Book Review: *A Critical Analysis of Jane Philpott's Health for All: A Doctor's Prescription for a Healthier Canada*

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My business is too difficult. My business is trying to arouse human pity. There are a few things that'll move people to pity, a few, but the trouble is, when they've been used several times, they no longer work. So it happens, for instance, that a man who sees another man on the street corner with only a stump for an arm will be so shocked the first time that he'll give him sixpence. But the second time it'll only be a threepenny bit. And if he sees him a third time, he'll hand him over cold-bloodedly to the police. – Bertolt Brecht, The Threepenny Opera

Despite Canadian authorities and Canadians touting Canada's health care system as a magnificent achievement, it is one of the least developed among wealthy nations covering only 70% of health care costs and exhibiting significant problems of access, equity, comprehensiveness, and efficiency (Blumenthal, et al., 2024). In regards to health and its determinants and the promotion of health equity – that is, fairness and justice in the distribution of health – many consider Canada to be a leader. However, Canada's quality and equitable distributions of living and working conditions – the social determinants of health – also lag behind most wealthy nations (Raphael, 2025). Thus, Jane Philpott, the author of *Health for All: A Doctor's Prescription for a Healthier Canada,* should not lack for material to consider in her quest for a healthier Canada. But sadly, the volume is striking in its omissions and profoundly naïve in its presentation of the problems Canada faces and its recommendations for their solutions.

Canada burst upon the health equity scene with the groundbreaking *A New Perspective on Health* (Lalonde, 1974) that identified the healthcare system as only one component of what makes for a healthy society. Since then, Canada has been seen as leader in promoting health equity through its publication of numerous government and government-funded agencies reports on the importance of addressing the social determinants of health through public policy action (see Butler-Jones, 2008; Canadian Population Health Initiative, 2008; Epp, 1986; Health Council of Canada, 2010; National Collaborating Centre on the Determinants of Health, 2024; Public Health Agency of Canada, 2018). Since its initial inception in the province of Saskatchewan in 1962 and across Canada in 1966, Canadians long viewed their public health care system – usually in comparison to that of the USA -- as a great achievement.

In both cases, health care and health equity, these views of Canada are now badly misinformed. In relation to health care, despite being among the highest spenders, Canada performs very poorly against the health care systems of most other wealthy nations. In a report by the Commonwealth Fund, Canada ranked seventh overall of 11 wealthy nations (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States) (Blumenthal, et al., 2024). These rankings were based on clusters of ratings for care process (Canada ranked fourth), access (ranked seventh), administrative efficiency (ranked fifth), equity (ranked seventh), and health care outcomes (ranked fourth).

In relation to health and its determinants, Canada lags in achieving health equity with most indicators of the quality and distribution of the social determinants of health depicting a grim

reality: the quality and equitable distribution of virtually every social determinant of health, income and wealth, employment security and working conditions, food insecurity, social spending, and housing affordability continue to rank amongst the worse of OECD countries (Bryant & Raphael, 2020). Canada's infant mortality rates – often seen as the most sensitive indicator of health – now ranks a dismal 30th of thirty-eight OECD nations (OECD 2024a). Canada is now one of the few rich countries showing an absolute decline in life
expectancy (Statistics Canada, 2023). Canada's life expectancy as recently as 1980 ranked 5th among 20 OECD nations, but now ranks 17th of 38 nations (OECD, 2024b).

My work has been primarily on the social determinants of health rather than health care although Philpott considers both as do I. Regarding the social determinants of health, my experiences over almost 30 years have been one of flashes of hope followed by profound disappointments. As one example, in 2015, physician author Philpott made headlines by being promoted to Federal Health Minister in Justin Trudeau's Liberal government and outlining a health equity agenda to address the social determinants of health. In a *Toronto Star* article published in November of 2015, she provides lessons for her medical student daughter:

> *Remember what really makes people sick and what makes them well. You will be taught about immunology, pathology, infections, and much more. But you already know that the social determinants of health actually set the stage for all these biomedical actors… Do your part to influence the social determinants. Speak up when you see the impact of poverty, unemployment, violence and more* (Philpott, 2015).

A headline in the Canadian Medical Association Journal of April 19, 2016, stated "Budget attacks social determinants of health" in which the federal Liberal government -- through Minister Philpott -- was seen as making major investments in tackling the social determinants of health (Sibbald & Eggertson, 2016). An April 9, 2016, report by the CHAIM Centre indicated that Philpott's commitment to addressing the social determinants of health had the potential for "Closing the gap with action for health equity" (Braedly, 2016).

Unfortunately, the results of these apparent commitments left much to be desired. Like another Liberal cabinet minister, Dr. Carolyn Bennett, who also had publicly expressed commitments to addressing the social determinants of health, Philpott was removed after a few years as Minister of Health and transferred to the Indigenous file becoming the Minister of Indigenous Services. Bennett went from being Minister of State for Public Health to Minister of Crown-Indigenous Relations. At the time I thought having these women responsible for Indigenous health issues was more politically comfortable for the Liberal government than having them accountable for broader issues affecting the health of all Canadians.

Philpott eventually was removed from Cabinet and expelled from the Liberal Caucus for expressing concerns about the government's handling of the SNC-Lavelin scandal and the treatment of Indigenous Attorney General Minister Jody Wilson-Raybould in relation to that scandal. In the subsequent federal election, Philpott ran as an independent candidate and lost to the official Liberal candidate. She then became Dean of the Faculty of Health Sciences and Director of the School of Medicine at Queens University in Kingston, Ontario. She has now (effective October 21, 2024) stepped down from these positions to take on a role with Ontario's Conservative government of Doug Ford as chair of a primary health care action team. More on Doug Ford's record on health care is provided later.

Considering the rather disappointing record of the Liberal government in addressing the social determinants of health, I very much looked forward to reading her 2024 volume *Health for All: A Doctor's Prescription for a Healthier Canada.* I hoped it would provide insights into the barriers she encountered as a government minister in addressing broader health-related societal issues, such barriers being a common theme in the contemporary Canadian health equity literature. I also expected it would provide directions for addressing the problematic public policy environment in which Canadians find themselves. While I assumed that much of the volume would be concerned with the health care system and the need for improving primary care – a long-standing concern of Philpott – the volume's book jacket promised she would address broader health issues:

> *What sets this book apart is that it's more than a prescription for better medical care. Philpott sees the big picture of health for all. This begins with an intimate look at the spiritual roots of well-being: hope, belonging, meaning, and purpose. Then through real-life stories, she examines the impact of the social determinants of health. Finally, she explains that none of this can happen without the political will to do the hard work of rebuilding a healthy society. The proposed remedy calls for serious leadership to implement what we already know and put the well-being of Canadians at the top of the agenda* (Philpott, 2024).

Let me say at the outset that Dr. Philpott appears to be a wonderful human being. After receiving her medical degree, she, with her family, spent almost a decade working in Niger as a physician with a faith-based organization. She then added later time a decade later in Niger with *Doctors Without Borders*. She is caring, sensitive, and empathic. She firmly believes in access to health care and health as a human right. She has contributed to having these issues considered as part of medical training. Her actions as a Liberal cabinet minister in the SNC-Lavelin affair demonstrated her moral integrity. Her story of the death of her young daughter in Niger is heart-wrenching as are her other presentations of experiences with patients as a medical doctor.

Having established her human credentials, let me state that I found the book to be a profound disappointment. I believe it illustrates many of the limitations of a noncritical liberal/reformist approach to understanding and acting upon the structures and processes of society that either promote or threaten health and wellbeing. I believe identifying these structures and processes – aspects of the economic and political systems that dictate how resources are produced and distributed -- is especially important as these are the primary factors shaping both health and the health care system. And the increasing evidence that the quality and equitable distribution of the social determinants of health, health itself, and the health care system are deteriorating under our neoliberal-inspired economic and political public policy environment makes such an analysis especially pressing (Raphael, 2024).

Stated simply, this volume presents a depoliticized romantic notion of Canadian society and those who serve as its political leaders. At best, Philpott's presentation is naïve. At worst, it is complicit in that it avoids mention of the powerful economic and political forces whose actions are profound threats to the health of Canadians in general and vulnerable groups in particular. In the following sections I critically analyze the parts of her book which she organizes as Introduction, Clinical, Spiritual, Social, Political, and Epilogue. I do so not for the purpose of denying the importance of primary health care nor her skill as a writer in presenting cogent portraits of some of those suffering in Canada, but rather for its superficial consideration of the forces that threaten

Canadians' health and Canada's health care system and the actions that must be taken to counter these forces.

Introduction

Philpott has certainly mastered the language of health equity directing attention in the Introduction to both the determinants of health and access to health care. She states:

> *Health for all matters for all. Canada's approach to both the determinants of health and health care must not become a case of the survival of the fittest, richest, or most well-connected. There is a negative impact on the whole country when some have easy access to healthy food, housing, and high-quality health care, while others slip further away from wellness in their daily lives and wait endlessly in the queue to access health systems. This growing inequality gap is a breeding place for anger, division, and political unrest* (p. 6).

Philpott appears then, to be taking a dual approach addressing both the health care system and the factors that shape health. She initially seems to use the term *health systems* as representing both these streams:

> *From the perspective of health services, we have a history of bold progress, such as the introduction of universal public health insurance, protected by the law. Yet as a result of several decades of denial, complacency, and neglect, our health systems are faltering* (p. 5).

Yet it becomes quickly obvious that the term – which appears 53 times in the volume -- is referring only to the health care system:

> *Our health systems suffer from arrested development after impressive progress in the last half of the 20th century. Canada's health systems did not implement the full version of the founders of Medicare, which included universally publicly funded pharmacare, home care, and dental care. Health systems stagnated under the weight of cowardice and shortsightedness* (p. 6).

> *Access to health care has been a long-standing, core Canadian value. It would be foolhardy to walk away from that value now. We can still work together to bring our health systems back from the brink* (p. 7).

Consistent with her equating of health systems with the health care system, Philpott raises the axiom of parents only being as happy as their least happy child, but limits it to the provision of health care:

> *Most parents are familiar with the sentiment that you can only be as happy as your least happy child. You know what it's like when one of your loved ones is suffering; until they are better, you cannot feel well. That's how I feel when people in our country cannot get the care they need. It drives me mad when I consider that six and a half million Canadian adults do not have a family doctor, or any other access to primary care* (p. 7).

But Philpott says nothing about the 3.7 million Canadians – adults and children – living in poverty, the 8.7 million Canadians experiencing food insecurity, or the 2.9 million households living in core housing need (unsuitable, inadequate or unaffordable housing) representing 11.6 % of all Canadian households (Statistics Canada, 2024; PROOF, 2024; Canadian Mortgage and Housing Corporation, 2024; DiBellonia & White, 2024). Indeed, her examples of those in need are almost always those with illness or disability, lack of care, and the need to have doctors – curiously nurses are rarely mentioned – provide health care. Indeed, while the word doctor is mentioned 223 times and physicians 59 times for a total 282 times, nurses are mentioned 45 times -- of which eight instances are of nurse practitioners. The term registered nurse or RN is never used.

This tendency of equating health with healthcare continues throughout her volume illustrating a prime example of "healthcare drift" where the broader aspects of health may be mentioned, but the recommended actions are all focused on health care. Consistent with this drift, in the Introduction there is a nod to the importance of social and political structures:

> *Specifically, we should provide genuine access to primary health care for everyone. To do that, we must fortify our social and political structures—the deepest determinants of the health and well-being of Canadians* (p. 6).

Unfortunately, throughout the remainder of the volume the question of defining these political and social structures is neglected, implying that what is necessary to improve and provide health for all is empathy, concern for others, and willingness to do good. The narrow focus upon good intentions and the neglect of the economic and political structures shaping the quality and distribution of the social determinants of health and the organization and delivery of health care services are significant flaws of this volume.

Part 1: Clinical

In the first chapter of this part, A Canadian Health Care Dream, Philpott provides compelling stories of individuals experiencing chronic physical and mental health issues but are unable to access a primary care physician. These people are frequently seen in emergency departments *w*hich Philpott notes, have historically been available on a 24-hour basis, but now due to ongoing cutbacks across Canada, are less so. She points out that roughly 22% of the adult population in Canada have no family doctor and no other access to primary care.

Philpott argues for the creation of primary care homes that would provide integrated care such that by 2025, every Canadian would have a primary care home described as follows:

> *Your primary care home is staffed by a team that includes doctors, nurse practitioners (NPs), nurses, and administrators, plus others according to the specific community needs. Some primary care homes have physiotherapists, occupational therapists, physician assistants, midwives, social workers, dieticians, pharmacists, and community paramedics. Where possible, the team is enhanced by the presence of health sciences students, as well as community volunteers. This is more than a collection of different health professionals and social service workers. They are more than the sum of their parts. They are trained to function as an integrated team in the delivery of care* (pp. 22-23).

Philpott provides the benefits of such an arrangement and argues that its universality – that is, its availability for all – would be similar to how public schools are organized across Canada. She provides examples of such reforms in Canada noting that in Ontario any number of these were piloted and then discontinued. These included *Family Health Networks*, *Family Health Groups*, and *Family Health Organizations*. *Family Health Teams* is now the current invocation. What these all have in common is their being organized around teams of physicians operating as small businesses, essentially the current model of primary care practice in Canada, but now involving the physician as manager of a larger team. She provides numerous reasons for their failure that include underfunding, physicians' resistance to change, and not being mandated.

Philpott does not question the dominant role of physicians in these proposed care homes. Indeed, in the following chapter *From Promise to Practicalities* her proposals revolve around physicians:

> *• A marked increase in the physician supply—ideally through expanding medical education in Canada rather than poaching physicians from other countries—thereby making the physician workforce less of a "sellers' market";*
> *• Incentives for medical graduates to become family doctors;*
> *•Incentives for family doctors to work in salaried models and teams that provide care for everyone in a geographic region;*
> *• Legal mechanisms to prevent doctors from establishing parallel private-pay health systems; and*
> *• Political courage, the likes of which Tommy Douglas, John Diefenbaker, Lester Pearson, Monique Bégin, and Pierre Trudeau needed in the 1960s and 1980s to forge ahead with smart health laws despite the opposition of some physician associations* (pp. 58-59).

Yet, there already exists a model in Canada that provides integrated care in an effective manner and at cost-savings to the current model: Community Health Centres (CHCs). Philpott dismisses them as a potential model of primary health care:

> *All along, there was another model of care in existence, the Community Health Centres (CHCs) that had been around since the 1970s, but these tended to operate in lower-income neighborhoods, and/or serve specific marginalized populations* (p. 27).

What are CHCs? CHCs exist across Canada and are described by the Canadian Association of Community Health Centres (2024) as follows:

> *Canada's first Community Health Centre (CHC), Mount Carmel Clinic, was established in Winnipeg in 1926. CHCs are often known by different names across Canada, but they all have several essential attributes. CHCs are multi-sector, not-for-profit organizations which have several core attributes.*
>
> *In contrast to solo practitioner models, CHCs offer high-quality primary care through a collaborative team approach. Social workers, family physicians, nurse practitioners, nurses, dietitians, chiropodists, dental hygienists, therapists and other clinicians provide services in a team environment, based on patient needs.*

> *CHCs integrate team-based primary care with health promotion programs, illness prevention programs, community health initiatives and social services focused on housing food security and other inputs for health. This reduces silos and makes services more accessible. CHCs exemplify the World Health Organization's definition and recommendations for "primary health care".*

Philpott's tunnel vision as to the possibilities of CHC-type primary care ignores the literature on how CHCs could provide primary care for all. She says nothing about its potential for providing the integrated primary healthcare to which she is committed. While she notes that a study found CHCs reduced visits to emergency rooms, this finding is only relevant because it was not integrated into her vision of physician-dominated primary care homes. Philpott ignores how CHCs are organized such that the apparently most odious aspects of physician-directed group work, the administration and management of the office and collecting fees from provincial authorities, is carried out by CHC staff.

Most reviews of primary healthcare reforms in Canada limit themselves to how physician directed private practice can be modified to incorporate interprofessional teams (Levesque et al., 2015; Marchildron & Hutchinson, 2016; Leslie et al., 2020). Perceived barriers include the lack of financial investment, resistance from professional associations to overly prescriptive approaches, and an overly centralized governance model. These reviews limit themselves by assuming primary health care will continue to be physician directed as a small business rather than a public service.

McCracken and Hedden (2023) offer a compelling alternative vision of primary health care that merits serious consideration by readers of *Health for All.* They argue the problem of lack of access to primary care is not due to a shortage of family physicians, but rather a shortage of family physicians willing to work in an outmoded primary care system.

> *Like most other workers in Canada, family doctors' preferences and choices about how they work have been changing over the last few decades. The majority want to work in teams, have a stable income, and be able to take a vacation and go on parental leave. Forty-seven percent would prefer to be an employee of a clinic, rather than a small business owner, an option that remains not readily available in most Canadian provinces and territories. We don't have a shortage of family physicians; we have a shortage of qualified people willing to work in an outdated model of care. That model used to work well, but no longer is a one-size-fits all solution* (p. 323).

McCracken and Hedden see lessons to be learned from public schools. Schools are not privately owned by teachers who then go about hiring the subsidiary staff necessary to run them. Such a model would work for primary healthcare. Such a model already exists in the form of CHCs This alternative compelling vision of primary healthcare has begun to make it into the mainstream public media. The CBC provides a cogent overview of the benefits of CHCs and the role that they could play in primary healthcare (Niazi, 2023).

> *Clients are able to access an array of services, from harm reduction and showers for the unhoused, to mental health services, help finding emergency shelter and an early years program for families with kids under five. There are also community health workers, dietitians and physiotherapists on hand. The centre's mission is to meet the health and*

social needs of clients who are complex and could be turned away by doctors restricted to standard, short appointments.

Another unique aspect of Centretown's model is how the clinic is staffed. Unlike traditional family practices, where doctors usually function like small businesses — bearing high overhead costs and significant administrative responsibilities, like hiring and firing — Centretown (a CHC in Ottawa) is set up as a not-for-profit organization where the more than 220 full-time and part-time physicians and nurse practitioners are employees of the Centre: "I don't want to be a small business owner. I want to do what I was trained to do, which is to be a clinician," says Dr. Erin Hanssen, one of Centretown's physicians.

Philpott's primary care home concept is certainly an improvement over the current fragmented primary care system. Yet Philpott limits herself to a physician-centred framework in which the allied health professions are organized around the physician. CHCs are dismissed. How these primary care homes would be organized remains vague. Medical dominance of primary health care is retained. Philpott's unwillingness to consider this model either as a new primary model of primary healthcare or as a subsidiary that could be expanded well beyond its present state is concerning.

In the second chapter of the *C*linical section, *From Promise to Practicalities*, Philpott provides as an example of how to go about this based on her experiences as the cabinet minister responsible for bringing Syrian refugees to Canada. To accomplish change it is necessary that:

- *Leaders understand and articulate a problem of national relevance.*
- *These leaders understood and articulate a shared vision with a measurable end result.*
- *Canadians demonstrate broad support for fixing the problem.*
- *Leaders can point to how all Canadians would benefit from solving the problem.*
- *The federal government has the authority to lead or co-lead on solving the problem..*
- *Provincial governments can collaborate with minimal squabbles about jurisdiction.*
- *Regional municipal leaders are engaged and prepared to help.*
- *Canadians and communities are willing to pitch in with many types of support.*
- *Governments exhibit a willingness to realign bureaucratic policies and processes; and*
- *The federal government sets the goal, develops the overall plan, and sees it through* (pp. 38-39).

Philpott indicates it seems to her these are all aligned to provide the integrated primary care she outlines. Yet there is a profound difference between bringing a group of refuges to Canada and realigning a health care system. She takes no account of Canadian authorities' general unwillingness to act proactively, a longstanding feature of liberal welfare states such as Australia, Canada, UK, and USA which limit redistribution and social spending and avoid management of the market economy (Lynch, 2019). Its key ideological inspiration is minimizing government intervention in a wide variety of areas. The implementation of Medicare in Canada was a significant aberration in the long history of Canadian public policy making.

Medicare came about in one of the moments when policy windows opened during the 1950s and 1960s in the era of civil rights and poverty reduction in Canada and the USA. The latest implementation of a universal affordable childcare system and the gradual implementation of both

Pharmacare and dental care is another example of such an opening. But for the most part Canadian governments of all stripes are usually reluctant to make policy changes. Is there any evidence that such a policy window is opening for a new approach to integrated primary health care? Philpott thinks there is. Others do not.

The third chapter of the Clinical part, Recovering a Species at Risk, is about increasing the number of family doctors. Philpott calls for adoption of the Periwinkle Model, which has a five-point framework (1) a healthy population, (2) better care, and (3) value for money through (4) care team well-being and (5) promoting equity. It contains many features of CHCs but is built around physicians as the core component:

1. The model is designed for the whole population of a geographic region.
2. Patients are attached to the whole team.
3. Doctors (and others) are paid by salary or by the shift.
4. Accountability is built in.
5. The workforce is expanded through learners and volunteers.
6. Services are expanded through the use of community partners.

Part 2: Spiritual

The first chapter in this part of *Health for All* is entitled Hope. Philpott provides us with details about her religious upbringing as the daughter of a Presbyterian minister. She expresses the view that -- at least for her -- belief in a divine being has shaped her life's direction. Philpott believes that in addition to physical and mental well-being, health requires a spiritual component. For her, spiritual health results from a commitment to an entity that transcends the self. Such commitment creates hope, the idea that a better future is possible.

She admits that hope is much more likely to be present when people have basic needs of education, housing, and clean water met. Rather than focusing on how many Canadians lack these resources and the difficulty of their attaining hope under these circumstances, she indicates that having hope can transcend the lack of resources to meet these basic needs. And hope is a result of faith: "Hope and faith are unavoidably linked" (p. 96).

Philpott provides a nod to non-believers "Humanism may not involve the supernatural, but I still consider it a type of faith. The hope in this case is in humanity, including the human abilities of reason and science." Like many others I take hope in a society informed by socialist principles of equality/fairness, democracy/freedom, and community/solidarity that do not fit easily into Philpott's concept of spiritualism (Wright, 2019).

Philpott suggests that even when material resources are available a spiritual commitment is essential to health. Examples of Indigenous concepts of hope are provided and these are said to promote resilience among those experiencing disadvantage. While Philpott suggests that hope is difficult for those experiencing disadvantage, the danger of positing a belief in hope as a response to disadvantage provides an out for the powers-that-be responsible for not providing the basic needs of many of education, housing, and clean water. Instead of providing these resources, efforts are undertaken to promote hope through religious, community-development social cohesion projects, and psychological counseling.

The second chapter on Belonging has Philpott stating the origins of health are to be found in a caring and loving family, and community.

If belonging is so important to mental wellness, it's worthwhile to consider what we can do to promote it or to enhance it. Belonging is linked to a number of other factors that are known to enhance mental wellness:
• the presence of a secure, personal, cultural identity;
• acceptance—the assurance of being loved in your authentic identity; and
• having a social network—not the online kind, the in-real-life kind (p. 102).

Philpott recognizes that she has been privileged in having such a favourable environment; however, for those who have not been so privileged she suggests the following:

- Choose your friends wisely and come to know yourself.
- Become a volunteer.
- Love others unconditionally.
- And seek counselling (p. 104).

` How children living with disadvantage -- for whom such disadvantage is the primary precursor to ill health, first as children and then as adults -- are to benefit from these suggestions is unsaid. Indeed, since health is embedded within family life, her failure to make explicit how family life is profoundly threatened by the economic and social insecurity that so many Canadians experience is disturbing.

It is difficult to avoid the conclusion that her suggestions for well-being are reflective of a myopic view of what makes for a good upper middle-class life. It would have been very helpful for her to note it is the economic and social conditions that people experience that enable families to provide these positive and nurturing conditions. The problem is that within her framework neoliberal-inspired political leaders and their enablers in the corporate and business sector can now exhort those adversely impacted by their activities to somehow make up for their disadvantage through their own activities. If people choose not to have friends who will assist them, love themselves, volunteer, or seek therapy, they become responsible for their adverse situations.

Philpott details the activities of Oasis Senior Support Living in Kingston that plans social events for seniors living in the same apartment building. She appears to be suggesting that similar programs can help to promote belonging among those experiencing loneliness. Not to belabour the point, belonging is more likely when individuals have their basic economic and social needs met. In 1954 Abraham Maslow presented a hierarchy of needs which indicated that Belonging would only be achievable when individuals' Basic Needs of food, water, and shelter and Safety and Security Needs of health, employment, property, and family needs were met. Considering the polycrisis in Canadian society involving all these domains, her proposed solution of self-care and agency supports seems rather limited.

In my own work I have examined how unionization and the collective bargaining that goes with it is an important support for health and well-being (Muller & Raphael, 2023). Mills (1959/2000) called the focus on individuals psychologism, whereby the structures of society and processes are ignored and societal problems are seen as personal issues.

The next chapter, Meaning, is about the death of Philpott's daughter Emily while the family was working in Niger. She tells this heart-wrenching story in some detail and indicates that she took meaning from this death and the survival of her other child Bethany. She further committed herself to providing health for all as a physician and later as a politician.

The final chapter in this part is entitled Purpose and provides further details on Philpott's commitment to providing health for all. She returns to Niger for two months in 2005 to provide medical care during a severe drought. Once back in Canada, upon experiencing burnout as a family doctor she resolved to attain a Master of Public Health degree. Philpott began to think about influencing who she perceived as holding the levers of power in Canadian society. This led to her entering politics, details of which are provided in the following parts of *Health for All*.

Part 3: Social

The first chapter in this part of *Health for All,* Health beyond Medicine, begins with the story of Tobe, a refugee from Africa. He is assisted upon arrival in Canada by the non-profit community-based organization Matthew House Ottawa. She calls for a greater investment in such organizations but says little about why there is such a need for these programs, i.e., issues of racism, discrimination, and the lack of jobs that pay a living wage for new Canadians (Canada has one of the highest rates of low paying jobs in the OECD (OECD, 2024c).

Philpott also provides details about the experiences of a woman with profound disabilities during the COVID pandemic. She talks about those that are unheard and the need for listening to their voices. Like many others she sees the solution to current problems being accomplished through the modification of Canadians' moral values rather than the balancing of existing power relations between differing sectors of society. Indeed, she appears to believe that values can exist and be changed independent of the material conditions of life that generate them. Certainly I and many readers of *Health for All* may see this differently.

> *The mode of production of material life conditions, the general process of social, political and intellectual life. It is not the consciousness of men that determines their existence, but their social existence that determines their consciousness* (Marx, 1859/1977).

Philpott concludes her chapter with comments made by her sister:

> *She pointed me to some of the arguments she has studied that suggest that the shift needs to occur in the moral fabric of society. Karen explained to me, by email, that "Empirical evidence isn't going to change the culture. Essentially, people's stories will. It's about literacy, but that's the case for everything about health for all. From my work in inclusive education, teachers and students are changed through empathy. We need to hear each other's stories"* (p. 157).

Empathy only takes you so far. As noted by Brecht in the opening epigram of this review, first-time elicitation of empathy usually brings a sympathetic response. The second time it brings indifference, and the third time outright opposition. Many would argue that what is necessary is a shift in our economic and political systems that will come about through the development of social and political movements to take control of the distribution of resources in our society. We cannot expect that the powers-that-be -- including the Liberal Party which Philpott talks about in the final section of *Health for All* -- that created these problems will be the ones to solve them.

Philpott has additional blind spots which are only too apparent in her section on the effects of COVID upon particular groups. Prominently identified are those in long-term care facilities, living in poverty, those without shelter and racialized people. She had nothing to say about people in service jobs forced to work due to the lack of legislation granting them sick days. She has

extensive discussion about low-paid personal service workers but says nothing about the fact that Canada has one of the highest proportions of low-paid workers in the OECD (OECD, 2024c) of which personal service workers are only a small proportion.

Like many in the medical profession, Philpott's gaze is focused on the tip of the material and social deprivation iceberg -- people living in dire poverty, on the streets and in long-term care. She has nothing to say about the broader working class, many of them are subject to material deprivation abetted by low wages, lack of benefits, and any sort of employment security. It is telling that her COVID material focused on medical and social care of those in long-term care homes rather than the average person whose difficult life circumstances made them especially susceptible to COVID infections and premature death. While the rates of COVID infection and death were clearly higher among residents of long-term care they constituted only 3% of all COVID-19 cases albeit a significant 43% -- less than a majority – of COVID-19 deaths (Canadian Institute for Health Information, 2021).

Philpott's discussion of the social determinants of health is remarkable for its neglect of the voluminous literature that has emerged over the last 30 years. Indeed, her discussion about the social determinants of health in *Health for All* says less than what was stated in the short Toronto Star piece she had written about her daughter mentioned earlier. Despite having referenced Marmot and Wilkinson's (2005) early volume on the social determinants of health, she did not use the list they provided, nor mention those provided by the World Health Organization's Commission on Social Determinants of Health (2008). Instead, like many of my undergraduate students who do not understand the social in social determinants of health, she provides a list taken from the Canadian government website that provides the determinants of health that include some social determinants, but also healthy behaviours, biology, genetics, coping skills and physical environments.

Philpott lists the three calls for action put out by the World Health Organization (2008): 1) improving daily living conditions; 2) tackling the inequitable distribution of power, money and resources; and 3) measuring and understanding the problem and accessing the impact of action. Yet she provides no details as to how these imbalances in power, money, and resources in society come about, who benefits from these imbalances, and how these imbalances create the daily living conditions that threaten health. In terms of tackling these issues, here is her big idea:

> *Perhaps we should create a poster with those directives and have it plastered to the walls of the cabinet rooms of cabinets across the country, to be read out before every meeting begins. Then again, why stop with cabinet rooms? Maybe the same recommendations should be considered in all of our public institutions, and beyond that, in the boardrooms of corporations or civil society organizations that commit themselves to the common good* (p. 143).

For those of us who have spent decades working to raise these issues, Philpott's failure to fully consider the profound barriers to health equity to her larger audience is profoundly disappointing. She mentioned earlier in the chapter her attempt to hire personal service workers and how she, as a former federal minister of health, would have influence in having the problem solved. It is sad that she did not take a similar opportunity to bring to the attention of the readers of *Health for All* the deterioration in the quality and equitable distribution of the social determinants of health. She lauds the late Minister of National Health Monique Begin and her contribution to health care

without taking the opportunity to mention Ms. Begin's statement regarding the social determinants of health:

> *The truth is that Canada – the ninth richest country in the world – is so wealthy that it manages to mask the reality of poverty, social exclusion and discrimination, the erosion of employment quality, its adverse mental health outcomes, and youth suicides. While one of the world's biggest spenders in health care, we have one of the worst records in providing an effective social safety net. What good does it do to treat people's illnesses, to then send them back to the conditions that made them sick*? (Raphael, Bryant, Mikkonen, & Raphael, 2020).

The second chapter in Social is entitled The Sound of Silence. Philpott provides details of her experience during the COVID crisis which saw her working on the front lines at Participation House in Markham Ontario, a group home for adults with intellectual and developmental disabilities. Extensive details of the difficulties of acquaintances who live with disabilities are presented. She does so without mentioning that Canada is the second lowest spender in the OECD on providing benefits and employment supports to those living with disabilities (OECD, 2024). This same pattern of very low spending is also seen across the areas of public pensions, employment training, social assistance, employment insurance, and family support. Philpott calls for hearing those whose voices are not being heard. Considering Philpott's rather high profile imagine the role she could have played by documenting how Canada's public policies are responsible for the problematic living and working circumstances of so many in Canada: new immigrants to Canada of colour, those with low paying jobs, renters paying more than 50% of their income on housing, and those experiencing food insecurity, among others.

Philpott is particularly drawn to the sickest, the most vulnerable, and those for whom she believes she has the skills to assist. This would not be surprising from an average family doctor. But we have here a former Minister of Health with a master's degree in public health who has indicated a commitment to address the social determinants of health. Her failure to mention Canada's very low levels of redistribution, social spending, and management of the economic system, the three characteristics identified by political scientist, Julia Lynch (2019) as having the greatest impact on the extent of health inequities is troubling. The Dean of Health Sciences and Director of the Medical School of a major Canadian university should be aware of these findings. An opportunity to make this information available to the public has been missed.

In this vein, it is well and good that Philpott in this chapter urges investments in upstream factors yet has nothing to say about the public policies over the last 30 years that had decimated government supported housing, made it more difficult to unionize, reduced government management of the healthcare system, as well its growing privatization. Philpott seem to believe that simply mentioning these issues will make them a priority for Canada. She certainly missed the opportunity to provide some understanding of how Canada arrived to this situation through acceptance of neoliberal approaches to governance, free trade agreements, and the imposition of what has been called austerity-lite by many of her colleagues in the Liberal Party of Canada (Labonte & Ruckert, 2015).

Whether this neglect is because Philpott is unaware of these issues or purposely avoids them is unknown. Are these issues beyond the understanding of a former member of Parliament, Minister of Health, and Dean of Health Sciences and Director of a Medical School? If such is the case, it says much about our present state of dystopia. Philpott's recommendation for a healthy

society seems limited to urging governments and corporations to take note of the importance of the social determinative of health and provide everybody with primary care. If that fails individuals can choose their friends wisely and feel good about themselves. We end up with a profoundly naïve analysis of the issues facing both health and healthcare in Canada.

In her chapter entitled Land, Language, Lineage, Loved Ones Philpott devotes extensive material to the issue of Indigenous well-being. While she certainly mentions the importance of self-determination, virtually all of her presentation is concerned about social work practices related to Indigenous mothers who had their children taken away from them. She details how as cabinet minister she was asked to implement the recommendations of the Royal Commission on Reconciliation. Numerous bills that were passed are mentioned, and apparently there has been some progress in the issue of Indigenous children being removed from their families. However, Philpot says nothing about recent findings that of all of the 94 Calls to Action from the Royal Commission on Reconciliation – of which the federal government is responsible for 76 – only 13 have been implemented with 81 unfulfilled (Jewell & Mosby, 2023)

Part 4: Political

The chapter Nothing but Medicine Writ Large section sees Philpott recalling how she came to run as a candidate for the Liberal Party. At a World AIDS Day event former Liberal finance minister and Prime Minister Paul Martin Jr. told her she could make more change in government than as an advocate. She also states that Paul Martin Jr. in 2004 was one of the few politicians since 1970 willing to fundamentally improve health services in Canada.

What goes unmentioned is that Paul Martin Jr. was the primary architect of the shredding of the Canadian welfare state in the early 90s (Scarth, 2004). As finance minister committed to eliminating the deficit, he reduced public spending to 1950's levels, profoundly shrinking the public programs that supported many of the individuals Philpott states as not being able to have their voices heard. Philpott appears to have given no considering of alternative parties, although she mentions in passing that she appreciated the approach taken by Jack Layton in one of the leaders' debates. The contradiction between her profoundly favourable view of Paul Martin Jr. and his dismantling the Canadian welfare state illustrates Philpott's limited understanding of the forces that create the quality and distribution of the social determinants of health.

Nothing illustrates the limitations of Philpott's vision of *Health for All* more then her discussion of the need to rebuild what she calls health systems. The most striking aspect of her presentation is the continual referencing of the importance of primary care. There is passing reference to "the foundational social structures (housing, employment, food security, social inclusion, etc.)" (p. 234) but over and over she returns to the importance of primary care, healthcare, and service delivery.

In the chapter entitled When Politics Works, Philpott begins with a story of one of her patients who became dependent on opioids noting how her interactions allowed her to learn about the factors that lead one to addiction. "I saw how our social structures failed to provide her with the security she needed to live and work with safety and stability" (p. 189) However, rather than examining the broader, social determinants of health and the public policies that drive them, Philpott focus on her experiences in reforming Canada's drug laws.

The work Philpott did as a cabinet minister included the legalization and regulation of access to cannabis and promoting harm reduction programs. Philpott details how she facilitated the provision of safe injection sites across the country. This is particularly interesting as Philpott has just taken on a position as advisor on primary care reform to Doug Ford who is shutting these

down in Ontario. He is doing so despite public health officials stating that this will lead to unnecessary deaths.

Philpott describes how in 2017 she prepared a detailed memorandum on how to respond to the opioid crisis suggesting this model can provide a model to be applied to other areas of public policy. These included:

- A whole of government approach.
- Appointment of a federal emergency task force on overdose deaths.
- A demand for data.
- Research.
- Development of best practices for the management of substance abuse.
- Support for supervised consumption sites.
- Linking these efforts to the Pan Canadian health organizations.

Of course, again the issue is that certain political issues, such as drug overdoses and deaths do not threaten ongoing business and corporate practices that have created our current polycrisis in so many other areas of Canadian life: income distribution, access to affordable housing, precarious work, food insecurity, and privatization of health care.

In the chapter Using Clinical Skills in Politics, Philpott suggest that physicians have certain skills that should be used in the political realm. She refers to what is called SOAP notes which all physicians use when seeing a patient and having to make a diagnosis. The S refers to a physician first listening to the patient to hear their problem. O involves collecting objective information about the situation through tests and other measures. A is then doing an assessment of the problem, and P is the formulating of a plan.

Philpott uses the example of the lack of affordable housing to illustrate how the SOAP model can be applied in politics. She gives the example of a 23-year-old woman who states she is unable to find an affordable place to live (S). The policymaker determines rental costs have skyrocketed (O). It is determined -- at least in her presentation – there is a shortage of housing supply, rapid population growth, and high interest rates and inflation creating the problem. The solution – according to Philpott is having "all orders of government working to amend any hindering regulations and spur the construction of more rental units (p. 215).

This could be accomplished by "way of incentives, direct investments, and accelerating innovation" (p. 215). There is no mention of all levels of Canadian government having given up their spending on affordable housing over the past few decades, nor how the financialization of housing supply by which affordable rental housing has been bought up by large companies that through the process of renovictions have driven tenants out of existing affordable housing and jacked up rents (Bryant, 2025). Again, it seems Philpott is profoundly naïve about the economic and political forces that are creating the polycrisis of which an important part is the lack of affordable housing.

She also suggests that the components of professionalism displayed by physicians should be applied to the political realm. She expects that both healthcare trainees and politicians should have virtues of:

- trustworthiness
- subordination of self-interest
- high ethical and moral standards

- accountability to a social contract;
- commitment to excellence and lifelong learning; and
- the ability to self-reflect, self-regulate, and incorporate feedback.

Philpott calls for collaboration between different members of political parties. This I believe would be rather wonderful but unfortunately politics doesn't work like that in a highly competitive society where the conflict between profit making and societal well-being, or as some academics term them, capital accumulation and social reproduction, is increasing common (Jayasuriya, 2023).

In the chapter entitled The Parable of the Crumbling Cottage Philpott tells the reader of how her family-owned cottage, overtime, began to deteriorate and required significant repair. She offers this as a metaphor for health systems suggesting that the same common sense that leads to one rebuilding a wooden cottage should be applied to the healthcare system to meet Canadians' healthcare needs: "We need decisive action investments, and a reconstruction almost from the ground up in a way that retains the soul that is the values and principles of Canadian Medicare" (p. 234). She reiterates

> *Decisive action on health requires attention to the many layers of well-being. This includes acknowledgement and support for the spiritual roots of wellness (hope, belonging, meaning, purpose) as described in Part Two. It includes the foundational social structures (housing, employment, food security, social inclusion, etc.) as described in Part Three. Most urgently, decisive action is required to overhaul service delivery as described in Part One, resulting in universal access to primary care at the core of health and social services. We can rebuild the rest of the health care system from that base* (pp. 233-234).

She calls for "individuals, groups, civil society, public institutions, and private corporations to do what they can to promote and protect the health of others." (p. 234). Again it is unclear what these calls for "decisive actions" would be and how these would be carried out. Philpott clearly believes that rational arguments supported by evidence can bring about decisive societal change. Unfortunately, in the Canada of 2024-2025 there is little evidence to support this view. *Health for All* is just the latest in numerous well-intentioned calls for societal reform that have been part of debates about the nature of Canadian society since the acceptance of neoliberal governance by Canadian authorities in the late 1970s. It will likely have the same effect, that is, little or none.

Epilogue

Philpott's heart is certainly in the right place. Her analyses and prescriptions for a healthier Canada, however, are sorely lacking. In *Health for All* she states:

> *The powers that drive us toward an ever more inequitable society must be tackled head on. It's up to us—all of us who call Canada home—to step into the breach, to protect the principles of the Canada Health Act, to elect people who will fight for fairness, and to not give up until each one of us can access the care we need* (p. 252).

She does not identify what these powers are. Indeed, some have suggested that a prime example of such sinister powers has been the Doug Ford government in Ontario that is engaged in

shutting down safe-injection sites, removing bicycle lanes, transforming farmland into highways, blaming homeless people for their own misery, and contracting out medical services to private for-profit companies at twice the cost being paid to health care providers within the public system (Ontario Federation of Labour, 2024).

Yet Philpott has taken on the role of special advisor to the Doug Ford Conservative government in promoting primary health care. Apparently, Philpott sees no contradiction between Ford's process of starving the public system and this statement she provides in *Health for All*:

> *The fate of Medicare hangs in the balance. Most politicians are too distracted by other priorities to take on this challenge. It's easier to let corporations step into the gap, and to look the other way when people who are willing and able to use their own money to pay for care are moved to the front of the queue. Others anxiously wait to be served by the health workers who refuse to abandon the public system* (p. 251).

Philpott appears to be open to health care systems that includes for-profit health care. In a TV Ontario program about the future of health care entitled *More private players in health care?* she stated:

> *So I think that it is unhelpful for us to be ideologically entirely opposed to private delivery of care or ideologically in favour, that that is going to solve all our problems. I think it is neither the whole solution. There are a whole range of other really important solutions. Nor is it something that we absolutely shouldn't be open to discussing* (TV Ontario, 2022).

Finally, for those who wish a serious consideration of the health care crisis in Canada and community-based approaches to primary health care, I suggest the 1989 volume entitled *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It* by Michael Rachlis and Carol Kushner which provides a thoughtful reflection of the problems facing Canada's health care system and the means of fixing them. (Nothing much has changed; see Rachlis, 2023). For those wishing to understand the social determinants of health in Canada, their health effects, and means of improving their quality and equitable distribution through public policy action, I recommend *Social Determinants of Health: The Canadian Facts* which is available online in English and French versions (Raphael, Bryant, Mikkonen, & Raphael, 2020).

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