the province of Newfoundland and Labrador began the process of formally increasing its recognition of the central importance of the social determinants of health, both as part of its government strategy, and as part of its health care strategy. A comprehensive 2017 government strategy, called The Way Forward commitment, states the following with regard to HiAP specifically:

> Our Government will build health impact considerations into all policy decisions, from infrastructure planning to labour market supports. This Health-in-All Policies approach will enable our Government to make all decisions in a manner that strengthens focus on measurable improvements in our health status. This will help prevent illness and create the healthy environments needed to support and promote not only healthy people, but also a healthy economy with improved outcomes in such areas as education, employment and crime prevention. Over the longer term, this approach will assist in reducing health care costs (Newfoundland and Labrador, 2022).

An important step occurred the following year, in 2018, when the province incorporated HiAP into its modernized public health legislation (Public Health Protection and Promotion Act, 2018). HiAP is now enshrined within the province's Public Health Protection and Promotion Act through the recognition that complex problems in the health sector are linked to the social determinants of health. It stipulates that the Minister of Health:

> shall be responsible for facilitating the consideration of the health of the population in the development of laws, policies and measures among government departments, agencies, boards and commissions in accordance with the regulations, including the consideration of those social determinants of health that have an impact on the health of the population (s6).

Another notable initiative with regard to integrating HiAP into the health care strategy began towards the end of 2020, when the province established a provincial Task Force supported by six strategy committees and four working groups with diverse representation from across the province (Newfoundland and Labrador, 2021). The Task Force's mission was to produce a province-wide agreement on the wisest course of action to follow to bring about improvements in the overall health of the population. The vision underlying their mission was that of achieving population health outcomes, as opposed to a more limited, traditional vision of how the health care system can be fixed. The work of the Task Force was based on the recognition that:

> [h]ealth outcomes in the province are among the worst in Canada, with the lives of Newfoundlanders and Labradorians shorter by 2.6 years compared to other Canadians. The lives of Canadian Indigenous people are shorter by a further 4.7 years. The province has among the highest rates of chronic disease as well as death from cancer, heart disease and stroke in Canada, even when adjusted for the older age of the population (Newfoundland and Labrador, 2021, p. 5).

A product of the Task Force consultations, the 2022-released, 10-Year Health Accord for Newfoundland and Labrador, claims that the province has the worst health outcomes in Canada, in spite of the fact that the province spends more money per capita than anywhere else in the country (Health Accord NL, 2022). It draws two main conclusions. First, there is a need to intervene in the social, economic and environmental factors that have an impact on health. This involves addressing the social determinants of health, ensuring individuals and families have a livable and predictable basic income, food security, and housing security. Second, there is a need for rebalancing the province's health care system across community, long-term care and hospital services, so that the health care system becomes "better integrated into the broader systems which influence health" (Health Accord NL, 2022, p. 224). Therefore, the Health Accord proposes that health care become more community-oriented, with teams to connect with schools, municipalities, the justice system, etc., and with services to support mental health and a continuum of care for older adults to facilitate aging in place and in age-friendly communities.

The Health Accord incorporates the philosophy of HiAP as part of its overall health and health care strategy. Just as was the case for Québec's PGPS, the Health Accord with its HiAP component is not designed as a stand-alone solution to address the social determinants of health in the province. Instead, it promotes a vision of better population health that explicitly builds on existing public policies, including a Poverty Reduction Strategy adopted in 2006, a climate action plan, initiatives on mental health and addictions, and education initiatives. The Health Accord is best understood as adding:

> an overarching view of the whole picture, a vision for a comprehensive approach and integrated direction, a call for transformation with emphasis on health promotion and early intervention, and

> new energy with realigned resources to integrate these strengths into the new vision (Health Accord NL, 2022, p. 16).

Of interest is how the Health Accord proposes to report and evaluate the success of its implementation, namely with indicators related to the social determinants of health considered alongside health and social system performance. A blueprint for action was released in 2022 with suggested timelines, estimated costs and implementation options. As can be seen, HiAP has gained momentum in Newfoundland and Labrador. It is a work in progress and well underway.

As can be seen, several Canadian FPT jurisdictions have already implemented HiAP, at least in part. The examples of Québec and Newfoundland and Labrador, examined in some detail, show HiAP has been implemented gradually over the years. Considering their experience, together with the existing gaps between HiAP in theory and HiAP in practice that were presented earlier, FPT governments might want to consider developing a pragmatic, partial HiAP approach first, and then ensuring its gradual reinforcement.

4 Unique opportunities for FPT governments

In this section, with examples of HiAP implementation in mind, we examine four of the unique opportunities FPT governments have to initiate or reinforce a HiAP strategy in their jurisdictions: integrating the social determinants of health (SDOH) into large-scale crisis planning; redressing what can be seen as imbalances in social policy from a population health perspective; supporting greater health equity for Indigenous peoples; and buttressing human rights and sustainable development.

4.1 Integrating the social determinants of health into large-scale crisis planning

It is a documented fact that the COVID-19 pandemic and its accompanying lockdown measures have exacerbated existing social health inequalities in Canada and beyond (Bambra et al., 2020; Public Health Agency of Canada [PHAC], 2021, p. 29). The disease and its most severe complications including deaths have occurred unequally among social groups. Some Canadians have been more likely to experience the disease or hardship, with experiences varying according to age and gender, social status and ethnicity and hardships taking the form of employment loss, reduction of working hours, financial insecurity, food insecurity, racism, family and gender-based violence, stigma and discrimination, mental health problems, and child development issues (PHAC, 2021, p. 25, 30-32).

Looking forward, many of the long-term consequences of COVID-19 are still unknown, such as the long-lasting impacts of the pandemic on children, and are expected to manifest in coming months and years. Government priorities, fiscal pressures and economic uncertainty following the pandemic make conceivable the prognostics of continued impact on the population's health and of growing inequalities (Bambra et al., 2021; PHAC, 2021). As a long-term strategic vision for public health is being renewed across Canada in the aftermath of COVID-19, HiAP offers a way to think the post-pandemic situation through and to foster a more systematic integration of the social determinants of health and health equity into planning to face future collective crises.

4.2 Redressing imbalances in social policy

Ensuring continued universal access to medicare while containing rapidly growing health expenditures has been for decades a central matter of concern for Canadian policymakers, who have had a persistent tendency to prioritize health care over other dimensions of Canada's social policy (Safaei, 2020; Romanow, 2002)[9]. A comparative analysis of health and social spending in nine Canadian provinces over a 31-year period examined ratios of provincial government spending on social services (excluding health and education) relative to spending on health care. It found that average per capita spending on health was about three times more than average per capita spending on social services, and that the expenditure gap increased significantly over the period (Dutton et al., 2018). In Newfoundland and Labrador, a recently released government report showed that health system spending increased by 232 percent between 1980 and 2018, while social spending (excluding health and education) increased by only 6 percent. The same report indicates that the observed difference in spending increases "signals a policy and political context that has historically valued health care more than other determinants of health and has not yet rebalanced these priorities in light of available evidence" (Health Accord NL, 2022, p. 21).

[9] In 2019, total health expenditure was expected to reach $265.5 billion in Canada, that is, $7064 per person on average. It is anticipated that, for the same year, health spending will have represented 11.5% of Canada's gross domestic product (GDP) (CIHI, 2021).

Available evidence is indeed accumulating to the effect that social and redistribution policies such as employment insurance, education, and social assistance do represent a major upstream determinant of population health, while the health care system accounts for only a portion of health outcomes (Lynch, 2020, 2017; Jacques & Noël, 2020; Dutton et al., 2018). One study showed that increased social spending in nine provinces between 1981 and 2011 was positively associated with population health indicators (life expectancy at birth, infant mortality, and potentially avoidable mortality), while marginal increases in health care do not directly contribute to improving population health (Dutton et al., 2018). Given that "additional spending on health does not necessarily affect population health outcomes" (Dutton et al., 2018, p. 69), the growing allocation of resources to health care is therefore not optimal from a population health perspective[10]. The authors suggest that reallocating existing budgets for public spending in favour of redistributive and social policies not directed toward health care will be key in future years from a Canadian population health perspective.

In the same vein, a report from the Organization for Economic Co-operation and Development (OECD, 2021) stressed that "Canadian policy makers need to maintain a balanced perspective across income, health, social conditions and the environment if well-being is to improve. Attention to distributional issues, including inequality, inclusiveness and disadvantage are also central to societal well-being (p. 12)." It would most likely be overly ambitious to expect a HiAP strategy to ensure a reallocation of existing budgets for public spending and to redress imbalances, from a population health perspective, in favour of redistributive and social policies not directed toward health care. This said, FPT governments may elect to use HiAP as a lever to ensure that incremental decisions made by policymakers across sectors, over time, move in that direction.

4.3 Supporting greater health equity for Indigenous peoples

In recent years, different voices have been supporting the idea that fostering healthy public policy development is a necessary step on the path toward greater health equity between Indigenous and non-Indigenous Canadians in future years. The Assembly of First Nations (2017), for one, recommended FPT governments should "adopt a cross-ministerial Health in All Policies approach with specific attention to the impact on First Nations health" (pp. 14, 113). Researchers Richmond & Cook (2016) highlighted the need to recognize and prioritize the rights of Canada's Indigenous people to achieve health equity, while also recognizing the positive role healthy public policy can play. British Columbia's First Nations advocated, not directly for a comprehensive HiAP approach, but "for enhanced [health] impact assessment guidelines that protect and promote Indigenous health" (Shandro & Jokinen, 2018, p. 4).

Indigenous peoples refer in Canada to First Nations, Inuit and Métis peoples (National Collaborating Centre for Aboriginal Health [NCCAH], 2013). Compared to non-Indigenous Canadians, they experience significant inequities in social conditions such as housing, access to safe drinking water and access to culturally safe health care and social services. Living conditions on reserves may comprise poor and crowded dwellings as well as unsafe drinking water (Richmond & Cook, 2016, p. 5). Indigenous peoples on- and off-reserve experience a disadvantage compared to other Canadians, with regard to other social factors such as workforce participation, income and education levels, and rates of violence and incarceration (McNally & Martin, 2017, p. 118). They experience higher

[10] When compared to other advanced industrial countries, Canada's poverty rates are mid-range (Organization for Economic Co-operation and Development, [OECD], 2021). Canada is not a progressive leader in social policy domains that have a positive impact on health (e.g., disability benefits, housing, labour market training and child care) or with regard to the generosity and comprehensiveness of its public programs (Jacques & Noël, 2020; Noël, 2020). This may appear counter-intuitive to many Canadians who believe their country has a generous social policy system, given a largely shared tendency to represent Canada's social policy by its universal health care system and to compare Canada's situation with that of the United States.

prevalence rates for chronic diseases such as high blood pressure, diabetes, arthritis, and for infectious diseases such as tuberculosis, sexually transmitted and blood-borne infections, and oral diseases (National Collaborating Centre for Indigenous Health 2021; NCCAH, 2013). Other significant disadvantages include rates of infant illness and mortality, disability, alcohol use, illicit drug use, and suicide. The life expectancy of Indigenous people is five to seven years shorter than that of other Canadians (McNally & Martin, 2017, p. 118).

Such disadvantageous conditions are considered part of "historical and contemporary political contexts, social structures, and resource distribution" (Reading, 2018, p. 13). They are "directly related to past and current assimilation and discriminatory government policies (including the residential school system), colonization and trauma stemming from cultural dislocation, which continue to shape the present social, economic and political landscapes for First Nations" (Shandro & Jokinen, 2018, p. 4).

At the federal level, the Government of Canada has officially recognized that "relationships built on colonial structures have contributed to the unacceptable socio-economic gap" between Indigenous peoples and non-Indigenous Canadians and has committed to "a renewed relationship with Indigenous Peoples based on the recognition of rights, respect, co-operation, and partnership" (Prime Minister of Canada, 2017). It has formed a Working Group of Ministers to review laws and policies related to Indigenous peoples.

The Government's commitment was made after the Truth and Reconciliation Commission of Canada[11] underscored the need for FPT and Indigenous governments to acknowledge that "the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools" (Marchildon et al., 2021, p. 578-579). The Commission's final report (2015) emphasized the need for Canada's jurisdictions to recognize and implement the health care rights identified in international law, constitutional law and under the Treaties.

Consequently, there has been a movement in Canada away from its traditional focus on proximal determinants of Indigenous health (e.g., health behaviours, physical environments) and toward greater Indigenous power and control over health care systems (Marchildon et al., 2021, p. 578; Reading, 2018, p. 13). As self-governance is considered a fundamental determinant of Indigenous community health (Richmond & Cook, 2016, p. 10), the movement toward greater control by Indigenous communities and governments over health care can be seen as a positive step on the path toward better Indigenous health. There is no question that First Nations, Inuit and Métis peoples experience "significant and ongoing health disparities compared to other Canadians" as a result of barriers to health care (National Collaborating Centre for Indigenous Health, 2019).

This being said, there are limitations to what more and better biomedicine and greater Indigenous power and control over health care can contribute with respect to reducing health disparities. Participants who took part in research interviews in eight Manitoba First Nations communities spoke to the need to delve into the social determinants of health and human-ecological interactions across the lifespan (Eni et al., 2021, p. 9). In the same vein, researchers McNally & Martin (2017) observed that "[a]chieving health equity for Indigenous peoples in Canada requires responses and reconciliation at all levels of healthcare delivery and policy, as well as social change to address broader determinants that negatively impact health" (p. 120).

[11] This Commission spent six years travelling across Canada to hear from the Indigenous people who had been taken from their families as children and placed in residential schools. These schools separated Indigenous children from their families for over 100 years.

The current period appears auspicious in terms of offering FPT governments opportunities to jointly explore, together with representatives from Indigenous governments and communities, how public policies beyond those directed at health care could foster better health and greater health equity among Indigenous and non-Indigenous Canadians. Two broad types of public policies could be considered with respect to their anticipated impacts on the health and welfare of Indigenous peoples and communities: policies intended for the whole population, and policies intended specifically for First Nations, Métis and Inuit peoples and communities (interview data).

A culturally sensitive approach would need to proceed from a recognition by all parties that different health paradigms exist, and that they reflect differences between western and First Nations, Métis and Inuit views and beliefs about health and its determinants, possible remedies to ill health and the overall implications for public policy (Fijal & Beagan, 2019; Campbell, 2014). Proponents of HiAP might for instance want to consider how current understandings of health impacts could be expanded to integrate First Nations, Métis and Inuit conceptions of health and its determinants and reflect a better appreciation of a holistic perspective on health[12].

4.4 Buttressing human rights and sustainable development

HiAP could be instrumental in breathing life into one of Canada's major commitments on the international scene. Canada is indeed one of the 193 signatory countries of the 2030 Agenda for Sustainable Development adopted by all United Nations Member States in 2015. This Agenda identifies 17 Sustainable Development Goals (SDGs) and recognizes that "ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests" (United Nations, n.d.).

At the federal level, all departments and agencies are responsible for implementing the SDGs. But implementation also requires "a concerted effort from all levels of government, public and private sectors, Indigenous communities, academia, and civil society. As such, the federal government has committed to working with these other stakeholders to develop a national strategy to implement the SDGs and associated targets" (Government of Canada, 2018).

Health is closely connected to most of the SDGs, and HiAP is considered "a rigorous methodology" able to support their implementation (Global Network for Health in All Policies & Government of South Australia, 2019, p. 7). Implementing HiAP at the FPT level is considered a compatible and supportive condition for advancing the SDGs (Becerra-Posada, 2015; Valentine et al., 2017).

[12] One example of an expanded model is the Circle of Health, which was created in 1996 "to promote population health, foster collaboration, and create a shared language around health promotion in communities." This interactive tool "links values, the Ottawa Charter, social theory, determinants of health, and the ancient wisdom of Indigenous cultures through the inclusion of the First Nations Medicine Wheel" (Prince Edward Island Health and Community Services Agency & Government of Prince Edward Island, 1996). Another example is the First Nations Mental Wellness Continuum Framework which addresses mental wellness among First Nations in Canada. This national framework was developed as a collaboration between Health Canada's First Nations and Inuit Branch, the Assembly of First Nations, and other Indigenous mental health leaders (Health Canada, 2015). See also St-Pierre (2021).

5 Summary and concluding remarks

Health in All Policies (HiAP) as discussed in the scientific literature is a concept that is expansive and potentially radical. But there are important gaps between what HiAP is in principle and in practice. HiAP is being implemented in a pragmatic way, to foster change from within existing government structures and processes and to focus more systematic attention on the effects of policymaking from non-health sectors on population health. A comprehensive HiAP approach is guided by a government-endorsed, overarching strategy to broadly address the social determinants of health, and develops tools and processes to influence policymaking and to create multidimensional solutions across sectors.

The experience of Québec and Newfoundland and Labrador has shown that HiAP can best be seen as a policy instrument which articulates a government-level vision comprising multiple dimensions of health prevention and promotion that extend beyond health care, and which supports coordinated action across sectors to improve the social determinants of health. It is not intended as a stand-alone solution. It serves as a complement to other already existing programs relevant to the social determinants of health and social health inequities.

FPT governments might want to consider designing a HiAP strategy in a pragmatic way, one which conceives of HiAP primarily as an additional lever for governing population health in a manner that improves the synergy between already existing public policies and programs. A pragmatic HiAP strategy can incorporate tools and processes that systematically influence non-health sectors to move toward healthier and more equitable public policymaking. Considering the existing gaps between HiAP in theory and HiAP in practice, as well as the experience of Québec and Newfoundland and Labrador, FPT governments might want to consider developing a partial HiAP approach first, and then ensuring its gradual reinforcement.

While governance levels – local and regional and FPT – do matter when it comes to HiAP implementation, this paper has highlighted the unique roles of FPT jurisdictions with regard to the macro-social, or root, causes of population health. FPT governments could adopt or reinforce HiAP as an overarching policy framework to influence policy development in relevant policy areas and to support action at the local level, thereby playing a role with regard to modifying the macro-social determinants of health. They could use HiAP as a policy instrument to support decision makers in proactively responding in a health-equity-informed manner to the COVID-19 pandemic recovery, and to foster a more systematic integration of the social determinants of health into emergency planning for other large-scale collective crises that are awaiting Canadians.

Political dynamics make the prospect of sudden changes that alter the balance of resource distribution between health care and other social programs that impact population health unlikely within a short-term horizon. However, HiAP could still play a role in prompting movement in that direction. HiAP can play the role of a vigilant reminder, in policymaking processes, of the impacts of all policymaking on population health. HiAP can ensure that the macro-social determinants of health and positive health outcomes receive more systematic consideration from policymakers and contribute to bringing about a more balanced perspective, from a population health point of view, with respect to incremental decisions on resource allocation over time. It is not suggested that HiAP represents a central solution able to remedy imbalances in Canada's social policy, or that it can replace a solid infrastructure supportive of social and redistributive policy.

For HiAP to be appropriate, respectful and relevant for Indigenous peoples living in Canada, there is a need to work with First Nations, Métis and Inuit communities to identify whether the implementation of HiAP could support their priorities. A culturally sensitive approach would need to proceed from the recognition by all parties that different health paradigms exist, and that they reflect differences between western and First Nations, Métis and Inuit views and beliefs about health and its determinants. There is also a need to explore whether HiAP could be expanded and whether it could be the model of choice for all parties to ensure consideration of a broad range of social determinants of health in policymaking, including those that are specific to First Nations, Métis and Inuit health.

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