CPRN DISCUSSION PAPER

Health beyond Health Care: Twenty-five Years of Federal Health Policy Development

by

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CPRN Discussion Paper No. H|04

October 2000

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Foreword

Knowing where we come from enables us to move forward. In this discussion paper, Legowski and McKay provide an account of the development of federal, non-medical health policy from the time of the Lalonde Report in 1974 to the end of the 20th century. The study is essential background to the Towards a New Perspective on Health Policy project undertaken by the Health Network at CPRN and directed by Sholom Glouberman. Other work completed or in progress focuses on provincial policies, information technology and the changes in our conception of health and health care. A final report will be published at the end of 2000.

Using three central policy documents as their guide, the authors trace the history of non-medical health policy within the federal government over the past 25 years. That history runs from the initiation of health promotion in 1974 in the release of *A New Perspective on the Health of Canadians,* to *Achieving Health for All* in 1986, to the switch to a new approach with *Strategies for Population Health* in 1994. Legowski and McKay analyse how each approach arises and is put into practice within the federal department responsible for health. The themes and issues – funding constraints, continual engagement with medicine and jurisdictional matters – provide valuable lessons regarding what has enabled and hindered health beyond health care. As such, this historical trajectory sheds light on the challenges facing the current model – population health.

Looking beyond health, “Health beyond Health Care” is a fascinating case study of how public policy is made: how ideas emerge, take hold, change, set the agenda and recede. The authors show the workings inside government, in the relationship of public servants to the Minister’s office and central agencies, in pitching ideas and making compromises. The influence of academics, think tanks, conferences of practitioners and peer group countries is evident, as well as the pragmatic aspects of human resources, program funding and politics. This account of federal, non-medical health policy and its documentation of the history of policy development within a federal government department will be of interest to health policymakers as well as those who follow public policy formation in Canada.

I wish to thank the authors for their journey through the archives, as well as the numerous people who gave their time to be interviewed and the peer reviewer who provided useful comments. The Advisory Committee for Towards a New Perspective on Health Policy has helped us to monitor the progress of this research program since work began in 1998. Special thanks are also due to our funders, whose names are listed at the back of the study.

Judith Maxwell
President

Executive Summary

"Health beyond Health care: Twenty-five Years of Federal Health Policy Development" is part of the Towards a New Perspective on Health Policy project directed by Sholom Glouberman of CPRN's Health Network. This report traces the historical evolution of non-medical health policy at the federal level of government from the publication of *A New Perspective on the Health of Canadians* (the Lalonde Report) in 1974 onward. Themes that emerge from this period put current health challenges in perspective.

The key contribution of the Lalonde Report was to conceptualise the idea of health policy beyond health care. Quoting from Thomas McKeown, the Lalonde Report argued that the major contributors to better health were healthier lifestyles, better nutrition and a healthier physical environment. It declared that these played a greater role in health than the advancement of medicine. To this end, the Department of National Health and Welfare created community programs and issue-specific social marketing campaigns throughout the 1980s to modify individual behaviour, particularly addictions. This aspect of health policy was dubbed health promotion.

Responding to changes in thought beyond the walls of government and beyond Canada's borders, the Epp Report of 1986 broadened health promotion from the emphasis on lifestyle to include environmental determinants. It introduced the idea of healthy public policy as an intervention upstream from what could be done by a health department alone (e.g., reducing social inequities). In the 1990s, the determinants of health were increased to include up to 12 factors focussed on the individual and the social and economic environment.

In the early 1990s, a third stream of thought emerged from an external think thank, the Canadian Institute for Advanced Research, under the rubric of population health. It focussed even more on the impact of the social and economic environment on health. The ideas were articulated in a 1994 report, *Strategies for Population Health: Investing in the Health of Canadians* published by the Federal-Provincial-Territorial Advisory Committee on Population Health. During that period, population health began to influence public policy debate and to compete with health promotion for attention, as well as resources.

Publication of the Lalonde Report came eight years after federal and provincial governments decided to establish universal health care insurance. By that time, financing health care had become a major concern. The Report argued that health promotion policies could contain and even reduce demands on the health care system. Cynical observers saw this as providing a rationale for limiting federal expenditure on health care costs. In contrast, the federal Department, and European governments, saw health promotion as a positive contribution to improving the health of the population. Either way, the emphasis on promoting health emerged in 1977, after the federal government shifted more financial responsibility for health care to the provinces through Established Program Financing.

The origins of these three influential reports are of particular interest. The two reports signed by federal ministers Lalonde and Epp emerged from temporary "think tanks" established inside the federal department. In both cases, a strong assistant deputy minister established protected space for a team of forward-thinking policy analysts to consider how to improve health in the future. These branches also benefited from the support of a committed deputy minister and minister. This pattern was broken with the adoption of the population health framework, which was developed by an external think tank and came to the department through the federal-provincial-territorial committee apparatus.

The present paper draws on evidence from historical documentation and key informant interviews to examine the conception, articulation and implementation of ideas contained in the three documents mentioned above, which mark the development of federal health policy over the last 25 years. Lessons from the past relevant to current debates are summarized below:

Key Ingredients for New Policy Thinking

- Champions for the new ideas within the department are critical to moving them forward into key documents and implementation.
- A think tank or dedicated time is vital to the ability of departmental staff to generate conceptual change and long-term thinking.

Barriers to Health Policy Initiatives

- Fiscal restraint often thwarts new policy development.
- Jurisdictional issues arising from federal-provincial-territorial relations have a considerable influence on the extent and way in which health policy is realized in Canada.
- Health care continues to dominate the agenda, pushing preventative efforts like health promotion and population health to a secondary rank.
- There is a greater willingness to fund narrow, issue-specific, time-limited strategies rather than long-term, broad approaches aimed at all citizens. Early on, careful planning gave way to ad hoc priority setting. Later, social marketing campaigns (raising the profile of government) were chosen over community development. At present, one age group, children, receives far more attention than citizens at other life stages.

Observations and Outcomes

- Releasing a document can be motivated by a desire to provide a new minister or committee with a policy platform independent of the previous government. For this reason, the release of a document may not signal a commitment to implementation.

- A significant result of the move to see health as much more than health care is the expansion and growing commitment to monitor the health of the population through investments in data development and analysis.

- Approaches to health do not last forever. When evidence shifted, champions left and government changed, health promotion did not have staying power. While *Achieving Health for All* complemented and enhanced *A New Perspective on the Health of Canadians*, the population health approach rejected key dimensions of health promotion such as community building.

Competing Ideas

- Divisions between proponents of health promotion, population health, public health and health care continued through the entire period and show little sign of abating.

- Although sharing a common trajectory and goal, health promotion and population health differ significantly as approaches shaping health policy. They make different assumptions about the nature of health, the purpose of research, research methods and the influences on health. Each approach holds a different view of the appropriate balance between research and action.

- One implication of the shift from health promotion to population health is that more resources have been allocated to research. Whereas health promotion emphasized action over research, this appears to have been reversed with population health in the 1990s.

Challenges

- Over a 25-year period it appears that the federal government's decision to contribute to the health of Canadians beyond health care has resulted in a logjam in health policy.

- Unlike health promotion, the population health approach has built evidence without identifying a policy instrument. The result is that it has become more difficult to see how health policy will move from theory into action in the future.

- Many of the influences on health lie outside the policy domain of departments of health. Attempts by departments of health to influence such areas as employment, housing and education have been branded as "health imperialism." While there is no doubt that cross-departmental and cross-jurisdictional efforts in this direction are necessary to implement policies that respond to population health research findings, many barriers stand in the way of fostering a willingness within other departments to incorporate or cooperate with a health mandate.

- While policy advisers often attempted to pursue broader health policies and programs, medicare continually drew attention away from other aspects of health. Yet, each conceptual

model demonstrates a need for the federal government to improve the non-medical "prerequisites" or "determinants" of health. By their own analysis, therefore, efficient resource allocation would prioritize health not health care. After 25 years, this message has not been heard.

- Research results from population health have yet to be implemented. This approach is in many ways still waiting for a champion and is stalled by the conflict between factions among the researchers, workers, jurisdictions and government departments involved in the health field.

Introduction

Twenty-five years ago, the release of the federal working paper *A New Perspective on the Health of Canadians* marked a significant change in health policy. By simply stating that health was more than health care, the document represented "a discontinuous jump in thought."[1] Although the origins of federal level health intervention lay in health protection measures, the introduction of physician and hospital insurance in the 1960s had positioned medical care as the chief area for federal government expenditure. As the responsibilities for universal health insurance became more regionalized to the provinces, the federal health department moved from an emphasis on disease treatment and cure toward disease prevention and health promotion. The shifts were guided by conceptual frameworks, the first of which was *A New Perspective* released in 1974 (subsequently referred to as the Lalonde Report). It was followed by two other key documents at approximately 10-year intervals, each articulating a theoretical shift that shared a common trajectory with its predecessor. These latter documents were : *Achieving Health for All: A Framework for Health Promotion* in 1986 and *Strategies for Population Health: Investing in the Health of Canadians* in 1994.

Viewing the conceptual underpinnings of the three documents as being on a common trajectory is a fundamental premise of this paper. It describes the evolution, principles and operationalization of three models that capture two related concepts, the first addressing "How do we improve the health of the population?" and the second asking "Why are some people healthier than others?"[2] Both the Lalonde Report and *Achieving Health for All* espouse an action oriented process of health promotion offering policy instruments that respond to the "how"; the Lalonde Report also shares with the *Strategies* document an approach to reflect on the "why," calling for research and information on what determines health. The questions and concepts are iterative – key theoretical aspects of health promotion found in the first two documents have had sufficient staying power as to be reincarnated in the population health approach, while conceptual points and strategies based on a population health approach have antecedents in health promotion.

Several analyses of all or part of this health policy trajectory now exist. One type of analysis compares the ideas of the three documents. Another type of analysis is to compare health promotion to population health. A third approach is to incorporate both the ideas and the policy actions associated with the documents. Our study falls into the third category but follows a different research strategy. A premise of many studies is that the thinking contained in the key documents is an expression of government policy, or that the conceptual change introduced in a document is the driver for new policy. Research questions are thus aimed at identifying successes that the theoretical change led to and the barriers to implementing that particular conceptual approach. On the basis of what was identified in the three documents as a "strategy," "action" or "challenge" to change, we can evaluate what was and was not followed through upon. This approach takes the degree of implementation as the degree of success. To understand why other action items were not implemented, this research strategy then seeks to identify barriers. Our decision not to follow this pattern is two-fold: first is the problem of defining "success" with the ensuing disagreements and the requirement for resolution; second is the assumption that the documents were produced or released with the intention of full implementation. To the contrary, our research suggests that conceptual documents are developed

and released for their own sake, not with intent of implementation – they may guide the direction of a department, but do not constitute an action plan, regardless of the "strategies" or "challenges" cited therein. Moving away from this frame of analysis freed us to independently evaluate how it is that certain ideas on how to improve the health of Canadians took hold and others did not. While the objective to hold government accountable for the ideas contained in these documents remains valid, examining more simply what happened inside the federal department of health allows us to reconsider the relationship between theory and action and identify policy drivers independent of particular conceptual frameworks. This is consistent with the relativist position of the sociology of knowledge that views knowledge as a social phenomenon produced and changed not by "discovering" a truth but by the particular conditions of a set time and place. "New ideas emerge and either flourish or diminish, in part, because of their exponents' ability to persuade influential social actors of their usefulness."[3] As an example, the broad agreement that health promotion was the way to improve the health of Canadians was not a fact uncovered but an idea that gained support for specific reasons.

This paper thus compares conceptual approaches to and the operationalization of non-medical health policy over the last 25 years within the federal department of health. Knowledge of this history will inform current and future health policy development. Information sources were Health Canada's archival material; files available in the Policy Coordination and Planning Directorate, Health Promotion and Programs Branch, Health Canada; and key personnel from the former Long Range Health Planning Branch and the Health Promotion Directorate of Health Canada. Interviewees were involved in the preparation and follow through related to *A New Perspective*, *Achieving Health for All* and the more recent policy development based on the population health approach in the *Strategies*. While influencing policy development in sectors other than health was and continues to be one of the goals of health promotion and population health, this paper does not examine in detail the impact of any of the three approaches on federal departments other than Health Canada. This would have required a survey of federal departments that was beyond the scope of this project. Instead, we have relied on the anecdotal information supplied by the key interviewees to develop a sense of the degree to which health department personnel liaised with other federal agencies in pursuit of health promotion and a population health approach to policy development.

The paper is divided into three parts plus an introduction and concluding discussion of findings. Each of the three parts begins approximately at the time of the release of a key document. Each describes the theoretical model and gives an historic account of how the concept in the document was developed and operationalized. Leaders and their contributions are described as are the organizational structural responses to the models. While the annual Departmental "Estimates" were studied to determine the funding related to operationalizing the concepts, the structural and reporting changes associated with policy shifts made year-to-year resource comparisons invalid over the course of the 25 years.

In a concluding section, we compile and discuss the factors or themes that comprise the confluence of events and people that have most significantly influenced how the two concepts were developed and implemented. To this we make a few observations on what the present has to learn from the past.

Part 1: *A New Perspective on the Health of Canadians*

1.1 A New Idea: The Health Field Concept

A New Perspective on the Health of Canadians: A Working Document was a "think piece" developed by policy analysts in the Long Range Health Planning Branch (LRHPB) of National Health and Welfare. During the Liberal government of Pierre Trudeau, with Marc Lalonde as Minister, this thin document was the first step to mobilizing thought across the country and internationally on a new approach to health. It was quietly released in 1974 in the House of Commons with "no announcements, no new resources, and no implementation plan."[4] Although the Minister advocated the ideas contained therein, other reports such as the *LeDain Commission on the Non-Medical Use of Drugs* (1973) and the *Working Paper on Social Security in Canada* (1974) received far greater public profile.[5]

As the oldest non-medical approach to health in the recent past, the Lalonde Report receives attention in many books and articles on health policy. Tempered praise best characterizes most reviews of the document. However, most references are cursory, citing *A New Perspective on the Health of Canadians* as a turning point in Canadian health policy without probing the substance of the document. The emphasis on lifestyle articulated therein was virtually the only concept to have formed the basis for policy implementation. It is pinpointed as the main influence and the greatest weakness of the report. While this remains valid, an appreciation of how the report was written[6] and knowledge of the departmental effort to design an implementation plan that was true to the essence of the document provide another view of this report.

Although the long list of "strategies for action" can and has been taken as the outcome to follow from this work, the centrepiece of the document was the health field concept. Four areas – human biology, environment, lifestyle and health care organization – were identified as the underlying causes affecting the health status of the individual (Diagram 1).[7] Implicit in the document was the association of each quadrant with a corresponding policy instrument (Diagram 2).[8] Lifestyle was the quadrant that had yet to be recognized as an equal factor in producing health.

Diagram 1: The Health Field Concept

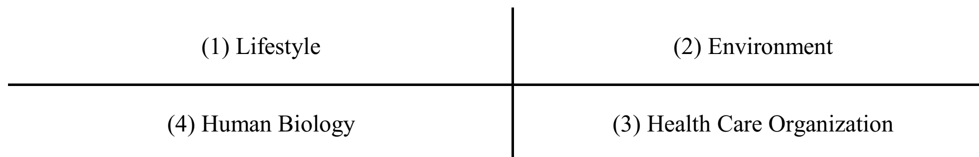
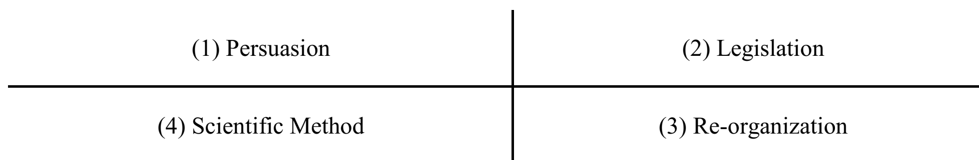


Diagram 2: Policy Instruments for Progress in Each Health Field



In the words of its author, the Director General of the LRHPB, the ultimate goal of the health field concept was "to shock both lay and professional readers out of their obsession with personal health care... as a means of improving health status."[9] Including a chart of the major causes of death by sex and age group, the first step to addressing major health problems was to use the health field concept framework to identify the underlying cause of health problems.[10] Where lifestyle was seen as the major determinant, persuasion was the tool to reduce "self-imposed risks." While each quadrant had a role to play, what was novel in the document was advocating that government modify the behaviour of the population for the sake of their own health.

The aim to increase the average number of disability-free days in the lives of Canadians could be achieved by: a greater understanding of what contributes to sickness and death; and, identification of courses of action to improve health.[11] Medical care was not the only answer. As stated in *A New Perspective,* "there is the paradox of everyone agreeing to the importance of research and prevention yet continuing to increase disproportionately the amount of money spent on treating existing illness."[12] Minister Lalonde's introduction states that the Government of Canada intends to give equal attention to lifestyle, environment and human biology as it has to financing health care organization.[13] This was an endorsement of the view that "the principal measures for raising the level of health now lie in solving problems in the lifestyle and environmental areas."[14] Evidence to support this argument was the historical work of Thomas McKeown and the use of the health field concept to identify underlying causes of morbidity or mortality. The Minister's addition to the final draft was the last chapter containing 74 courses of action. Following two broad objectives to reduce health hazards and improve the accessibility of health care, action items were organized into five strategies close to the parallel chart of policy instruments: health promotion (persuasion); regulation (legislation); research (scientific method); health care efficiency (re-organization); and goal setting.[15]

The release of *A New Perspective* provided Health and Welfare with a new role as they eased out of administering health care insurance over the course of the 1970s. As shortcomings in providing universal medical care from an administrative point of view became apparent, the federal response was to divest responsibility. As described by Marmor, Barer and Evans, enthusiasm for medical insurance waned at this time in all developed countries as three realizations were made: first, medicine could absorb an inordinate amount of money and, if not controlled, would expand indefinitely. Without a "built-in shut off valve," stopping the flow was much more difficult than starting it. Second, universal access did not lead to equal access to health. Third, a "flattening of the curve" had been achieved: "the early and dramatic improvements in health status resulting from medical intervention were not repeated."[16] In response, the federal government both initiated cost containment by accepting more provincial autonomy for medical services and introduced measures to improve health motivated in part by the argument that this would reduce usage of the health care system. Describing new prevention initiatives as "part of the Department's input into health care in Canada" indicates that the ideas contained in the Lalonde report may have been used as a leverage point in negotiations with the provinces to demonstrate a changing contribution to health care rather than withdrawal.[17] Conceptual change on what contributed to health gave the Department another way to continue participation and responsibility for health outside the medical care system.

Policy change at this time was also a response to Health and Welfare's gradual divestment of its leadership role in subject-oriented public-health-type work where experts had focussed on research and development of technical expertise that had been passed on to the provinces. The provinces were relying less on the federal government as their own health care infrastructures matured, so Health and Welfare abolished its subject-oriented divisions and reorganized itself in 1971. One result of the reorganization was the Long Range Health Planning Branch, the group of "outside-of-the-box" thinkers who developed a new vision for the Department.

1.2 The Challenge of Operationalization

Prior to and upon its release, Health and Welfare Minister Lalonde played a role in disseminating the idea of health as a field that could be subdivided into four parts. In speeches to medical professionals, he promoted the health field concept but made no commitments to new programs or funding. He also sought and received endorsement of the concept by the provincial Ministers of Health in February 1974. Yet, it was two years after *A New Perspective* was released that the Department formally responded. Two reasons contributed to the slow response. First, the conceptual nature of the document did not lend itself to immediate action. Aimed at changing thought in the health field, the working paper intentionally did not contain an organizational framework for structuring programs or recommend lines of command within the Department to execute the new ideas. Policy instruments for each health field quadrant were not explicit and the list of 74 strategy items in the last chapter was too long, lacked prioritization and linkage to the health field concept. Pointing out a direction over a comprehensive health field at a theoretical level was easier in some sense than designing concerted actions that were dependent on many other considerations, be they political, fiscal or jurisdictional. The federal and provincial ministries of health deliberated extensively on how to move forward with the health field concept, and more specifically, how to use the public health system to integrate the other sectors identified in the concept. Secondly, members of the Long Range Health Planning Branch, notably the Director General, Hubert Laframboise, who wrote the document, and others, had moved on to other posts. Laframboise had made his contribution; it was up to others to act upon it. In the shadow of other policy papers, there was no prior planning of what steps to take following the release of the document. Much like the branch where it was created, *A New Perspective* stood independent of the activities of the Department.

A key philosophical issue raised by *A New Perspective* was whether the government should be in the business of modifying human behaviour (i.e., the marketing of social change adopted from the business sector). The new science of human psychology, behavioural science, used in social marketing was promoted by the Director General of the LRHPB. He was optimistic that this technique could be successful in achieving health gains.[18] More skeptical views in the Department made support for this idea a challenge to achieve. The *Task Force Report on the Cost of Health Services in Canada* in 1969 recommended the expansion and intensification of health education on condition that it be "subjected to more critical evaluation with respect both to their effectiveness in informing the public, and especially of influencing behaviour in the desired direction."[19] Speaking of the "dangers of government proficiency," others associated behavioural modification with ideas of thought control and propaganda.[20] As well, the health field concept appeared to potentially diminish the attention paid to the relatively dominant

personal health care system and to those who worked within it.[21] It was concern about how physicians would receive ideas about health not based on the medical model that led Minister Lalonde to launch *A New Perspective* publicly at a nurses' conference.[22]

A separate contributing factor to the delayed response was the federal and provincial ministries of health being significantly distracted by a sharp increase in health care costs in 1975. To stabilize the financing of the existing health care system, the federal and provincial governments negotiated the change from the federal/provincial cost-sharing system to block funding (*Established Program Financing* [EPF] *Act*) which came into effect in 1977. In this context, the pause in organizational response to the Lalonde Report may have been due simply to the time required to change direction away from health insurance and toward the health field concept in a manner that was mindful of provincial responsibilities and actions.

Despite the issues and preoccupations, Health and Welfare was active in developing and supporting a sense of ownership for the health field concept among the provinces.[23] The Conference of Deputy Ministers of Health at their meeting in June 1974 asked public health policymakers on its Advisory Committee on Community Health Services to study and report on the document's potential strategies and proposals.[24] The Conference also directed that two sub-committees be established under the Advisory Committee: a sub-committee on health promotion and one on environmental health.[25] At the January 1975 meeting of the Ministers of Health, it was agreed that a special "Ad Hoc Priorities Planning Committee in Relation to the Document *New Perspective on the Health of Canadians*" would be struck to advise the Ministers through their deputies of the implementation priorities to be taken from the wide scope of concepts and objectives recommended in the Lalonde Report.

A "rational planning exercise" was finally embarked upon to direct implementation of *A New Perspective*. The Department of National Health and Welfare appointed the Chair of the Priorities Planning Committee and struck an internal Steering Committee representing all departmental branches.[26] The Steering Committee decided after two meetings that what was needed was a health problems framework and priority setting criteria. Two tasks had to be undertaken immediately:

- health problems and all existing and potential programs had to be classified within the four quadrants of the health field concept; and
- operational criteria to assign priorities to health problems and existing and potential programs had to be established.

A special "Working Group on Priorities and Strategies Re: *A New Perspective on the Health of Canadians*" undertook these tasks. Identifying which health problems deserved the greatest attention was the first stage. To do this, a framework was developed first using the systematic and integrated analysis of available epidemiological data concerning the causes of ill health and the associated risk factors. With this the Working Group then determined the contribution of the four quadrants of the health field concept to a given problem, then listed in order all existing and potential programs according to the quadrant addressed. Priority was to be given to programs that addressed the quadrant (lifestyle, environment, human biology or health care organization)

that contributed most to a health problem. The Working Group would then design the appropriate strategies for implementing these programs.[27] This process using the framework more or less replicated the planning process suggested in the Lalonde Report. Use of the health field concept as an analytical tool was advocated within the Department around this time on the basis that it ensured expenditures were targeted at the primary cause of morbidity and mortality. Worth noting is that, in the 1970s, the degree to which each quadrant of the health field concept contributed to a particular health problem could only be based on a subjective judgement due to a lack of substantive evidence.

In April 1975, the internal Steering Committee approved the Working Group's framework and priority setting criteria document, "Suggested Framework and Criteria for Priority setting in Relation to *New Perspective*, A Working Paper," with some revisions. The Federal/Provincial Ad Hoc Priorities Planning Committee adopted the framework and criteria on May 7, 1975, with one amendment adding another criterion – the existence of an evaluation mechanism – and further requested that the Working Group prepare the first outline of the priorities to emerge from application of the framework and criteria by the fall of that year. The proposed methodology was then submitted and supported at the meeting of the Conference of Deputy Ministers of Health in June 1975.

In spite of the seeming progress, the results from the comprehensive examination of overall program priorities were taking too long. Rather than wait until the planning exercise was complete, the deputy ministers selected three urgent priority areas that required immediate attention. This action forfeited the Working Group's ideal sequencing of events based on priority setting through the framework. Without evidence to support prioritization, traffic accidents, occupational health and alcohol abuse were selected for immediate attention.[28] For all three, lifestyle was identified as the underlying cause. For occupational health and alcohol abuse, it was decided that persuasion through social marketing was the appropriate policy instrument. By contrast, legislation to enforce compulsory seat belt use was the agreed upon action to reduce traffic injuries.

The Working Group responded to the identification of these priorities by commencing the development of strategies, program proposals and monitoring for each area. With problems and policy instruments identified, tackling these priorities involved traversing departmental divisions and striking interdepartmental collaboration. Work on traffic accidents was coordinated by the Health Programs Branch; alcoholism was headed by the Non-Medical Use of Drugs Directorate; and the work on occupational health was located in the Health Protection Branch.[29] Seat belt legislation involved work by the federal departments of health and transportation.[30] Simultaneously, the Working Group continued the planning exercise by ranking all immediate causes of ill health and identifying contributing factors. Three factors were applied in the ranking: the potential years of life lost by major causes in 1972 (a methodology developed in the Long Range Health Planning Branch); patient days in general and allied special hospitals by major causes in 1971; and admissions to psychiatric facilities by major causes in 1971.

By the fall of 1975, the Working Group acknowledged that priority setting was taking more time than anticipated; the need for strategy development to advance the *New Perspective* was urgent. While they may have wished to avoid another simple selection of health problems, they were

forced to do the same. Their priority setting applied “seat-of-the-pants” judgement in selecting more of a limited number of specific topics arising from the *New Perspective* for which strategies would also be developed. This list included tobacco use; physical fitness; nutrition and obesity; drug use; stress; and quality of physical environment.[31]

In 1976, publications and programs inspired by *A New Perspective* finally reached the public. In January, the Working Group had four documents in hand: “The Development and Application of the Conceptual Framework” from the planning exercise, plus three public documents dealing with the first three priorities the deputy ministers had selected: traffic accidents, occupational health and alcohol abuse.[32] In March, two programs visible to the Canadian public were launched: “Dialogue on Drinking” and “Operation Lifestyle,” both developed by the Information Directorate of Health and Welfare. For two years, “Operation Lifestyle” delivered lifestyle messages to Canadians through resources for use in the workplace, a computerized Lifestyle Profile, and Lifestyle Awards given to exemplary citizens. These initiatives indicate that hesitations about the role of the federal government in social marketing had clearly been overcome.

Of the four fields in the health field concept, the lifestyle quadrant was the most actively pursued.[33] To reduce traffic accident injuries, individual seat belt use, not safer roads, formed the strategy to reduce injury. Occupational health and alcohol abuse strategies also took aim at lifestyle rather than environment. This followed the thrust and novel dimension of the Lalonde Report. In a section on the relationship between lifestyle and the environment, *A New Perspective* advocated that “the deterministic view must be put aside in favour of faith in the power of free will.” Personal empowerment through a change in values could persuade individuals to abandon self-destructive habits. With the caveat that addiction and environment hobbled the power of the individual, lifestyle was defined as “the aggregation of decisions by individuals which affect their health and over which they more or less have control.”[34] This was not a prescribed route or the only inspiration National Health and Welfare could have taken from *A New Perspective*. It did, however, present a policy direction that could be pursued within the Department and without challenge to entrenched interests that programs based on environmental legislation, for example, could imply. With a policy direction shaped by selected health problems rather than careful planning, the policy instrument of persuasion, attached to lifestyle, was beginning to take hold in the concept of health promotion. At National Health and Welfare, the Health Education Division in the Health Programs Branch was renamed the Health Promotion Division.

In 1977, the federal and provincial governments completed the move from health care and education cost-sharing to block funding through the Established Program Financing arrangement. Possibly motivated by the idea contained in *A New Perspective* that preventive initiatives through lifestyle and health promotion would decrease medical care costs, the Deputy Minister and Executive Committee of Health and Welfare agreed that initiatives with this aim should become a high priority. Health promotion was both an opportunity for joint federal/provincial action and a legitimate federal activity that was understood to contribute positively to the cost containment dimension of health care now relegated to the provinces.[35]

This move by Health and Welfare was reaffirmed and supported by the Conference of Federal and Provincial Ministers of Health in June 1977.[36] The Conference urged an emphasis on joint planning, collaboration and evaluation of efforts through a Federal-Provincial Advisory Committee on Health Promotion. An advisory committee on nutrition and one on alcohol and other drug problems that had reported to the Conference of Deputy Ministers of Health were brought under the new Advisory Committee as sub-committees.[37]

Within Health and Welfare, several programs in different branches dealing with nutrition, alcohol, fitness, family planning, cardiovascular disease, health education, media campaigns, the aged and mental health were identified as health promotion programs. Some of these programs facilitated lifestyle and health promotion initiatives; others had regulatory responsibilities; still others had leadership roles themselves or through intermediaries. To deal with the issues in a coordinated manner, the Executive Committee of National Health and Welfare decided in early 1977 to develop a responsibility centre for lifestyle and health promotion. The initiative passed through three consolidation phases: a Proposal and Initial Planning Phase from April to November 1977; an Interim Phase from December 1977 to late April 1978; and a Transition Phase that started in May 1978 and ended later that year.[38]

Two important developments thus summarize this period. First, the attempt at rational planning was abandoned for an ad hoc selection of health problems deserving the greatest attention. Although not perceived to be ideal, this overcame the challenge of how to operationalize an almost purely theoretical document. Second, with medical care regionalized, the conditions necessary to fulfill the vision of Hubert Laframboise that other contributors to health could vie for funding independent of the treatment and cure system were realized at National Health and Welfare. A space was created within the Department in which a new means to intervene in the health of the population could grow. With support from authority figures, the ball toward "health beyond health care" was set in motion.

1.3 The Health Promotion Directorate

What firmly established health promotion at National Health and Welfare was the establishment of a directorate. Through the reorganizing of the branch, an idea was given a home, which allowed health promotion programming to develop. By demonstrating how the new role for the Department would look, this conceptual approach became entrenched.

An intra-departmental proposal for a lifestyle and health promotion thrust was prepared in July 1977 during the first consolidation phase. As a result, an interim "Focal Point" on Lifestyle and Health Promotion (at the Directorate level) was established in the winter of 1977-78 and located temporarily in the Health Programs Branch, pending a departmental reorganization.[39] The Focal Point brought together a group of health professionals convinced of the need for healthier lifestyles and willing to act as catalysts and advocates for change.[40] Their main purpose was to develop greater collaboration among governments and other agencies in lifestyle and health promotion activities and to bring about better coordination of activities within National Health and Welfare.[41] By early 1978, they released a Prospectus to be used to convince other players to establish ongoing lifestyle and health promotion programs through a centralized coordinating

body.[42, 43] The Focal Point's modus operandi was not to be an operational unit with a program as an end in itself but to plan, liaise and encourage concurrent programming within existing structures in departmental units and other agencies.

By the spring of 1978, the Department was considering options for Lifestyle and Health Promotion that would abolish the Focal Point approach due to a lack of organizational clout.[44] That summer, a branch option was chosen for lifestyle and health promotion – the Health Programs Branch was reorganized into the Health Services and Promotion Branch. Rationale for this decision was to ensure coordination of health promotion issues, deliver a high profile to health promotion, achieve a critical mass of programming; and offer flexibility to adjust resources for new issues.

The new branch option was operationalized with four directorates: Health Promotion and Prevention; Health Services; Research Programs; and Policy, Coordination and Evaluation. The Health Promotion and Prevention Directorate combined five units: the Focal Point; the promotion segment of the Non-Medical Use of Drugs; the nutrition education unit of the Health Protection Branch; the education unit of the Family Planning Division; and an epidemiology unit from the Laboratory Centre for Disease Control.[45, 46] This integrated alcohol, tobacco, drugs, nutrition, family planning and child health programs.[47] Shortly after its creation, the name of the unit was changed to the Health Promotion Directorate (HPD). With the objective to operate as a foundation or infrastructure for the Department's lifestyle and health promotion efforts, the first national health promotion program in the world was created.

The new branch and directorate were the most substantive changes to emerge from the departmental reorganization of that time, with changes to other branches being largely cosmetic.[48] While this demonstrated the Department's acceptance of the health promotion

Changes in the Federal/Provincial Advisory Committee Structure

None of the transitions were smooth and free from conflict. Public health and health promotion shared a focus on consumption and contagion. Yet, each perspective advanced different means to control these potential impediments to health. Public health advanced education through institutional sites: workplaces, clinics and schools. The new field of health promotion advanced large-scale social marketing as the educational tool of change. Tensions arose in practice due as much to common interests as differences. This was evident in activities and changes in the Federal/Provincial Advisory Committee (FPAC) structure.

In 1978, the Deputy Ministers of Health established the first FPAC on Health Promotion. Health promotion was one of five committees struck at that time, the others being: institutional care services; health manpower; environmental and occupational health; and community health services. At the first meeting of the FPAC on Community Health Services, public health workers expressed concern that their responsibilities and interests overlapped with those of the FPAC on Health Promotion. Communication linkages and project divisions in health education were attempted between the two committees but found inadequate. A motion passed by the FPAC on Community Health Services expressed its preference that the FPAC on Health Promotion become its standing sub-committee. This failed and the committees co-existed until 1984 when they were amalgamated into the FPAC on Community Health. Critics of the amalgamation felt that this was a *de facto* take over that should have seen the more future-oriented health promotion committee absorb community health services.

Source: McKay, Lindsey, "Changing Approaches to Health: The History of a Federal/Provincial/Territorial Advisory Committee," Background paper, Canadian Policy Research Networks, 2000.

recommendations in *A New Perspective*, this continued the limited adoption of the whole vision and philosophy of the working paper. Of the four health field quadrants, health care organization was sidelined to the provinces rather than re-organized, human biology left in the hands of medical research and bolstered with the establishment of the National Health Research and Development Program in 1975, and, aside from the continuation of health protection, the environment was neglected while lifestyle took centre stage.

Without the leverage of cost-sharing, Health and Welfare's influence was dependent on its leadership quality, the force of the Department's program proposals, and the sensitivity with which it could respond to the health and social needs of Canadians and their provincial governments.[49] The course health promotion would take was also shaped by other changes. As part of the departmental reorganization, the health and welfare sides were merged under one deputy minister. Possibly bringing the two dimensions of well-being closer together, separate planning and policy research functions, intergovernmental liaison functions and information systems were also combined by the Fall of 1978. Indicating that the motive for this change was financial, budget and staff cuts occurred simultaneously. Contribution funds were cut by 60 percent and staff were reduced by 30 person-years for 1979-80.[50] While the significance of creating a new directorate is enhanced in the context of financial restraint, this meant that resources for the new group were limited. This was the first appearance of a pattern that would recur: investment in a (health promotion) vision inhibited by fiscal restraint.

1.4 Directorate Programming

A first challenge of consolidation was to create a sense of cohesion between pre-existing entities now located under one roof. Each of the new Health Promotion Directorate units had its own priorities, client groups, commitments and style of working. In terms of staff, there was felt to be a relative over-concentration of expertise in nutrition and in alcohol, tobacco and drug use, and an under-concentration in family planning, self-care, child development and other areas.[51] In particular, the Non-Medical Use of Drugs (NMUD) Directorate was the largest organization to be integrated into the new directorate, larger than the others put together, and was seen to dominate integration activity.[52] Its issues and behavioural science expertise remained central within the new directorate and its senior managers became the new directors.[53] Some observers consider this relative dominance a reason for the emphasis on lifestyle change. Influenced by the popular science of the day, encouraging individuals to change was regarded as the best means to end addiction.

A second challenge was to fulfill the mandate of the new directorate with limited resources. Objectives to be met were ambitious:

- improve personal and social acceptance and adoption of behaviour conducive to good health and the avoidance of risk;

- influence public and private institutions to provide goods and services consistent with personal and public health; and

- improve the effectiveness of and access to intervention programs for persons whose behaviour exposes them to risk.

This work to be undertaken was divided into four broad categories:[54]

- social marketing (public education and information);
- supports to community action (funding programs);
- policy and program development; and
- research.[55]

It was understood that the range of health promotion concerns exceeded the capacity of the Department to respond with the given resources. To ensure balance, an effort was made in setting priorities for action to have an equal number of programs aimed at individual behaviour relative to those that took aim at the social climate.[56]

The major lifestyle problems with which the health promotion program was concerned were not new. In priority order, they were: nutrition; fitness; smoking; alcohol use; drug use; accidents; family planning; immunization; personal health and self-care; and stress.[57] The top two issues in 1980-81 in terms of the allocation of operating funds were alcohol use and nutrition, receiving 34 and 25 percent of the total operating funds respectively.[58]

A positive effect of consolidation was that the continuation of pre-existing programs provided the new Directorate with an opportunity to think and plan. Although there was some pressure for the new unit to demonstrate its role, given the amount of energy expended in reorganizing the Department to reflect aspects of *A New Perspective*, thorough planning was encouraged by the Assistant Deputy Minister and proved to be fruitful.[59] The two programs that emerged during the early 1980s – the Health Promotion Contributions Program (HPCP) and the "Generation of Non-Smokers" – were lauded as exemplary. Despite a prevailing climate of departmental cutbacks, the budget for the HPCP increased from $1.7 million to $4 million over three years.[60]

In contrast to previous campaigns, the *Generation of Non-Smokers* was the "first truly integratively planned program" that the Directorate operationalized.[61] A long-term project that went beyond educational literature, the anti-smoking initiative became the model for future programs. It was characterized by: concentration on selected issues and population groups; continuity of themes and resources over 10 to 15 years; and, synchronization with current social trends (most Canadians did not smoke). Four national strategies for health promotion – informing the public, promoting a supportive social environment, promoting self-help and encouraging the incorporation of health promotion into established social programs – were also utilized in this program.[62]

After about 18 months of health promotion program operation, the Department approached Cabinet to clarify direction and increase resources. It wanted a national theme and identity for the federal health promotion program; recommended publication of a "white paper" on health

promotion for discussion with voluntary and professional groups, the provinces and the public; and suggested a higher profile for national leadership in health promotion similar to the attention Minister Marc Lalonde gave *A New Perspective* in 1974.[63] The Department also wanted to bring to a larger scale the health promotion principles of the *Generation of Non-Smokers* program.[64]

Now that health promotion had demonstrated performance capacity, Cabinet was receptive. The social marketing campaigns had raised the profile of the federal government, putting them in a positive light as actors in health. Although the "white paper" was not authorized, in March 1982 Cabinet approved a permanent health promotion policy and program. This could be seen as a response in anticipation of the Report of the Federal/Provincial/Territorial Ad Hoc Committee on National Health Strategies finalized two months later.[65] Established by the Conference of Deputy Ministers of Health in February 1981, the mandate of this committee was to identify priority problems and propose goals and strategies. Based on the health status evidence available at the time, accidents, arthritis and joint disorders, cancer, cardiovascular and cerebrovascular diseases, maternal and infant health problems, mental disorders and respiratory diseases were identified as problems. The order of priority and task of quantifying the goals were left to the provinces and territories. Five strategies – health risk reduction, early detection, treatment, rehabilitation, research, evaluation and data collection – were set in an operational framework that presented a continuum "extending from health promotion through prevention and treatment to rehabiliation and palliative care."[66] It is notable how the language chosen to classify problems, particularly the degree of medicalization, influences the end goal and point on the continuum considered the appropriate point at which to intervene. Disease categories are tied to the aim to restore health to the ill, whereas "accidents" (rather than "violence" or "crashes") imply fate rather than human control. At a conceptual level, health is thereby constructed as either sickness status or level of wellness. Emphasised in the National Health Strategies Report was the preventative nature of most of the identified problems pointing to the front end of the continuum. Based on what was considered suitable to federal jurisdictional boundaries, this document endorsed a strategy of health risk reduction through funding health promotion on a permanent basis.

The funding decision gave the health promotion program a comprehensive mandate complete with aims, issues, target groups, and strategies, but Treasury Board approved few new resources. With approximately $5 million and 122 person-years, about a quarter of the resources needed for full implementation of the mandate, the program scope for the next five years combined issue-specific initiatives dealing with, for example, tobacco, alcohol, drugs and nutrition, and developmental work in so-called core programs directed at target populations, including school and workplace health, heart health, child health as well as a national health promotion survey.[67, 68] The program was shaped by building selectively on existing experience, particularly the former Non-Medical Use of Drugs Directorate with its strong community development approach to programming.[69]

As programs were deemed a success, the health promotion approach enrolled more supporters and the Directorate rose in profile. Critical to this crescendo of the 1980s was the positive departmental and political reception to the Health Promotion Contributions Program (which gave the federal government a presence in MPs' ridings) and *Generation of Non-Smokers*.

Health Status Knowledge Development

One outcome from the Lalonde Report that stands apart is the effort to assess the state of health of Canadians.[1] Following the insertion of the Panorama of Mortality in Canada in *A New Perspective*, a Canada Health Survey was designed by Statistics Canada in the late 1970s modelled on the health field concept. Although the survey was cancelled in 1978-79, the work that was done provided some data and established a capacity to execute surveys.

The same year, Statistics Canada co-sponsored with the independent Institute for Research on Public Policy research and publication of *The Healthfulness of Life: A Unified View of Mortality, Institutionalization, and Non-institutionalized Disability in Canada*, by Russ Wilkins and Owen Adams.[2] Further to this work, a Studies Unit within the Health Promotion Directorate pursued research on health behaviours.

Led by another champion of health promotion, Dr. Irving Rootman, one of the most significant accomplishments of the Unit was to design and conduct the Canada Health Promotion Survey in 1985.[3] Suited to health promotion thinking in the early 1980s, the survey was aimed at evaluating health practices with a focus on lifestyle. The cross-country roadshow presenting *Achieving Health for All* to professionals and the public included the dissemination of survey results relevant to practitioners.

The 1985 survey contributed directly to the modified Canada Health Promotion Survey of 1987 and 1990. It has been followed by the 1994 and 1999 National Population Health Surveys. Only after the change in approach to population health has survey research received enough support to become a permanent endeavour. Expanding knowledge on the health status of Canadians has been a central task of the Federal-Provincial Advisory Committee on Population Health from its establishment in 1993.

Thus alongside programming a research capacity to evaluate the health of the population was established during the predominance of the health promotion approach. This work was expanded and took on greater importance within the population health approach.

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1 Interview with Irving Rootman, March 24, 2000.
2 Russ Wilkins and Owen Adams, *Healthfulness of Life: A Unified View of Mortality, Institutionalization, and Non-institutionalized Disability in Canada*, Montreal: Institute for Research on Public Policy, 1978.
3 Thanks to Owen Adams for pointing out the influence of *A New Perspective* on data collection in his review of an earlier draft of this paper. Numerous smaller, more specific surveys were conducted during the 1980s by the Studies Unit, HPD and Statistics Canada.

1.5 Hiatus from Centre Stage

Once again other changes in the Department affected health promotion. Although the government remained the same, leadership changed with Monique Bégin replacing Marc Lalonde as Minister of National Health and Welfare in 1977-79. After a brief change of government, she returned as Minister from 1980 to 1984. Around this time, provincial management of health care came to dominate the agenda. Just as HPD's mandate expanded, the Health Services and Program Branch reverted to focus on health care from approximately 1979 to 1984. This was provoked by the controversy surrounding provincial violations to medicare. After fruitless negotiations with the provinces and territories over user fees and extra billing, the federal Liberal government passed the *Canada Health Act* unilaterally in 1984. This is seen as Minister Begin's legacy. From the perspective of "health promoters," this piece of legislation presented an opportunity to require provincial health promotion action as a condition of block funding. Aware of this possibility or not, senior bureaucrats chose not to impose a new condition

for a number of possible reasons: to avoid provoking the provinces already irritated by the federal reprimands for their attempts to control their own costs; because of a lack of understanding of the importance of health promotion in a broad-based approach to health; and/or the Act was felt to not be the appropriate vehicle for encouraging health promotion.[70]

Diversion of key activity away from health promotion and an indifference among senior staff under a new minister meant that, from their perspective, the Health Promotion Directorate did not make the genuine progress toward fully operationalizing the health field concept, much less move the markers ahead of the Lalonde Report, to which they aspired. While action on the health field concept and particularly the lifestyle quadrant had progressed from 1974, the Lalonde Report remained an unfulfilled vision given that only some of the 74 action items were acted upon and not all quadrants received attention. In their perspective, a key barrier within Health and Welfare that impeded full implementation of the health field approach was the attention given to health care funding and the federal/provincial EPF Act, both in terms of resource allocation and departmental focus.

A more distant observation would note that the hiatus from centre stage in programming appears once again to have provided room for conceptual enrichment. By the end of the 1970s, the concept of health promotion had disseminated widely enough that a range of professional actors, internal and external to government, were now enrolled in support of the notion that this was a legitimate means to improving health and an appropriate role for government. Health promotion was defined in *A New Perspective* as a strategy that "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health."[71] A discourse of health promotion was fully established within what has been described as a professional social movement such that ideas flowed in more than one direction.[72] Inevitably, discussions evolved into debates and a wider range of contributors to the new approach to health led to new ideas and criticism. Counter to the individual focus characteristic of health promotion at the time was the concept of social support as a contributor to health. This idea became prominent in health literature in the late 1970s. As well, the release in 1980 of Sir Douglas Black's report in the United Kingdom provided evidence that health was far more than a function of individual lifestyle. The Black Report brought international attention to the widening of social inequality and the relationship of social class to morbidity and mortality. The author demonstrated a social gradient to health whereby higher class was shown to have a positive correlation to health consistent to the finding that lower class members had poorer health and earlier death. Related to these ideas emerged a critique of health promotion and the Lalonde report that grew in strength over time. The charge was that most health promotion programs aimed at influencing personal habits, not the social environment that encourages or discourages health behaviour. While the intent had been to empower people, the emphasis on personal responsibility for health was criticized as "blaming the victim."[73] As academic and popular voices of criticism spread, the theoretical flaw of how health is produced came to be accepted and began to shift the concept of health promotion within official circles in Canada and abroad. Inevitably, this point of contention had an effect on the work of the Directorate.

A conference in 1980 jointly sponsored by the University of British Columbia, Continuing Education Department, the Vancouver Health Department, the BC Ministry of Health and the

federal Health Promotion Directorate contributed to conceptual changes. Entitled "The Shifting Medical Paradigm Conference: From Disease Prevention to Health Promotion," the event helped to legitimize the alternative health movement by introducing a wellness paradigm in which the individual's experiences were more important than medical diagnoses. A year later, participants of the "First National Conference on Health" put forward another position. They argued that the overwhelming focus on the individual obscured the importance of environment. Social context was a stronger determinant of health because it shaped individual behaviour. Some factions added the claim that lifestyle choice was dependent upon social class. Smoking, for example, was not the greatest health problem for a poor single parent with insecure housing.[74] Another variation on this theme – first raised in the House of Commons in response to *A New Perspective* – was that the federal government used an emphasis on lifestyle to avoid addressing the problems that affected the lower class.[75] By comparison, a broad-based view of health promotion implied a commitment to dealing with inequities (including socio-economic status), extending the scope of prevention and helping people to cope with their circumstances.[76] Linking their "professional movement" to the grassroots ferment of the time, some health educators and promoters began to declare the core issues of various social movements as health promotion issues, for example, sexism, homophobia and poverty.[77]

It was at this time (1984) that the government changed from the Liberal Party to the Progressive Conservatives. Jake Epp became the new Minister of Health and Welfare, and a new assistant deputy minister took over the Health Services and Promotion Branch while the former ADM, supportive of health promotion, became first an associate deputy minister and then the Deputy Minister.[78] [79] While his first undertaking was to stop lotteries and his second to implement the *Canada Health Act*, thereafter health promotion received much of the Minister's attention.[80] With commitments to social justice and equity in health in his speeches, it was during the tenure of this Minister that health promotion excelled.

A shared vision among a "critical mass" of health promoters in the Directorate coalesced in the mid-1980s to push health promotion into what can be considered its pinnacle of success period. A confluence of factors allowed for the flourishing of health promotion as the new policy area.[81] One factor, consistent with changes in health promotion discourse, was acceptance at the senior departmental level that health promotion needed to broaden the emphasis on lifestyle to include the influence of the social environment.[82] Another factor was the provincial and territorial governments paying more attention to health care reform. As envisioned in *A New Perspective*, the reorganization of medical care entailed the inclusion of health promotion, disease prevention and population health status considerations.[83] Following and in comparison to the difficult relations experienced in implementing the *Canada Health Act*, working on health promotion with the provinces through programming was a positive project that did not present jurisdictional conflict.

Part 2: *Achieving Health for All*

Most contributors to this field describe the period from 1983 to 1993 as one of "maturation." Ideas were changing and momentum gathering at the grassroots level just as government action was taking new steps into health promotion. The provinces and territories expanded their traditional roles in health education to incorporate health promotion in their efforts. At the municipal level, public health departments, particularly the Toronto Department of Health, began to tackle "structural" problems such as poverty, unemployment, workplace health and safety and powerlessness."[84] A mix of community development and advocacy strategies were adopted as the means of improving health. For example, the Health Advocacy Unit at the Toronto Department entered debates about pollution and poverty being, among other social conditions, major health blights.[85]

Capturing this energy, an international conference was held in Canada in 1984 called "*Beyond Health Care*," with the joint sponsorship of the Toronto Board of Health, the Canadian Public Health Association and National Health and Welfare. At the conference, the relationship between Canadian health promoters and the European Office of the World Health Organization (WHO) was openly strengthened and two key ideas of health promotion were born: healthy public policy and the healthy city.[86] The concept of healthy public policy was that it was wiser to anticipate than to respond to unintentional impacts of government policy. For example, if macro-level issues such as unemployment and poor urban planning are addressed, the problems they cause, such as low self-esteem, powerlessness and alienation, may be alleviated. It was time to make deliberate attempts to directly influence health status "upstream" via non-health sector policy decisions.[87] Like the Lalonde report, the incentive was the belief that improvements in health resulting from a long-range strategic plan would alleviate the economic pressures on the health care system. "Healthy cities" advanced the idea of empowerment and public participation promoting health through decentralization of power to local communities. Ontario supported this concept and British Columbia implemented policy on this basis.[88]

2.1 The Creation of *Achieving Health for All: A Framework for Health Promotion* and the *Ottawa Charter for Health Promotion*

Health and Welfare's work with the World Health Organization (WHO) European Regional Office in 1984 was a second influence that contributed to a re-definition of health promotion. At a critical meeting of the European Region WHO, it became clear that Canada was falling out of step with the principles of health promotion in other countries. The "new" health promotion was based not on lifestyle but on social and environmental factors.[89] This was consistent with European governments' focus on changing social and physical environments. By comparison, the Canadian health promotion strategy – focussed on lifestyle – appeared very narrow. The contrast elicited a need to redirect federal level health promotion in Canada in a fundamental way.

While a commitment from each country to "Health for All by the Year 2000" was achieved at this conference, plans for the next event were made. The strategy of primary care with a multi-sectoral approach, community involvement and appropriate technology components for the

“2000” plan reinforced the environmental health promotion direction.[90] The idea of an international conference on health promotion was proposed with a request that Canada be a sponsor. Upon the urging of the Director-General of Health Promotion, the ADM of the Health Services and Programs Branch sought and received the support of the Minister’s policy advisor. With the promise of a public document that would “put him on the map,” Minister Epp agreed to not just sponsor but host the conference.[91] Regardless of the credit owed to the Lalonde Report, the change in government meant that reference to it was “off” for political reasons: it had been written under a government of the opposition party. A new conceptual approach with the new Minister’s stamp on it was an appealing proposal. As a new government, the atmosphere of dynamism and high hopes for achievement made the Minister’s office receptive to new ideas.[92] Advancing health promotion would fill a niche that fit with the growing jurisdictional division between provinces and the federal government in health. While all these factors played a role, what may have been most important was the congruence between the ideas presented to the Minister and his values and ideas about health.[93] On the basis of these motivations, plans to host the First International Conference on Health Promotion in Ottawa in November 1986 in collaboration with the WHO and the Canadian Public Health Association were set in motion.[94]

With political will and senior bureaucratic support, work began in the Health Promotion Directorate on the promised document, briefing notes and speech for the Minister to present at the conference. With a deadline to meet, Ron Draper, the Director General, was sent off to write. While he did not have the pen in the end, a former player in the HPD noted the similar fashion by which *Achieving Health for All* and *A New Perspective* were written.[95, 96] Both documents were written in relative isolation, with little internal consultation and virtually no consultation with the provinces, national non-governmental organizations or professional associations. *A New Perspective* was reviewed in other departments through Cabinet, prior to release, but almost not at all within National Health and Welfare; the vetting process for *Achieving Health for All* was the opposite. Ideas contained in the documents were tested in the Ministers’ speeches at non-threatening events prior to the official release.[97] Additionally, both documents articulated the ideas of a small group of people within the Department who had a strong leader. Bert Laframboise, DG of the Long Range Health Planning Branch and Ron Draper, DG of the Health Promotion Branch were both described by interviewees as unique human beings. While distinct, they were both politically astute, talented and committed to their work. Spoken about with admiration, it appears that they excelled when given the opportunity to do creative work.

In the case of Ron Draper, producing what became *Achieving Health for All: A Framework for the Health of Canadians* was not entirely smooth sailing. Reaction in the Department beyond the Health Promotion Directorate to the draft paper and its future policy proposals was not altogether positive.[98] Objection came from the Health Services Branch, which considered its contribution to health excluded from the document. Indeed, there was no mention of medicine playing any role in the health of Canadians. Strongly attributed to the writer and perspective of those who worked at HPD, this exclusion was intentional and not without wider support. It reflected in part an embrace of the anti-medical critique of the alternative health movement. Adopting the “new health promotion” idea that environment is as important, if not a more important determinant of health, than the individual, led to the endorsement of a broad-based conception of health. Excluding the cure system was perceived as simply a strategy founded on the view that to make a point one often has to overstate the case. Given that the public understood the contribution of

medicine to health, it was necessary to exclude its presence entirely in order to demonstrate that many other factors influence health. Regardless, bureaucrats in the Health Services Directorate felt that medical practitioners had a role to play in the health of Canadians and in health promotion (a consultative role in private practices, for example) and ought to be included in the framework for health articulated in the paper.[99] They took exception to the fact that their work was not given any value. The implicit criticism that the medical model was too narrow and the profession too hierarchical to treat patients as persons and too domineering to even be at the table meant an exclusion some felt was unfair to the diversity and possibilities of the profession. Moreover, the long-term interest in health was the same and some saw an opportunity to work together.[100] Hence Health Services required and did receive changes to aspects of the paper prior to release.

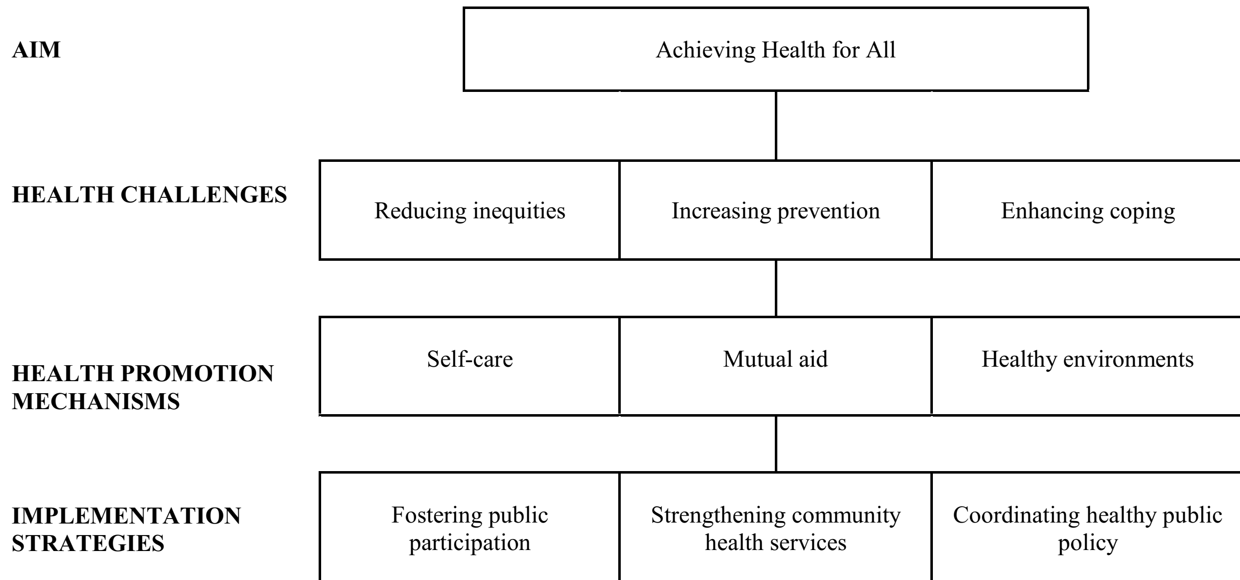
Another factor which may have contributed to internal tensions stemmed from inter-departmental competition for attention and resources. Within the informal networks of other branches and directorates in the Department, particularly the Health Protection and Policy Branches, there was resentment, suspicion and distrust of the Health Promotion Directorate.[101] This was based on the perceived preoccupation of the Minister with health promotion and the international conference; the fact that a Cabinet document had been created by a small program branch as opposed to the policy branch; and that a small program branch had so dramatically influenced the Minister.[102]

Regardless of the difference of opinion on content, the Director-General's briefing paper had to be condensed. A re-write and edit plus some new material along with graphics made the final product an accessible and more inclusive public document. Released at the First International Conference on Health Promotion in 1986 and attributed to Jake Epp, *Achieving Health for All: A Framework for Health Promotion* represented the federal government's intellectual follow-up to the Lalonde Report. It moved from the post-Lalonde Report concentration on one quadrant, lifestyle, to a broader vision of health promotion. The document embraced criticisms from the "professional social movement" of health promotion to fall in step with the broader approach of European nations. Determinants of health – referred to as "prerequisites" – are taken for granted within this model. Research on the extent and exact influence of each determinant related to a particular health problem was thereby side-stepped in favour of action.

2.2 *Achieving Health for All*: A New Conceptual Approach

The content of the document was organized into a framework that highlighted three challenges to the health of Canadians; three health promotion mechanisms to address the challenges; and three strategies to operationalize the mechanisms (Diagram 3). Unique to the conceptual approach (compared to the Lalonde Report), *Achieving Health for All* included equity of low versus high income groups as a challenge to health. This dimension of the framework can be seen to illustrate the international impact of the Black Report in the United Kingdom.

Diagram 3: A Framework for Health Promotion



Source: National Health and Welfare, *Achieving Health for All: A Framework for Health Promotion,* Ottawa, 1986.

Another key and complimentary result of the First International Conference on Health Promotion was the adoption of the *Ottawa Charter for Health Promotion* (hereafter the *Charter*). The concepts underpinning this document were developed over a number of years at health promotion summer schools that had been held around the world. These formed a legacy that climaxed at the First International Conference.[103] The *Charter* legitimized what was labelled a "new public health movement" focussed primarily on industrialized countries but extending concerns to developing regions. Designed as a declaration, the *Charter* included a pledge calling for a commitment to health promotion by all participants of the conference. It defined health promotion as "the process of enabling people to increase control over, and to improve, their health."[104] This included the ability for an individual or group to "be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment." Expressing overall possibly the broadest official definition yet, the *Charter* states that health is a resource for everyday life. As such it "goes beyond health life-styles to well-being."

The *Charter* articulated fundamental conditions and resources of peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as prerequisites for health. Well-being could be realized through providing the "opportunities and resources to enable all people to achieve their fullest health potential."[105] Ensuring gender equality in all planning efforts, five "health promotion action" strategies were identified as the means for change:[106]

- Build Healthy Public Policy: advocacy for health directing other sectors to "accept their responsibilities for health"
- Create Supportive Environments: health impact assessment of the environment followed by action
- Strengthen Community Action: programs to strengthen community control

- Develop Personal Skills: provision of education for health
- Reorient Health Services: change within the health sector to focus on the total needs of the individual beyond clinical and curative services

As to the *Charter*'s acceptance in Canada, conference delegates returning to Canada were surprised not to find more official governmental acknowledgment of what had been named the *Ottawa Charter*; in their opinion it was significant enough to warrant a commemorative plaque.[107] As many commentators have said of the Lalonde Report, international reception of the *Charter* may have been warmer than that found in Canada even though it was co-authored by Health and Welfare Canada and the Canadian Public Health Association with the WHO.

What is most significant about *Achieving Health for All* and the *Charter* is that they gave official sanction to a different concept of health promotion. By legitimizing the contributions to health of structural factors such as living and working conditions, lifestyle focussed health promotion was re-defined for the Department and all others attuned to a broad-based interpretation of health promotion.

2.3 Operationalizing *A Framework for Health Promotion*

Even with its concise health promotion mechanisms and implementation strategies, *Achieving Health for All* resembled its precursor the Lalonde Report as a “think piece,” without quantitative evidence, intended to stimulate thought and debate. It had senior bureaucratic and political support from the Minister and Cabinet, but no specific implementation directions nor any commitment to additional program resources.[108, 109] Given the lack of promises made in connection with both documents, it is not clear that they were intended or understood to be statements of government policy. While those who produced *Achieving Health for All* may have perceived the document as such, intellectual contribution to a broader and more sophisticated understanding of health promotion was the only offer formally made.

Unlike the Lalonde Report, the Framework was intensely promoted after its release. Beyond presentations to all Health and Welfare branches and senior staff of several other federal departments, a cross-country roadshow brought the document to every province. Government departments, national non-governmental organizations and professional associations were targetted for dissemination of the document along with results from the 1985 Canada Health Promotion Survey. *Achieving Health for All* was also distributed with special inserts in professional journals such as the *Canadian Journal of Public Health* and the *Journal of the Canadian Medical Association*.[110] In spite of the effort to explain the document to people working in health, those involved at the time encountered misunderstanding, which they blamed on minimal consultation outside the Health Promotion Directorate during the document's development.[111] However, prior discussion may have only prolonged the production of *Achieving Health for All* without mitigating this reaction, given that this was not the first nor last time conflict between these communities flared. The Framework minimized the role of health protection and health care, conveying the impression that the Department thought these to be no longer as important as health promotion.[112] This probably explains the poor reception of public health/health protection and health care workers who competed with health promotion for

funding, territory and priority, across a jurisdictional divide. Another contributor was the conceptual presentation of health promotion as an enabling process with a range of "environment" activities so broad as to make what comprised "health promotion" vague.[113]

Significantly different from *A New Perspective,* a mechanism for program implementation to follow through on the new ideas already existed. Yet, the Health Promotion Directorate only accelerated the same work they were doing before: lifestyle social marketing campaigns alongside community-based projects. Despite the conceptual change articulated in *Achieving Health for All*, it was not an acknowledgment of a broad-based approach to health promotion that brought new money to the Health Promotion Directorate but special initiatives with immediate political and public concern. While two campaigns addressing drinking and smoking were already underway, it was under the Progressive Conservative government led by Brian Mulroney, from 1984 to 1993, that six new well-funded social marketing campaigns were launched. Five-year strategies became popular for issue-specific lifestyle-focussed health promotion as opposed to fundamental programs such as school and workplace health, knowledge development through research and community development/mobilization. For example, in 1987-88, initiatives dealing with tobacco, Canada's Drug Strategy, the National Strategy to Reduce Impaired Driving and the fight against AIDS caused the Health Promotion Directorate budget to triple while its core funding was eroding.[114, 115] Within the Department and government, funding was more easily acquired for proposals that took aim at identifiable social problems.

Following the release and promotion of *Achieving Health for All* in 1986 to 1992, departmental bureaucrats provided the leadership in health promotion as opposed to the ministerial level.[116] The Directorate was conducting some high profile, national social marketing campaigns that put National Health and Welfare "on the map."[117] While they mobilized the campaigns on four fronts (media and marketing, education and training, research, and community action), they concentrated on the more visible components – public awareness and marketing through the Program Promotion Division. Directorate staff knew that they had to continue to do what was understood by and most visible to politicians and the public in order to secure the resources needed to continue environment-focussed health promotion work.[118, 119] It was considered too difficult "a sell" to convince central agencies to support community development work because it was based on abstract concepts compared to social marketing campaigns that addressed immediate problems.

Thus in pursuing money where they thought they could get it, the Health Promotion Directorate made a compromise. In order to address environmental determinants of health, they inserted broad-based health promotion principles into issue-specific lifestyle strategies. Core funding was also reserved as much as possible for "true health promotion" approaches. These were comprehensive, cross-sectoral and population-based programs considered fundamental to the values they developed in *Achieving Health for All*.[120] Particularly good examples of core health promotion initiatives were the Health Promotion Contributions Program and support for the Healthy Communities and Strengthening Community Health projects from 1988 to 1991. An example of an integrated health promotion effort is the 15-year Heart Health Initiative, which involved Health Canada, 10 provincial departments of health, the Heart and Stroke Foundation of Canada and more than 300 voluntary, professional and community organizations across

Canada. Another collaborative development process that spanned several years was the significant revision of *Canada's Food Guide to Healthy Eating*.

Given the lifestyle/social marketing two-pronged approach to health promotion that developed after 1985 in the Health Promotion Directorate, it may be most fair to consider the impact of this era by distinguishing between lifestyle social marketing and environment health promotion. The former expressed the idea that the best way to improve the health of Canadians is to convince people to do what is good for them through large-scale campaigns. Individual health could be attained by changing what is considered socially acceptable and creating the conditions in which the individual either came under pressure or found the ideological conditions supportive of healthy behaviour. With the exception of the ParticipAction fitness campaign, this approach targeted those who were at risk or already engaged in unhealthy behaviour, especially teenagers. Regulating the level and ways in which addictive substances – alcohol, tobacco and (non-medical) drugs – were consumed dominated the period from 1976 to the introduction of an HIV/AIDS campaign in 1989-90. Many of the players involved believed that an ideological social revolution of sorts occurred as a result.[121] Smoking is now rarely referred to as a pleasure; only a bad habit. Drinking and driving is now socially unacceptable. People are now normally expected to be more responsible for their health, for example, with fitness regimes and healthy eating.

Broad-based health promotion is perceived by many to have fallen short of "success." Although this sentiment often includes lifestyle social marketing campaigns that were designed to expire by the early 1990s, it is the abandonment of broad-based health promotion along with termination or reductions in core health promotion programs that are seen as indicators of failure. Yet, there were significant achievements, such as the Healthy Cities movement. This may have been the most the Health Promotion Directorate could achieve given the political preference for issue-specific lifestyle strategies and the difficulties inherent in convincing central agencies to fund "true health promotion" approaches that are comprehensive, cross-sectoral and population based.

It is also important to note that the policy instrument for lifestyle change did not remain limited to persuasion, as identified in *A New Perspective*. Forays into legislation and regulation to modify behaviour have been made beyond seat belt legislation. The goal of social marketing campaigns in the later 1980s and 1990s was often acceptance of legislation. Legal and regulatory rules were introduced restricting the age for purchasing tobacco, mandating warnings of health risks on cigarette packages and limitating advertising and sponsorship by tobacco and alcohol companies. The aim is to limit messages that compete with positive health habit messages (although such efforts have had varied success – changed ideas do not necessarily result in changed behaviours). Another approach to adjust lifestyle is the idea of limiting where people engage in their bad habits. Designating federal government buildings "smoke-free" was introduced under Minister Epp in the late 1980s. Regulating the spaces in all office buildings has extended as a health trend to private businesses in the late 1990s, for example, coffee shops, bars and restaurants. While critics see this as punitive and not broad-based because of its focus on one pollutant with no attempts to address the underlying motives for smoking, it is consistent with the historical emphasis on curbing individual bad habits.

While evidence exists that health promotion advanced conceptually and programmatically as a result of *Achieving Health for All,* the advances have been called uneven.[122] The Health Promotion Directorate essentially adopted a two-pronged approach: issue-specific lifestyle/social marketing that drew political and central agency support; and broad-based health promotion in core community development programs, with some uptake into social marketing strategies. The second approach was not widely recognized beyond its proponents. It has been suggested that advocates of broad-based health promotion – influenced by anti-medical aspects of the alternative health movement – missed the opportunity to include the disease prevention and health promotion interests of public health and health care.[123] In doing so, they lost strong allies, perpetuating the conflict between these groups instead. As well, those on the front line suggested that there was confusion over the prioritizing and application of the key elements of health promotion. The concept was so broad that it became vague and, to some extent, lost momentum.[124] Nonetheless, the pinnacle of health promotion success was 1985 to 1989, when line management from the director level up to the Deputy Minister and Minister supported the general principles of health promotion.

Part 3: *Strategies for Population Health*

Just as health promotion concepts in *A New Perspective on the Health of Canadians* and *Achieving Health for All* charted a new course for the federal health department out of a preoccupation with health care, so too did population health research, coalescing among academics and researchers in Canada and abroad, and most notably at the Canadian Institute for Advanced Research (CIAR). And just as the concepts of the first two documents owed their influence on policy to singular confluences of events and people, so too does the current acknowledgement of the impact of socio-economic determinants on health.

In spite of the conceptual similarities between health promotion and population health (without trivializing the significant philosophical and technical differences between them), some have viewed population health's emergence and growing popularity over the 1990s as being at the expense of health promotion. Still others have claimed that, due to the similarities in the two concepts, population health was a "lifeboat" for health promotion because on its own it was not able to withstand the criticisms, chiefly from central agencies, that there was no evidence base to justify its strategies.[125]

Regardless of the differing viewpoints, the 1994 document, *Strategies for Population Health: Investing in the Health of Canadians,* produced by the Advisory Committee on Population Health (ACPH) and accepted by the Conference of Ministers of Health, marked the point at which population health became the prevailing health policy paradigm in Canada, replacing health promotion. Structural changes within Health Canada characterize the greatest response to the new approach. This was likely due to an environment of fiscal restraint and new mechanisms and understandings of federal/provincial relations limiting the policy and program actions the federal government was able to take.

3.1 Health Promotion Recedes

Beginning in early 1989, numerous events occurred and influences emerged that contributed to a gradual shift of attention away from health promotion within the federal health department. Most notable were changes in leadership and a concern with the financial state of the federal government.

First, Jake Epp left the Health Minister's office in 1989. Although his successor was like Epp in wanting ministerial visibility and profile, Perrin Beatty did not share Epp's personal resonance with health promotion.[126] Also important was that the Privy Council Office at the time was adjusting its expectations of the senior cadre of the bureaucracy, particularly the deputy ministers, in light of the growing concern with the federal deficit and debt. Whereas deputy ministers and other senior bureaucrats had previously been appointed to some extent according to their knowledge or understanding of a particular portfolio, they were increasingly being appointed not as advocates of their departments but as instruments for the government of the day to concentrate on more generic administrative functions. In Health and Welfare Canada, the changes in minister and ministerial politics coincided with changes in the Deputy Minister and Assistant DM dealing with health promotion. Consequently, support for health promotion at the

senior levels began to dissipate.[127] This in turn disillusioned those people who had been closely aligned to health promotion concepts and principles and, over time, caused a number of them to leave. Thus Health and Welfare's capacity for supporting and evolving health promotion began to suffer. In addition, a 1989-90 Price Waterhouse evaluation of the Health Promotion Program recommended a deeper evaluation of the Department's capacity to promote and pursue healthy public policy. It exposed the difficulties that a number of departmental branches had with healthy public policy, as well as the challenges, issues and questions facing the Department in operationalizing it – "[the healthy public policy] paradigm which envisages health as the product of "anything and everything" does not readily lend itself to being actioned..."[128]

Underlying the sudden questioning of health promotion as the way for government to improve health status was a change in the academic world. The decline of behavioural science meant that the conviction that lifestyle could be modified was no longer taken for granted; it had to be proven. The methodology used by accounting firms such as Price Waterhouse established quantitative measures as constitutive of acceptable evidence. Given the relative lack of funding and priority placed on monitoring and evaluation by the Department during the 1980s, and the inherent limitations to establishing causality with respect to human behaviour (as opposed to counting profit margins from marketing in the private sector), the value in health promotion may have been overlooked. What fed the call for evidence was a period of fiscal restraint inspiring the search for areas to cut back spending. Changing the standard and form of evidence considered acceptable undermined the ability of health promotion to justify its existence. What is more, although health practices had improved at an aggregate level, the rationale that this would reduce the cost of health care never materialized.

Major federal government cutbacks began in the late 1980s and early 1990s. For example, one emergency move in 1991 to subsidize western grain farmers in financial distress caused budget cuts throughout the federal bureaucracy. The overall fiscal restraint brought into question the federal government's role intervening in citizens' lives for the sake of health improvement. Provincial funding of broad-based health promotion programming at the grassroots level allowed the federal health department to question whether it needed to continue in the field, particularly if its resources were limited and the provinces resented federal intervention at the community level.[129] The social justice and otherwise value-based nature of health promotion may also not have "fit" with the emerging political agendas of the late 1980s and 1990s, which generally criticized social programs as undermining individual initiative and unnecessarily draining the public purse. In this context, key projects such as Strengthening Community Health and Healthy Communities, which had successfully operationalized the essential broad-based health promotion concept of healthy public process and policy, were never recast from being projects to becoming examples of broader policy and sustainable practice.[130] Project termination symbolized the beginning of a divestiture of the leadership role that the Health Promotion Directorate and the federal government had developed and held since the early 1980s regarding health promotion.[131]

At about the same time as the HPD was apparently losing its leadership role in health promotion, an attempt to combine health and social policies to reflect a broader vision of health saw the Health Services and Promotion and Social Service Programs Branches integrated to form the Health and Social Programs Branch in 1992.[132] This move was short-lived and effectively reversed when, in June 1993, Cabinet announced a major restructuring of the government, with

one action being the removal of all welfare components from the Department of Health and Welfare, creating Health Canada. A number of Health and Welfare's social service programs were assigned to a new Human Resources and Labour Department.[133] A dramatic move in inter-provincial relations was made when the federal government introduced the Canadian Health and Social Transfer (CHST) in the 1995 budget. Responding to the desire by provinces to run their own programs, the CHST ended several cost-sharing programs to replace them with a single block funding transfer. While provinces could divide the money between health, social and educational programs as they saw fit, the amount of money transferred since its implementation in 1996 has steadily declined.[134] Within the Department, the new Health Canada had reorganized by 1994-95 into five branches: Health Programs and Services, Health Protection, Medical Services, Policy and Consultation, and Corporate Services.[135] These changes, an internal reorganization of the Health Promotion Directorate and continuing budget cutbacks caused a state of relative paralysis regarding health promotion programming at the time, apart from the issue-specific national strategies underway dealing with HIV/AIDS, breast cancer and tobacco.[136]

Cutbacks continued with the most significant challenges to the Health Promotion Directorate being the program reviews of 1993 and 1995.[137] The reviews posed such difficult questions to health promotion that the survival of the Directorate was threatened. Calling health promotion "religion not science," Treasury Board required a stronger emphasis on evidence, particularly quantitative evidence, to "figure out what works and stop paying for what does not."[138] Although the Studies Unit of HPD began monitoring programs on an annual basis in 1984 (operational projects more closely than contribution projects) based on a comprehensive evaluation framework, the data available were not considered sufficient.[139] The nature and standard of evidence required had shifted to outcome measures beyond the budget and at odds with the priorities of the Directorate. Competing for resources in such an environment privileged rigorous scientific evaluation methodologies and more medically oriented practices proven by these methodologies. Also privileged were interventions that could demonstrate positive outcomes in the shorter term, whereas many health promotion programs may show measurable impact only in the longer term.

While other branches and directorates were better able to defend their fiscal allotments by virtue of legislative or contractual requirement (e.g., First Nations and Inuit health), the political sensitivity of their issues or their apparent involvement in immediate life and death issues (e.g., Health Protection Branch), the Health Promotion Directorate by comparison was considered to be lightweight. Its social marketing strategies were viewed diminutively as programs of "fridge magnets and posters" despite evidence of their effectiveness in at least raising public awareness.[140, 141] The evidence that did exist for a whole variety of health promotion initiatives was not sufficient to fully protect them, partially due to the impediment of needing standardized data collection at the community program level to demonstrate comparative effectiveness. Inadequate funding and a lack of priority placed on research were other contributing factors to the inability to produce the kind of evidence suddenly demanded. Health promotion was and continues to be hampered by the difficulty of, first, measuring what did not happen, and second, providing causal accounts of what did to demonstrate efficacious intervention.[142] Moreover, the original rationale that health promotion would decrease usage and therefore the cost of the health care system had never been proven. On a separate point, health

promotion may also have reached a stage of maturity where its more challenging aspects, for example, broad scale healthy public policy, had to be operationalized for the concept to advance; the relatively easier components such as lifestyle/social marketing strategies had been tried and proven to a much greater extent.

Coincident with the demand for evidence was a change in political priorities. Government intervention through social engineering to create a just society had dwindling credibility or saleability in the context of dealing with federal deficit and debt.[143] Government leadership was being assessed less on positive action and more on financial accountability. Federal bureaucrats sensed that the growing sentiment by the 1990s was a public perception that Canadians were generally healthy, and that consequently government intervention was justified only in response to specific problems. Health promotion was unable to defend its value in this environment. It did not have broad enough support and was not entrenched enough to withstand a less friendly sociopolitical context. In addition to health care and public health, where bridges were not built, another place stronger endorsement could have been created was through the federal-provincial-territorial advisory committee apparatus. When the Advisory Committee on Health Promotion was absorbed by the Advisory Committee on Community Health in 1984, health promotion lost a dedicated body of cross-jurisdictional advocates that may have helped defend it against the challenges of the early 1990s. In retrospect, it appears that a focus on the task at hand rather than building a coalition of support to ensure longevity could have contributed to the demise of health promotion as the approach of the federal department of health.

In spite of ceasing after 1993 to be the dominant non-medical health policy approach at Health Canada, health promotion remained alive and well elsewhere. In addition to remaining a common means of intervention in federal programs, Health Canada financially supported a two-year project in the mid-1990s conducted by the Canadian Public Health Association entitled, "Perspectives on Health Promotion: Towards National Consensus."[144] This approach has also remained the more popular policy approach in most countries around the world. In developing countries it takes a more public health focus, whereas at least in one country, Estonia, doctors act as health promoters.[145] By 1999, hospitals had joined community health centres in collaborative efforts to promote health through information centres. In a path population health would also take, health promotion's adoption within the academic community remains solid in Canada. A network of health promotion centres formed in the early 1990s continues to advance this field, linked to international bodies, an international journal and a regular conference circuit.

3.2 Population Health Emerges

It was into a context of fiscal restraint and demand for evidence that population health research emerged. Population health, or the determinants of health model, began for the most part in Canada in 1987. It was developed by Dr. Fraser Mustard and participants of the Program in Population Health, an academic pursuit at the Canadian Institute for Advanced Research (CIAR) using epidemiological research methods to identify factors that contribute to health.[146, 147] Their research was influenced by the broad view of health that became popular in the 1970s and evolved into the 1980s to include social, economic and political factors. Evidence to support their claims relied on the now more popular quantitative and scientific research methods, giving

legitimacy to their position in communities unaccepting of other research methods as equally valid. From at least 1987 onward, members of CIAR's population health group, who were distinguished researchers credible within the wider academic community and particularly within policy circles, disseminated widely the population health perspective (most members had been advising policy makers before joining the CIAR group).[148] They presented compelling empirical evidence of non-medical determinants of health to a wide range of interested parties, including federal, provincial and local politicians and public servants. Members' publications began in approximately 1990 with Evans and Stoddard's *Producing Health: Consuming Health Care*, followed by other key pieces such as the CIAR's own paper, *The Determinants of Health*, released in 1991 and *Why Are Some People Healthy and Others Not* (Evans, Barer and Marmor, eds.) in 1994. Their most important contribution was thought to be the development of an integrated analysis – a population health framework – where the "anomalous findings" on determinants from their own research and that of others were synthesized into a coherent explanation of the social gradient observed in the Black Report.[149]

In keeping with the fundamental message of the Lalonde Report and *Achieving Health for All,* the basic thrust of the CIAR's determinants of health research is that health of the population is determined by factors in the social and economic environment outside the formal health care system. These are:

- income and social status
- social support networks
- education
- employment and working conditions
- physical environments
- biology and genetic endowment
- personal health practices and coping skills
- healthy child development
- health services

(Health Canada eventually added three other determinants: social environments, gender and culture.[150])

Provincial governments were the first to adopt a population health approach to policy development in the early to mid-1990s, namely Quebec, British Columbia, Manitoba, Ontario and Saskatchewan. Exemplified by the Premier's Council in Ontario and wellness model in Saskatchewan, most jurisdictions produced a document outlining a population health vision prior to 1993 and at least half had a division or branch called "population health."[151] Building on ideas introduced most prominently by the Black Report, the CIAR shifted the causal importance of inequity from a taken for granted fact (in the *Achieving Health for All* framework) to a subject of analysis critical to informed intervention. As provincial governments became enrolled in the view that research into what determines health was important, adherence to the population health approach grew in strength. In addition to provincial influence at the tables of various federal/provincial health committees, such as the Advisory Committee on Community Health, CIAR members were invited to present their ideas directly to politicians and bureaucrats. Their individual and collective authority, the type of evidence and expertise they presented and the

growing discourse on population health in the literature created a momentum that had an impact on the federal level.

A determinants of health perspective had penetrated the Conference of Deputy Ministers by mid-1992. The Conference had been considering how to restructure its advisory committees to achieve a more strategic policy focus. After consolidating numerous committees down to four, the Deputy Ministers changed the Advisory Committee on Community Health to the Advisory Committee on Population Health (ACPH).[152] In addition to adopting most of Community Health, the ACPH incorporated the committees on Environmental and Occupational Health; AIDS; Mental Health; Alcohol and Other Drug Problems; and Women's Health.[153] Also important to the ascendence of population health as the predominant policy approach was the Prime Minister's launch of a National Forum on Health in 1994. The presence of a determinants of health working group gave population health formal recognition as a valuable way to look at the health of Canadians. The studies produced and attention to issues raised by the Forum contributed significantly to the adoption of population health as the approach of the federal government.[154]

Although there were some clear turning points and grounds for the adoption of population health, the reason why population health rose in prominence when it did was considered by some to be "a timely accident."[155] What CIAR members were seen as delivering was empirical evidence of the connection between the social environment and biological pathways that appeared independently in the Lalonde Report and *Achieving Health for All.*[156] This was appealing because it tackled the finding of gradients head-on by linking socio-economic factors to health. Furthermore, in giving a prominent role to the economy and equity, population health was simultaneously attractive to "advocates of the welfare state" and "neo-conservative sensibilities and interests."[157] While the importance of wealth generation versus distribution of wealth would later become a central debate, population health made the claim that sustained economic growth was essential to improving overall health status. As well, in the context of increasing fiscal restraint, central agencies were calling for evidence-based decision making, which further privileged the scientific and analytical findings of population health research.

Assuming its leadership role, the Advisory Committee on Population Health began its work to determine priorities for action that would improve the health of Canadians. Its first decision was to consider national health goal setting as a tool for developing health policy in general and for priority setting in particular, to get the best value for money. While it was understood that health goals were not the only tool suitable for priority selection, they were attractive because they could be related directly to the health status of a population.[158] Hence the ACPH saw an opportunity to link the CIAR research and the maturing population health framework to health policy. Three reasons for having national health goals were articulated:[159]

- to help improve population health and correct health status disparities;
- to focus attention and resources on important determinants of health that lie outside the control of the health sector and facilitate intersectoral action; and
- to better link decision making and resource utilization to health outcomes.

The ACPH struck a Task Group on National Health Goals/Priorities, which contracted an *Analytic Review Towards Health Goals for Canada,* completed in early 1994. The project was not intended to actually develop health goals but was to propose a framework for their content and propose principles, approaches and options for a process to develop them jointly with the federal, provincial and territorial governments.[160]

The framework was based on commonalities among the health goals frameworks already adopted by several provinces and was consistent with the frameworks of other countries. It had seven major categories of goals: health status; individual health practices; individual capacity and coping skills; social and economic environment; physical environment; health services; and tools and supports. These were grouped into three broad areas: the health status of the population; the determinants of health (the second to fifth categories); and the tools and supports necessary for taking action to improve health.[161]

What the *Analytic Review* proposed was that the most workable option to setting national health goals was to establish measurable but non-quantified objectives at the national level. National indicators, baseline measures and quantified targets could then be developed for selected high priority objectives (pending data availability and agreement on numbers) with corresponding measurement, monitoring and accountability for progress according to the seven goal categories. Provinces and territories would be left to set objectives and targets in areas that fit their jurisdictional responsibilities and capacities.

However, the *Analytic Review* found that the conditions for success were not all in place at the time, and, in addition, were numerous and difficult to operationalize.[162] Most daunting may have been the requirement for an adequately resourced body with sufficient credibility and skills to design, manage and facilitate a federal/provincial consensus process to first, lead the development of goals, and second, to champion, guide and monitor the implementation of the goals to sustain action. The provinces were already involved in their own goal setting processes and were not enthusiastic about trying to reach consensus on a set of national goals that might conflict with their own. Funding issues also arose.[163] As a result, the ACPH decided to not proceed with specific national health goals but to instead use the national health goals framework in a broader upstream manner as a framework for population health. In other words, it identified the key health determinants requiring attention and the tools and supports needed to proceed with action. In this way, the framework could guide provincial goals and targets but did not require their specification.[164] It was thus that the national health goals framework that first appeared in 1994 in the *Analytic Review Towards Health Goals for Canada* was exactly duplicated as a population health framework slightly later in the same year in what was to be the defining document for a new conceptual approach to direct health policy at Health Canada, namely the *Strategies for Population Health: Investing in the Health of Canadians* (see Diagram 4).

Formation of ACPH

Four of 11 of the members of the ACPH created in 1993 were members of the disbanded Advisory Committee on Community Health (ACCH). The Terms of Reference of the ACCH had been for the most part:

- to act on or study priorities in areas of disease prevention, health promotion and community care;
- recommend priorities and strategies for the achievement, promotion and maintenance of good health; and
- advise on developing and implementing policies and programs.

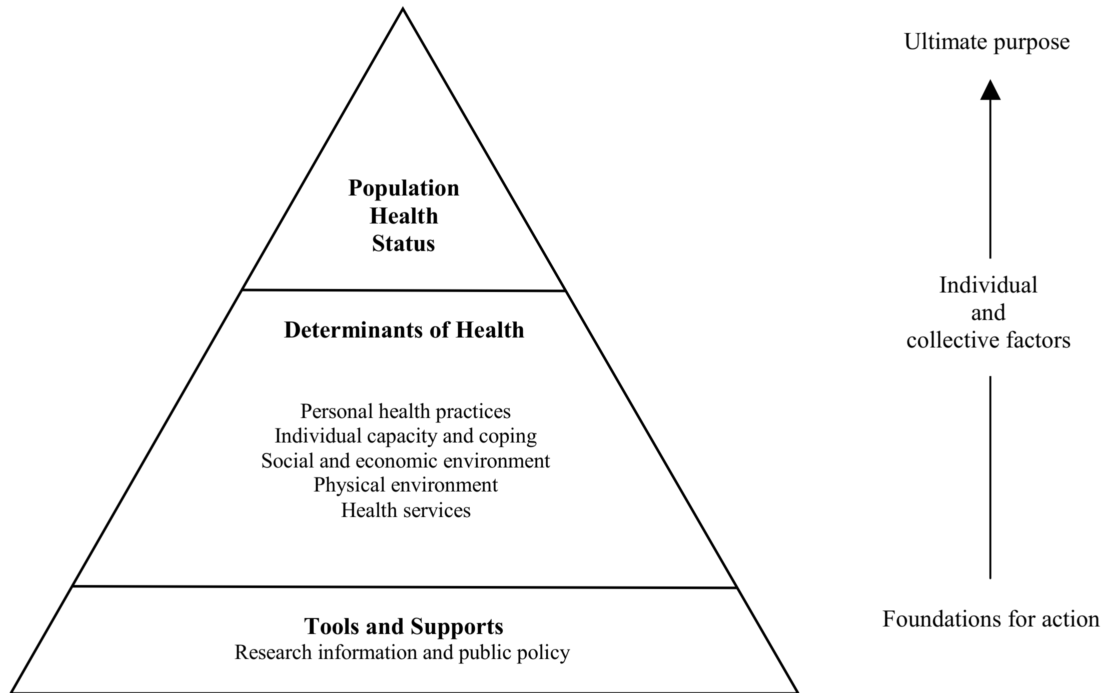
By comparison, the ACPH was to:

- address major issues that affect the health and well-being of Canadians as a whole as well as groups with less favourable health status, by making recommendations based on analysis of population health data, as well as the factors that influence health, in the context of finite resources; and
- to advise on national and interprovincial strategies that should be pursued to improve the health status of Canadians and significant sub-populations.

During the ACPH's first meeting, it decided that setting priorities required development of a policy agenda conceptually structured through a health goal approach. An objective became the development of a small list of national goals that could be acted upon regularly, building on the experience of jurisdictions that had already done work in setting goals.

Source: McKay, Lindsey, "Changing Approaches to Health: The History of a Federal/Provincial/Territorial Advisory Committee," Background paper, Canadian Policy Research Networks, 2000; Minutes of the 1st Meeting of the ACPH, Toronto, March 25, 1993; Business Plan of the ACPH, November 18, 1994; ACCH Terms of Reference, 1984.

Diagram 4: Framework for Population Health



Source: Health Canada, *Strategies for Population Health: Investing in the Health of Canadians*, prepared by the F/P/T Advisory Committee on Population Health for the Meeting of the Ministers of Health, Halifax, Nova Scotia, September 14-15, 1994.

3.3 Population Health as the New Health Paradigm

On the recommendation of the ACPH, the *Strategies for Population Health* document was accepted by the Conference of Deputy Ministers of Health and in June 1994 the Ministers of Health recognized population health as the new paradigm to direct health policy. (The *Strategies* document was not released until February 1995.[165]) The *population health approach* (also known as the determinants of health approach) was to be the application of population health research findings to public policy.[166] The *Strategies* document described population health, identified the determinants of health according to the CIAR analysis, and proposed three strategic directions for national action. The approach espoused addressing the entire range of factors that determine health through strategies that targeted entire populations rather than individuals. The three strategic directions for Health Canada were:[167]

- stengthen public understanding and public support for the determinants of health and the actions needed to improve health status
- build understanding and support for the population health approach among government partners in sectors other than health
- develop comprehensive intersectoral population health initiatives for a few key priorities that have the potential to significantly impact population health.

Even with the F/P/T Conference of Ministers of Health accepting a population health approach to policy development, debate was sparked within Health Canada. From one perspective, a determinants of health model was expected to be an "easy sell" within the federal government: there were compelling international and domestic research findings underpinning the approach; it had wide support in the academic community, among NGOs and the private sector (for example, the Conference Board of Canada); cross-jurisdictional consensus brokered through the ACPH was already in place; the approach was already formally adopted by four provinces; and it provided socio-economic levers with which to articulate a new federal role in health. Population health also spoke to interdepartmental coordination that was being independently promoted within the federal government at the time, for example, through the Interdepartmental Policy Research Coordination Committee (the Policy ADMs Committee) and in the Report of the Task Force on Strengthening the Policy Capacity of the Federal Government.[168, 169] It was also consistent with the late 1980s and 1990s understanding of growth and economic development in the private and public sectors. As an exclusive and academically conceived approach from the CIAR, population health (in contrast to the grassroots nature of health promotion) emphasized quantitative evidence and used conventional scientific language. It therefore appeared objective, with its reliance on determinants of health data to direct health policy, and, due to its call for a research agenda, appeared to answer more definitively the question of why some people were healthier than others and what the exact links are between determinants and health. By comparison, health promotion did not question what appeared to be obvious prerequisites of health.[170] This meant that less emphasis was placed on research, less evidence was required for funding and that the research carried out was aimed at evaluating health behaviours and interventions. Health promotion also argued for the importance of an inclusive process of drawing diverse community voices into policymaking. Given the change in context, population health was regarded as having the potential to reach new and different players than those influenced by health promotion.[171]

Population health research directing Health Canada's policies and programs was also timely given that issue-specific strategies were to sunset and funding for core programs was expected to drop significantly. Central agencies were indicating that no new money was to be expected for programming, that departments had to reallocate resources from within. With determinants pointing out clearly that departments/sectors other than health had responsibility for health status, the population health approach had the potential to allow Health Canada to justifiably withdraw to some extent from programming.[172, 173] The model may also have been timely in that the provinces and territories were challenging federal action in the area of health and social service policy, thereby constraining the federal government's earlier leadership role in health promotion with its direct community development facets.[174]

From a different perspective, political and public challenges were expected if Health Canada were to make a case for investing in action that would positively affect the determinants of health while the government was responding to economic pressures, in particular, deficit reduction – "[b]ecause human development and economic development goals may conflict in the short term, winning public and political acceptance for trade-offs may be difficult."[175] The gains accruing from pursuing economic development would likely be more immediate (for example, under 10 years) and more tangible than the diffuse and sometimes abstract benefits to health that can occur over the course of a lifetime or beyond with social level investments in, for example,

schooling, housing and waste management.[176] Put another way, if the returns on social investment were to be measured only in economic terms, the time frame for the investment becomes too long.[177] Particularly difficult in the political sphere would be determining the types of communication (marketing) strategies required to "bridge the gulf between long-term processes, and short-term expectations" and political mandates.[178, 179]

The broadness of the non-medical determinants of health and the corresponding intersectoral action needed appeared as a challenge to Health Canada's leadership and credibility among other federal departments. Other departments could rightly argue that they were already acting in the interests of the public good from the point of view of their policy frameworks and could view the pervasiveness of the population health approach as "health imperialism."[180] As well, the extensive cross-sector policy planning required a new administrative/organizational capacity.[181] There were also fears of public cynicism toward the determinants of health approach, it being seen as a means to obscure shrinking resources for health care.[182] Acceptance of the new paradigm, where determinants of health other than health care would be privileged with resources, was seen to require a concerted communication effort to significantly increase the health literacy among stakeholders and the public, to inspire Canadians as citizens rather than consumers to support the approach.[183]

As to Health Canada's prevailing culture, the population health approach in the 1994 *Strategies* document was unsettling to those who had supported, advocated and advanced the health promotion policy paradigm that had dominated the preceding 15 years. The *Strategies* document made no mention of health promotion's accomplishments and contributions, for example, to the healthy public process and policy – clearly related to the intersectoral collaboration required in implementing a population health approach.[184] The philosophical differences between proponents of each approach ran deep. Some health promoters saw population health as a top-down narrow emphasis on macro-level socio-economic levers that ignored the importance of participatory community level processes in policy development. On the other hand, some advocates of population health saw only the lifestyle/social marketing component of health promotion and not the broad-based bottom-up community development aspects, therefore underestimating its contributions to social determinants of health.[185, 186]

An attempt was made to reconcile the two positions from a conceptual perspective in 1996 by a "population health promotion" model developed in the Health Promotion Development Division of HPPB.[187] The model combined population health and health promotion into a three-dimensional policy and practice cube that intersected the determinants of health, all the levels of population from the individual to society and the five health promotion strategies in the *Ottawa Charter.* While the integrated model was genuinely supported both within and outside Health Canada and gained some currency when the shift in paradigm was discussed, the population health approach with determinants continued to ascend within Health Canada. "Population health promotion" was also unable to placate all advocates of broad-based health promotion who continued to see health promotion as unduly eclipsed by population health, particularly in a context of competition for scarce resources.[188] Health Canada's legacy of health promotion began to fade in corporate memory and its decline left a sense of grief among some over the loss of leadership at the national level.[189] Despite the uncertainties and controversies surrounding a

population health approach, it became the new overarching model to guide health policy across the Department and its business lines.

3.4 Health Canada's Role Changes

The acceptance of the new paradigm by Health Canada represented a significant shift regarding policy development for the federal health department between the 1980s and the 1990s. Whereas it had been a leader in concept development and future direction regarding health (promotion) policy in the 1980s using its own capacity, the Department in the 1990s came to accept the research on the determinants of health of an outside organization – the CIAR – through a cross-jurisdictional structure – the ACPH.[190, 191] The influence of the ACPH was applauded by some who saw the proper location for health policy development to be a federal/provincial/territorial body as opposed to a federal department policy shop. Producing research and driving policy significantly broadened the scope of activity for an advisory committee whose previous function was limited to information sharing and advising the Deputy Ministers of Health. Also new was the fact that an outside research agency directly supplied the direction for policy development for Health Canada. This was viewed negatively by some who saw it as evidence of the decline in policy development capacity within government departments.[192]

Theoretically, the determinants of health model allowed the Department to identify, and within the federal role, act on the best investments to influence the determinants that lie outside the health care system. A maturing body of population health research supported this move and the new federal emphasis on greater horizontal policy coordination. Evidence became a new lever and Health Canada saw its new core functions as:[193, 194]

- a national/international focal point for health intelligence;
- a national focal point for the analysis and synthesis of this intelligence;
- a catalyst for leveraging national action on the basis of the intelligence, that is, move from direct delivery and unilateral responsibilities to mobilization of action by virtue of joint efforts, transfers and partnerships.

3.5 Operationalizing a Population Health Strategy

Reduced fiscal resources, the underlying context of the 1990s, profoundly shaped how the new approach would be operationalized. To signal the acceptance of population health as its paradigm for thinking about health, Health Canada adopted a determinants of health perspective in its mission statement. With population health in mind along with reduced funding, the Department began adapting structurally by streamlining itself around four core businesses:[195]

- Health System Support and Renewal (health insurance, health services)
- Management of Risks to Health – Products and Disease Control
- Population Health Strategies – Groups at Risk

- Delivery of Services to First Nations, Inuit and the Yukon

Two other business lines captured the remainder of Health Canada operations: Health Policy, Planning and Information, and Corporate Services.[196]

Between 1993-94 and 1994-95, at the time that Health Canada was created, the Health Services and Promotion Branch changed to the Health Programs and Services Branch (HPSB). However, in March 1995, the Branch underwent a major restructuring to integrate its programs and policies along the departmental business lines. The HPSB changed to the Health Promotion and Programs Branch (HPPB) divided into four directorates: Research and Program Policy and Planning; Population Health; Systems for Health; and Management Planning and Coordination.[197] With most population health activities falling within HPPB, the Branch took the lead on the Population Health business line and the development of a Population Health Strategy although both crossed all branches of the Department.

In mid-1995, an inter-branch Steering Committee and Working Group on Integrated Population Health Strategies began to address the conceptual and organizational challenges posed by the transition to a determinants of health approach in the Department. Informing the task later on was the April 1996 document – *Toward a Common Understanding: Clarifying the Core Concepts of Population Health for Health Canada.*[198] It provided a working definition of the population health approach, a conceptual framework for the approach and focussed on the conditions of risk as targets for investment. In the same year, ACPH delivered its first *Report on the Health of Canadians*. As the first of two sets of data on the state of Canadians' health produced by this Committee in the 1990s, the report took the amount of knowledge of the health of the Canadian population to a new level. Based on Canada's Health Promotion Survey of 1990 and the National Population Health Survey of 1994-95 (and the second one, the National Population Health Survey of 1996-97), statistics on each determinant of health are presented. This serves as the basis for identifying challenges and priority areas to improve health status.

Following the directions of program review, by early 1996 the Steering Committee and Working Group conceptualized a Population Health Strategy that permitted the Department to organize and priorize future programs as a group, with envelope funding. The *Strategy's* framework had three major life stages into which programs were to be organized: children and youth; early and middle adulthood; and later life. As an organizing principle, the life cycle structure was seen as consistent with the population health research literature, which stated that success or failure at previous life stages can play an important role in determining the probability of success in subsequent life transitions.[199]

The intention was to give programs stability by shifting them from contingent funding to ongoing operational funding (A-based). Grouping the programs was also intended to reduce the number of submissions to Treasury Board and allow more internal discretion and flexibility in allocating resources to new or emerging issues while reducing the pressure of issue-specific interest groups.[200, 201, 202]

In early 1997, Health Canada's Memorandum to Cabinet on Population Health was received at the Privy Council Office (PCO) and subsequently the Cabinet Committee on Social Development Policy. It had the benefit of input from 18 departments outside Health Canada by virtue of an Interdepartmental Reference Group brought together by HPPB for collaborative work from a population health perspective.[203] Cabinet formally agreed to adopt the population health approach to guide its health policy. Health Canada was confirmed as the lead with its Integrated Population Health Strategy. From other ministers, Cabinet wanted a commitment that they would work with Health Canada in developing tools and mechanisms to assist in assessing the health impacts of federal policies and programs.[204]

Population Health Framework

To give the population health framework "greater momentum and reach," decisional structures and mechanisms needed to be adapted to ensure that public policies balanced health with other sectoral priorities. Options for such mechanisms included:

- intra- and interdepartmental exchanges of policy staff
- population health responsibility centres identified in each department
- re-establishment of formal links between health and social portfolios
- fuller application of specific "lenses" that support the population health model (for example, gender-based analysis)
- establishment of consortia of federal departments and agencies with major influence on key determinants, each under the leadership of one minister
- assigning Health Canada the responsibility to review the activities and decisions of other departments and to advise Cabinet
- creation of a National Population Health Institute as an overseer of population health trends and evaluator of public policy.

Source: *Population Health: From Vision to Action*, 1997, p. 12 and 13. Population Health – Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

Health Canada realized that it needed "a vision and strong leadership to champion the concept and ensure that it effectively '[took] root.'"[205] It began work on modules that were to advance the new population health paradigm:

- *consultation and consensus building* within the Department, with federal/provincial/territorial mechanisms, with the voluntary sector and through a population health conference;

- *securing support* ranging from within the Department, to Cabinet, to the provinces and territories, NGOs, the Canadian public and international bodies;

- *building infrastructures* to support population health accounts[206] and joint projects; and

- *research and knowledge development* with support for new and ongoing infrastructures and initiatives including adoption of concepts such as "sustainable human development" and "health as a component of well-being."[207]

The communication strategies to accompany the launching of Health Canada's population health approach were delicate. Not only were messages about strategic action on population health expected to be clear and consistent, they were to be separate from messages about budget reductions. As well, all external communication documentation was to be reviewed by the PCO before release.[208]

In 1997-98, Health Canada was moving to implementing the Population Health Strategy. Programs left after sunsetting were organized by the three life stages with three remaining issue-specific allocations, namely HIV/AIDS, breast cancer and tobacco.[209] However, the 1997 federal budget and the federal general election confirmed the Liberal's objective of a balanced budget, creating the expectation that the source of funds for new initiatives in the Red Book II would fall short of their original commitments.[210] So despite the endorsement of population health as an upstream approach to improving health, no new money meant that the Population Health Strategy was threatened as the majority of activities related to population health were based in programs due to sunset in 1998-99.[211, 212]
Between 1996-97 and 1998-99, funding for the Population Health business line was to decrease by 34.9 percent.[213] (The figures do not include additional funds for special F/P/T and Red Book commitments, examples of which, in 1997-98, were the Community Action Program for Children (CAPC), the Canada Prenatal Nutrition Program (CPNP) and Aboriginal HeadStart).[214, 215]

With 80 percent of the Population Health Strategy resources allocated to HPPB, the impact of funding decreases was significant on the HPPB program issues/initiatives/strategies (19 percent had been allocated to the Health Protection Branch and 1 percent to the Policy Coordination Branch).[216] HPPB resources for fiscal 1995/96 were about $325 million down to an expected $149.4 million for fiscal year 1998/99 (including additional funding for special initiatives). The majority of the Branch resources (about 72 percent) was within the

Population Health Defined

In January 1997, the ACPH defined population health as follows:

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.

As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.

Source: Health Canada, Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians*, September 1999.

Population Health business line. In the meantime, Health Canada was also considering modernizing medicare with pharmacare and home care programs; strengthening the health system infrastructure; and resourcing information collection and research. So whereas all Canadians were the intended target of a strategy to improve health based on population health research, the significantly reduced funding along with competing priorities limited Health Canada's ability to play out all of its new roles. With all programs being pared back, tough choices were made. Children and youth, including community action, were given priority while fewer programs in the adult and senior stages could be fulfilled at that time.[217] HPPB was to attribute 65 percent of its funds for the Population Health business line to three ongoing major children's programs, such as the Aboriginal HeadStart Program, the Community Action Program for Children, and the Canada Prenatal Nutrition Program.[218, 219] Following a pattern of limited funding that hindered operationalization of the Lalonde Report and *Achieving Health for All*, the federal government's fiscal preoccupations once again compromised the broad vision of a new approach.

3.6 The Current Situation

In the Fall of 1997, a *Blueprint to Promote a Population Health Approach in Canada* was released, identifying six action areas and expected outcomes that were to institutionalize a population health approach within HPPB. The core areas were:

- theory – develop further the theoretical framework for population health to integrate evidence that suggests policy and program interventions and provide a knowledge base for developing tools needed to apply a population health approach;

- policy – incorporate the population health approach into the public policy process in all sectors with tools for priority setting and accountability, such as population health reporting and health accounts;

- evidence – encourage research agendas that address population health priorities and health information systems that capture population health data;

- marketing – inform and influence decision makers, stakeholders and the public about population health through communication campaigns, workshops, presentations and publications;

- mobilization – develop tools, partnerships and approaches that support implementation efforts; and

- institutionalization – strike joint committees, establish appropriate policies and structures within organizations, and provide organizations with clear mandates for reporting and evaluating population health initiatives.

To champion the institutionalization, a Major Projects Directorate was established, albeit as a temporary body to be disbanded once population health was firmly established.[220] A team of

champions, expected to be at the Director General level, were to be lead by the DG of the Major Projects Directorate. Shortly after its creation, the Directorate was tasked with acting on the recommendations of the National Forum on Health regarding establishing a population health institute.[221]

This idea was taken to the next stage of development with the establishment of a population health initiative within Health Canada that was seed funded with $1 million from the HPPB policy branch and the Health Transition Fund. This enabled development of an interim governance structure and support for demonstration research projects to show the potential of an institute. When new funds under a broader health information initiative involving the Canadian Institute for Health Information (CIHI) and Statistics Canada were announced, the initiative moved to CIHI.[222] This was given the title the Canadian Population Health Initiative.[223]

However, progress toward institutionalizing a population health approach was uneven and a momentum was not achieved in the Directorate. At the outset, some new people had come to the Directorate who had not been involved in the development of the *Blueprint* document and taking action on the core areas was felt to be confusing.[224] As well, the influential team of DGs was not realized, rather the members were mostly at the Director level. In addition, the Directorate eventually became permanent and was given new responsibilities for other special projects, for example, hepatitis C. But, no new resources were allocated because of competing priorities, one of which was the ADM wanting to increase the policy capacity of HPPB.[225]

In the meantime, Health Canada's public profile with regard to population health had been outlined in *Health Agenda 2000*, a companion to the *Blueprint*, with four visible strategies emanating from it:[226]

- leadership in population health and accountability to the public through a number of high profile initiatives;

- partnership with the voluntary health sector to increase the capacity of public empowerment and consumer participation;

- ensuring optimal child development through a substantial expansion of community programming for children (healthy child development and initiatives part of the National Children's Agenda[227]); and

- continued disease and injury prevention and coping with an aging population through initiatives dealing with tobacco use, breast cancer, HIV/AIDS, Canada's Drug Strategy and a National Framework on Aging.

Over 1998, ministerial attention was to be directed at children's issues, working with Cabinet and provincial/territorial health ministers to establish the National Children's Agenda, then securing resources for expanded children's programming and reaching federal/provincial/ territorial agreements on implementation under the umbrella of the social union.[228] The Minister was also to secure further resources for targeted health promotion efforts to improve balance and to respond to emerging issues, for example, prostate cancer.[229]

By 1998-99, all action was realigned into the lifecycle framework.[230] The Department had shifted from viewing health as an objective to seeing it as a consequence of policy coming from all federal departments, with its task to work horizontally as key informant or steward of the policy impacts on determinants of health.[231, 232] By extension, the Department was moving from a resource base that supported direct community action through individual strategies to one expected to support community action only by exception.[233] The top priority for action was consultations with provincial and territorial and other partners to identify opportunities for intersectoral collaboration and a strategic plan for partnerships. Repeating the rationale for health promotion, efforts were to be focussed on investments that could realize a significant multiplier effect in later savings in health and social service sectors.[234] The earlier Population Health Strategies – Groups at Risk business line was renamed Promotion of Population Health.

Expectations for 1999 were: that the federal position with respect to action for children would be consolidated, including the launching of Centres of Excellence for Children's Well-being, and that the visibility of a number of population health initiatives would be raised; the release of a second *Report on the Health of Canadians* in September 1999; announcing the resources for a Population Health Institute; launching a Population Health Clearinghouse within HPPB; acknowledging the International Year of Older Persons; a number of millennium initiatives; and further development of national population health accounts. In the year 2000, the Population Health Institute is to be launched along with "Millenium showcases" and an international conference on population health.[235] Each high profile component of the *Agenda* was to have a launch, media coverage and visible activity.[236]

At this juncture, the primary ways in which the *Strategies* document and the population health approach have been operationalized within Health Canada are: structural change, investing in research on the determinants of health and promoting acceptance of the approach. To move beyond these steps, Health Canada faces a number of key challenges:

- establishing structures and mechanisms for sustainable intersectoral policy development and collaborative action[237]

- demonstrating the ability of the population health approach to produce better health outcomes, and

- ensuring that it is a sustainable approach to health (lest it ascend and decline like health promotion)

Aside from research to find the causal links between socio-economic determinants and health status, population health has yet to offer the other means to improve health status. In producing volumes of statistics, at least one observer thought that this approach set far more ambitious health improvement goals for which government may be held accountable.

Meanwhile, the federal government has expressed renewed engagement and concern with medicare. The current Minister of Health, the Honourable Allan Rock, showed interest in expanding pharmacare and home care while cutbacks to health care became a point of contention between the provinces and federal government. Public support for the insurance of "the repair

shop" suggests that the vision of equal expenditures for prevention as for cure articulated in the Lalonde Report may be just as far out of reach at present as was the case 25 years earlier.[238] The single most daunting challenge facing proponents of a population health approach to improving health, may be suggested by the following:

> ... the healthier Western society becomes, the more medicine it craves – indeed, it regards maximum access as a right and duty. (Roy Porter, 1997. [239])

Conclusion: Themes and Observations

Over the 25 years of health policy development at the federal level, the development and operationalization of the two dominant and related paradigms – health promotion first, followed by population health – have been affected by a number of factors or drivers, or "confluences of events" as a number of interviews pointed out. It was not enough to conceive of an idea for it to be implemented, nor perhaps was implementation always the intention of policy documents. We have found certain drivers that have prevailed and we have taken these to represent crosscutting themes. In taking this tactic, we do not judge the relative success or failure of each approach. Instead, we compile the themes and construct an account of the most significant factors to have influenced health policy development and implementation at the federal level since the release of *A New Perspective* in 1974. To conclude, two observations are also raised in response to the history of federal health policy development.

The shared trajectory of the three documents and their health promotion and determinants of health concepts represent policy paradigms founded on evidence that health care spending is delivering diminishing returns. This points to promoting health upstream from the treatment and cure system not only for its own sake but to eventually reduce the health care burden. As the first means to that end, the Lalonde Report served to transform one of the mainstays of public health, health education, into health promotion. A confluence of political and public wills, an inspired bureaucracy, federal/provincial jurisdictional issues and fiscal constraint gave rise to "thinking outside the box" such that at least one non-medical determinant of health, lifestyle, moved to the forefront. Approximately 10 years later, virtually the same factors influenced the creation of *Achieving Health for All,* which tightened the conceptual connection among the four quadrants with a healthy public policy approach. It was based on public empowerment strongly attached to a bottom-up process aimed at addressing inequities in health. By the late 1980s, the community action orientation of *Achieving Health for All* was replaced by a top-down, more institutional approach to addressing the determinants of health. Population health called for scientifically rigorous research to find specific social and economic levers that influence health status as the basis for health policy.

As to the development of the three documents, the way in which they came about warrants contrast. Both the Lalonde Report and *Achieving Health for All* were conceived within Health Canada by specifically tasked "think tanks" that were to different extents removed from the day-to-day demands of the bureaucracy. Despite federal power and responsibility for health care receding with successive federal/provincial/territorial funding arrangements over a 25-year period, health service issues, policy and programming remained relatively dominant and pervasive. Given this context, the emergence of creative ideas of both new paradigms (health promotion and population health) appeared contingent on the opportunity to step away from routine. The protected space of the kind that the Long Range Health Planning Branch and, to a lesser extent, the Health Promotion Directorate enjoyed was crucial to the germination of new ideas. By the early 1990s, such spaces no longer existed. Instead, the CIAR, an external research body, contributed to the development of a population health framework and delivered the new paradigm to Health Canada.

Regarding the individual factors that have prevailed and influenced how health promotion and population health concepts have been operationalized over 25 years, a key factor is the *preoccupation with medicare.* Non-medical health policy was and continues to be sidelined each time health care concerns are raised. In 1977 it was the EPF, then the development of the *Canada Health Act*, its enactment in 1984 and subsequent implementation. More recently, health care has been on the agenda with the Canada Health and Social Transfer and the current interest in modernizing medicare with pharmacare and home care. This reoccuring trade-off in attention paid to one or the other reflects the separate spheres that have developed between health promotion and population health on the one hand, and medicine and the health care system on the other. Contributing to this, *A New Perspective*, *Achieving Health for All* and the *Strategies* document make a clear separation of health from health care. While this may have served a valid purpose in calling attention to social aspects of health at the time, drawing out the connections between health and health care may be critical to making non-medical approaches sustainable and a primary rather than secondary means to improving health. Although other factors such as jurisdictional matters and ability to influence certain determinants of health cannot be underestimated, reconciliation may be the best way to ensure that population health remains a policy focus at Health Canada.

During this period, dovetailing with the reoccurrence of attention toward health care is *the pressure to reduce federal spending*. In response, Health Canada limited its reach with health promotion and the population health approach. Even at its pinnacle during the mid to late 1980s, the vision of broad-based health promotion embedded in core programs of the HPSB and later HPPB was overshadowed by higher profile issue-specific strategies with significant social marketing components. At resource allocation time, it was the issue strategies that could compete to a greater extent with the visibility of health care issues. More recently, the potential fiscal implications of modernizing medicare have contributed to Health Canada dealing mostly with the inequities in health related to one life stage, early childhood, as opposed to addressing the broader vision of population health at all points in the life cycle. The pattern of funding visible, issue-specific social concerns instead of broader mandates raises the question of whether this approach is preventative or remedial. What role any government, and the federal government in particular, should have in protecting and improving the health of Canadians, remains open to debate. It is tied to, but separate from, the debate on how health is achieved. Together, the mire of confusion and conflict between jurisdictions and researchers over what should be done in health has culminated in a logjam.

Jurisdictional issues between the federal and provincial/territorial governments have been a constant element of the backdrop to health policy development in Health Canada. Health Canada has been withdrawing from direct program delivery in favour of other mechanisms or agencies for intervention that do not collide with provincial jurisdiction. With the division between federal and provincial responsibilities and actions regarding health becoming more distinct over the 25 years, Health Canada has had to re-invent its national leadership role. While it found a footing with health promotion, in particular through issue-specific lifestyle/social marketing initiatives, evolving as a leader in dealing with inequities in health is one consequence of the delineation and evolution of federal versus provincial/territorial roles and responsibilities that may pose a great challenge to Health Canada. In fact, the leadership potential for Health Canada may become diffused as other levels of government and voluntary organizations become more involved in

population health, and evidence mounts that more and more of the determinants of health and corresponding interventions lie outside the health sector.[240]

Another consequence of the firming up of jurisdictional boundaries has been the *growing influence of cross-jurisdictional mechanisms* for jointly exploring and developing health and social policy. The Advisory Committee on Population Health is a good example of such a mechanism. While its relatively strong influence on the uptake of a population health approach to policy development in Health Canada owes much to the influence of its members (and the Conference of Deputy Ministers), it nonetheless demonstrates a change in when and how federal/provincial/territorial consensus is reached regarding high level policy direction. Whereas *A New Perspective* and *Achieving Health for All* were conceived within Health Canada and then promoted to the provinces and territories, the population health approach came to Health Canada from the Canadian Institute for Advanced Research via the ACPH (and the Conference of Deputy Ministers of Health), with some provinces already having adopted the approach.

Health Canada owes its evolving role in health policy in part to the *influence of champions* on the conceptualization and uptake of ideas. Critical players created and guarded "space" for the viewpoints they supported in order to nurture ideas and allow them to grow. Health promotion in particular benefited from such support. Regarding a population health approach, a champion and political vantage point within Health Canada is yet to be found. However, the broadness of the determinants of health and the corresponding requirement for cross-sectoral policy development suggest that the next leaders may, in fact, not be from Health Canada. Witness the 1998 child tax benefit initiative of Human Resources Development Canada. If healthy public policy is to be pursued within the population health promotion rubric, a champion's role and tenure, no matter from which department, may be defined by a particular determinant and policy and may be comparatively short. Advancing a population health approach, therefore, calls for a collective of champions from various sectors seizing opportunities for action when they arise.

A related theme, whose emphasis has grown over the 25 years since 1974, has been *the call for cross-sector collaboration* in developing policy that affects health. The Lalonde Report stated "[o]ne of the main problems in improving the health of Canadians is that the essential power to do so is widely dispersed among individual citizens, governments, health professions and institutions...[u]nder the Health Field Concept, the fragments are brought together into a unified whole...[t]his unified view ...may well turn out to be one of the Concept's main contributions to progress in improving the level of health."[241] Indeed, this was a seed for the legacy of cross-sector collaboration that evolved as "healthy public policy" in *Achieving Health for All* and was re-labelled "intersectoral collaboration" in the population health approach. The call for collaborative action has been echoing for 25 years from many quarters of the federal government. While it is intuitively appealing and understandable, it is also one of the most difficult initiatives required to address inequities in health.

A final theme spanning the period 1974 to 1999 was *the contribution of social marketing* to the acceptance and longevity of concepts within the government and among the public, in particular, health promotion. While it is said to address the relatively easier components of broad-based health promotion, that is, dealing mostly with individual behaviour, social marketing nonetheless packaged messages about certain lifestyle issues in such a way that the messages were absorbed

and, in some cases, created or supported a social culture that promoted healthier behaviour. As well, the positive nature of the messages was palatable and understandable to politicians, hence gained their support and the resources they controlled. Regarding population health research findings, it is uncertain that such techniques can be applied – can Health Canada package a determinants of health message to develop a general understanding and support for the concept, given that most health determinants are outside the health sector, are beyond the control of the individual and still require more definitive research? From this perspective, the longevity of political support in Health Canada for deriving health policy within a population health paradigm may appear uncertain.

Appendix A

Ministers of Health since 1974

Minister	Political Party	Tenure
Marc Lalonde	Liberal	November 27, 1972, to September 15, 1977
Monique Bégin	Liberal	September 16, 1977, to June 3, 1979
David Crombie	Progressive Conservative	June 4, 1979, to March 2, 1980
Monique Bégin	Liberal	March 3, 1980, to September 16, 1984
Jake Epp	Progressive Conservative	September 17, 1984, to January 29, 1989
Perrin Beatty	Progressive Conservative	January 30, 1989, to April 20, 1991
Benoit Bouchard	Progressive Conservative	April 21, 1991, to June 24, 1993
Mary Collins	Liberal	June 25, 1993, to November 3, 1993
Diane Marleau	Liberal	November 4, 1993, to January 24, 1996
David Dingwall	Liberal	January 25, 1996, to June 10, 1997
Allan Rock	Liberal	June 11, 1997, to present

Appendix B

National Goal Setting

> "'If your health strategies are to be effective they will have to go far beyond statements of good intent, however genuine these may be. They will have to indicate in very practical terms what action your countries will in fact take in the health sector and in other sectors concerned.'" (Dr. Halfdan Mahler, Director General of WHO, May 1980. [242])

One idea put forward several times during this period that did not come to fruition at the federal level is setting national health goals. As early as 1974, one of the five strategies proposed in the Lalonde Report was goal setting. National goals were to provide a united and reinforced sense of direction for those who work in the health field; they were to have time limits and be stated in quantitative terms. In contrast to Canada, Sweden, the United States and the WHO European Region were inspired by the Lalonde Report to develop specific health objectives and strategies.[243]

There has been considerable energy devoted to the idea of setting Canadian health goals over the past 25 years. From Health and Welfare, Dr. Maureen Law, Assistant Deputy Minister and Deputy Minister from 1986 to 1989, spoke of "objectives" and "sub-objectives"as early as 1980 at the annual conference of the Canadian Public Health Association (CPHA). This was raised as an example of how to develop the commitment and momentum to prevent or substantially reduce the risk of handicap in newborns.[244] Since 1984, the Canadian Public Health Association passed resolutions at its annual meeting expressing the need for national health strategies and goals.[245] During the meetings with provinces, territories and NGOs in 1987, following the release of *Achieving Health for All,* frequent mention was made of health goals. They were a high priority for both provinces and NGOs. By 1989, Ontario had qualitative provincial health goals and Quebec and New Brunswick were proposing them.[246] At the first national conference on chronic diseases in May 1989, one of three conference objectives was goal setting regarding chronic disease prevention. In the same year, the F/P/T Advisory Committee on Community Health was discussing a paper on goal setting and the topic was discussed at a Conference of Deputy Ministers of Health.[247] At the 1989 National Symposium on Health Promotion and Disease Prevention sponsored by the provinces, Dr. Law again addressed goal-setting.[248] In 1992, the CPHA's number one recommendation in its issue paper on F/P/T arrangements for health policy was that Canada establish an overall strategy for health with clear goals for health status.[249]

In 1994, the ACPH struck an F/P/T Task Group on National Health Goals/Priorities, which produced an *Analytic Review Towards Health Goals for Canada.* The analysis was to assist the Task Group in making recommendations to the ACPH about possible joint development of national health goals by the federal, provincial and territorial governments. While the project was not intended to actually develop health goals, it proposed a framework for their content based on commonalities in work done in Canada and abroad, and to propose principles, approaches and options for a process to develop them.[250] However, because a number of provinces were already involved in their own goal-setting process and were not enthusiastic about trying to reach consensus on a set of national goals, and because funding issues arose, ACPH decided to not proceed with national health goals. Instead, it transposed the health goals framework into a

population health framework and produced the *Strategies for Population Health: Investing in the Health of Canadians*.[251]

The ACPH reiterated its recommendation for national health goals in its 1996 *Report on the Health of Canadians* and in 1997, called for the establishment of national population health goals and a Canadian "health charter."[252] Goals would be established within the framework of three life stages in which Health Canada programs were aligned. Analogous to the Canadian Charter of Rights and Freedoms, a Canadian "health charter" would articulate the rights and obligations of citizens, governments and other organizations/institutions with respect to health and establish a legal framework for priority action on health issues.

Another document produced by the Institute of Health Promotion Research in British Columbia, submitted to the Health Promotion Development Division of Health Canada in 1996, also called for national health goals and objectives with a corresponding health impact assessment tool to evaluate the impact of health reform on health and quality of life.[253] Another corollary to national health goals was a department or arm's length agency (for example, a National Population Health Institute) as an accountability mechanism for monitoring attainment of goals.[254]

In 1997, the departmental Population Health Steering Committee's vision for Canada by 2005 was for national membership in the group of OECD nations that have established and are monitoring progress toward population health goals. Success was expected to be partly due to a gradual shift in policy focus from deficit reductions to re-investment of resources in human development.[255]

By 1998, federal/provincial jurisdictional issues lead the ACPH to change its mind regarding national health goals and targets. It instead developed the following national health strategies with a population health perspective, endorsed by the Conference of Deputy Ministers of Health, that define a framework for the provinces to adapt to their own needs:

- ensuring positive and supportive living and working conditions in all communities;
- ensuring a safe, high quality physical environment;
- ensuring individuals have opportunities for healthy development and supports to make choices that enhance their health and foster their independence;
- ensuring appropriateness of and affordable health services, accessible to all; and
- reducing preventable illness, injury and premature death.

The challenges to national goal setting are formidable. Debate continues as to whether goals make any difference to performance. Advocates argue that targets are necessary or at least useful to ensure there is action taken to improve health status. Critics argue that innovation is less likely when there is formal adoption of goals since they are simplistic in that they ignore or underestimate the variety of conditions and practices surrounding a disease or condition. Agreement between federal and provincial governments on achievable goals is also difficult. Funding between levels of government is contentious as is accountability for goal attainment, and there is fear of the political consequences of setting time limited goals that may not be achieved.[256] There is also debate over whether goals should be quantitative or qualitative, for example, the goals developed by the Ontario Premier's Council on Health Strategy are

qualitative.[257] If they are quantitative, then the concern arises that the data needed to measure goal achievement must be valid and reliable.[258, 259, 260] Perhaps the strongest argument against specific national health goals may have been that most of the goal and target setting action is taking place at the provincial and regional levels where responsibility for health resides; if the federal government were to set goals, it is likely to arouse jurisdictional issues.[261]

Notes

1. Interview with Huguette Labelle, former Chair of the Working Group on Priorities and Strategies re: *A New Perspective on the Health of Canadians* from 1974 to 1976, December 8, 1998.

2. Hayes, Michael and Sholom Glouberman, "Population Health, Sustainable Development and Policy Future," CPRN Discussion Paper No. H|01, Ottawa: Canadian Policy Research Networks, September 1999, p. 3.

3. O'Neill, Michel and Ann Pederson, *Two Analytic Paths for Understanding Canadian Developments in Health Promotion*, in Pederson, A., O'Neill, M. and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto, W. B. Saunders, 1994, p. 43.

4. McKay, Lindsey, "Making the Lalonde Report: A Brief History," Background paper, Ottawa: Canadian Policy Research Networks, 2000.

5. McKay, "Making the Lalonde Report," op. cit.

6. Ibid.

7. Lalonde, Marc, *A New Perspective on the Health of Canadians: A Working Document*, Ottawa: National Health and Welfare, April 1974, p. 31.

8. McKay, "Making the Lalonde Report," op. cit.

9. PAC, Department of National Health and Welfare, RG 29, volume 1733, file no. 6670-14-8, Letter from Bert Laframboise, DG, LRHPB, to Dr. Lee Hyde, staff at the House Commerce Committee, Washington, dated September 18, 1974.

10. Lalonde, *A New Perspective,* op. cit., p. 33.

11. Ibid., p. 37.

12. Ibid., p. 30.

13. Ibid., p. 6.

14. McKay, "Making the Lalonde Report," op. cit.

15. Ibid.

16. Marmor, T. R., M. L. Barer, and R. G. Evans, "The Determinants of a Population's Health: What Can Be Done to Improve a Democratic Nation's Health Status?," in Robert G. Evans, Morris L. Barer and Theodore R. Marmor (eds.), *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, New York: Aldine De Gruyter, 1994, p. 221.

17. "Notes of Welcome to Members of Parliament by the Acting Deputy Minister of Health, Briefing to MPs by the Health Side," National Health and Welfare, RG29, volume 1559, file 1008-6-3 dated December 12, 1974.

18. H. L. Laframboise, Director General, LRHPB, wrote frequently of social marketing. In 1972, he circulated an article on the topic by Philip Kotler and Gerald Zaltman entitled "Social Marketing: An Approach to Planned Social Change." He introduced it by saying the technique was "central to many health issues" and suggested that the "propositions advanced in the article should perhaps be made available through the employment of one or more skilled marketing specialists on the health side who could advise the many units who are involved in promoting social change." RG29, volume 1556, file C-1010-5-1A (1008-5-1), Memorandum to senior management (including Ron Draper) dated November 29, 1972.

19. Quoted in Robin F. Badgley, *Health Promotion and Social Change in the Health of Canadians*, in Pederson, A., O'Neill, M. and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto: W. B. Saunders, 1994, p. 25.

20. Lalonde, *A New Perspective*, op. cit., p. 36.

21. Ibid., p. 37.

22. Interview with Huguette LaBelle, December 8, 1998.

23. Ibid.

24. RG29, volume 6, file 6009-NI-3, "Priorities and Strategies: Overall Review," January 1976, p. 1.

25. RG29, volume 2, file 6009-NI-2, "Why Are You Here?: Background to New Federal-Provincial Advisory Committee Structure," p. 16.

26. RG29, volume 2, file 6009-NI-3, "Working Group on Priorities and Strategies in Relation to the Document 'New Perspective on the Health of Canadians,'" February 25, 1975, by Thomas J. Boudreau, Assistant Deputy Minister, Long Range Health Planning Branch, p. 1.

27. Ibid., p. 2.

28. Ibid., p. 3.

29. RG29, volume 2, file 6009-NI-2, "Departmental Steering Committee Priority Planning in Relation to the 'New Perspective,' Minutes of Meeting July 28, 1975," p. 2.

30. Interview with Jo Hauser, September 13, 1999, former Policy Planning Consultant, Long Range Health Planning Branch, Health and Welfare Canada, from 1971 to 1974.

31. RG29, volume 6, file 6009-NI-3, "Working Group on Priorities and Strategies – Progress Report," November 1975, by Neil Collishaw, Working Group on Priorities and Strategies Re *A New Perspective on the Health of Canadians*, p. 8.

32. RG29, volume 6, file 6009-NI-3, "Priorities and Strategies: Overall Review," January 1976.

33. Pinder, Lavada, *The Federal Role in Health Promotion: Art of the Possible,* in Pederson, A., O'Neil, M., and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto: W. B. Saunders, 1994, p. 97.

34. Lalonde, Marc, *A New Perspective on the Health of Canadians,* Ottawa: National Health and Welfare, April 1974, p. 32. Notable in the worldview presented in the report is an absence of the family. Individuals and the environment are the two categories of existence, independent of relationships in between.

35. Health Canada, *Health Promotion in Canada: A Case Study,* Ottawa, June 1997, p. 21.

36. RG29, volume 9, file 6030-T-25-2, part 1, "Organizational Options for Lifestyle and Health Promotion," May 2, 1978, p. 1.

37. RG29, volume 155, file 60400-F-17-1, "Notes for an Address by Mr. R. A. Draper to be presented at the First Canadian Conference on Health Promotion – Roles and Action Priorities for the 80's, Ottawa, January 19-20, 1981," p. 6. The Advisory Committee on Health Promotion gave its first attention to establishing a health promotion planning framework and selecting areas of priority interest. This was completed by its last meeting in September 1980. The six priority areas were: tobacco; safety; nutrition for pregnant women and pre-school children; health promotion for adolescents; alcohol use among adolescents and young adults; and emotional well-being.

38. RG29, volume 9, file 6030-T-25-2, part 1, “Lifestyle and Health Promotion Directorate Guide to Transition Phase,” p. 1.

39. Ibid., p. 2.

40. RG29, volume 9, file 6030-T-25-2, part 1, “Action plan document [for the Focal Point],” July 12, 1978, p. 1.

41. RG29, volume 9, file 6030-T-25-2, part 2, “Lifestyle and Health Promotion Prospectus (Draft),” February 13, 1978, by Focal Point on Lifestyle and Health Promotion, p. 6.

42. Halsall, Michael, *Vision in Progress: A History of the Health Promotion Directorate at Health and Welfare Canada,* unpublished paper in fulfilment of the requirements for History 698 credit, University of Waterloo, April 21, 1993, p. 33.

43. RG29, volume 9, file 6030-T-25-2, part 1, “Lifestyle and Health Promotion Directorate Guide to Transition Phase,” p. 1.

44. RG29, volume 9, file 6030-T-25-2, part 1, “Organizational Options for Lifestyle and Health Promotion,” May 2, 1978, p. 5.

45. RG29, volume 5, file 6001-8-4, “[Health Promotion] Program Description,” p. 1.

46. Physical fitness, the only health promotion activity not included, was allowed to remain as part of the Fitness and Amateur Sport Program pending a decision to move toward an emphasis on excellence in amateur sport. Source: RG29, Vol. 5, file 6001-8-4, “[Health Promotion] Program Description,” p. 1.

47. Pinder, *The Federal Role in Health Promotion*, op. cit., p. 97.

48. Halsall, *Vision in Progress*, op cit., p. 33.

49. RG29, volume 15, file 6001-8-1, part 2, “Draft: Reorganization of the Department of National Health and Welfare...,” September 20, 1978, p. 1.

50. RG29, volume 5, file 6001-8-4, “[Health Promotion] Program Description,” p. 1.

51. RG29, volume 5, file 6001-8-4, “Issues to Be Resolved before Classification Review,” p. 1.

52. RG29, volume 5, file 6001-8-4, Memorandum “Meeting with Dr. Law, July 25th” July 24, 1978, by Don Ogston, p. 1. Note: Of the total 123 potential person-years to be transferred to the new Directorate, 78 were from the Non-Medical Use of Drugs.

53. Pinder, *The Federal Role in Health Promotion*, op cit., p. 97.

54. RG29, volume 5, file 6001-8-4, Memorandum “Meeting with Dr. Law, July 25th” July 24, 1978, by Don Ogston, p. 2.

55. Interview with Irving Rootman, former Chief of the Health Promotion Studies Unit, March 24, 2000.

56. Ibid., p. 2.

57. RG29, volume 5, file 6001-8-4, “[Health Promotion] Program Description,” p. 11.

58. Ibid., p. 10.

59. Halsall, *Vision in Progress*, op. cit., p. 40.

60. Ibid., p. 41.

61. Ibid., p. 42.

62. Ibid.

63. RG29, volume 5, file 6001-8-4, “Ministers Briefing, Health Promotion Program,” p. 6 and 8.

64. Halsall, *Vision in Progress*, op. cit., p. 45.

65. Health and Welfare Canada, “Report of the Ad Hoc Committee on National Health Strategies,” May 1982.

66. Ibid., p. 7.

67. Pinder, *The Federal Role in Health Promotion*, op. cit., p. 98.

68. Halsall, *Vision in Progress*, op. cit., p. 44.

69. Health and Welfare Canada, “Report of the Ad Hoc Committee,” op. cit., p. 20.

70. Halsall, *Vision in Progress*, op. cit., p. 51.

71. Lalonde, *A New Perspective*, op. cit., p. 66.

72. Michel O’Neill and Ann Pederson, *Two Analytic Paths for Understanding Canadian Developments in Health Promotion*, in Pederson, A., O’Neil, M., and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto: W. B. Saunders, 1994, p. 50.

73. Ronald Labonté was the academic who led this criticism.

74. Example offered by Jo Hauser, interview on September 13, 1999.

75. Related to the recent release of the *Working Paper on Social Security in Canada*, Progressive Conservatives, New Democrats and Social Credit members also argued that if the Minister was serious about the health of Canadians he should fight inflation, restore funding to the Medical Research Council and improve social security. Twenty-ninth Parliament, 2nd Session, House of Commons, Wednesday, May 1, 1974. Tabling of Document “A New Perspective of the Health of Canadians,” Commons Debates volume II, p. 1919.

76. “Targeted Health Promotion/Disease Prevention Committee: Key Documents and Initiatives,” March 9, 1995. File 2000 - 0, Health Policy Block, Policy and Programmes, 01/95 – 02/96, p. 2.

77. Ibid.

78. Interview with Lavada Pinder, former Director, Non-Medical Use of Drugs from 1977 to 1986, Acting Director-General then Director-General of the Health Promotion Directorate from 1986 to 1992, September 23, 1999.

79. Halsall, *Vision in Progress*, op. cit., p. 54.

80. Interview with Ian Schugart, former Senior Policy Advisor to Minister Epp, September 23, 1999.

81. “Targeted Health Promotion/Disease Prevention Committee: Key Documents and Initiatives,” March 9, 1995. File 2000 - 0, Health Policy Block, Policy and Programmes, 01/95 – 02/96, p. 19.

82. Pinder, Lavada, “From *A New Perspective* to the *Framework*: a case study on the development of health promotion policy in Canada,” *Health Promotion*, volume 3(2), 1988, p. 207.

83. Health Canada, “Health Promotion in Canada: A Case Study,” June 1997, p. 21.

84. Labonté, Ronald, *Death of Program, Birth of Metaphor: The Development of Health Promotion in Canada,* in Pederson, A., O'Neil, M., and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto: W. B. Saunders, 1994, p. 82.

85. Ibid., p. 81.

86. "Targeted Health Promotion/Disease Prevention Committee: Key Documents and Initiatives," March 9, 1995. File 2000 - 0, Health Policy Block, Policy and Programmes, 01/95 – 02/96, p. 3.

87. "Workshop to Prepare for 'Beyond Health Care: A Working conference on Healthy Public Policy,'" RG29, 1995-96/224 s.2, file 6030-H3-1 Health Services and Promotion Branch.

88. Ibid.

89. O'Neill and Pederson, *Two Analytic Paths*, op. cit., p. 41.

90. "Workshop to Prepare for 'Beyond Health Care: A Working conference on Healthy Public Policy'" RG29, 1995-96/224 s.2, file 6030-H3-1 Health Services and Promotion Branch.

91. Interview with Peter Glynn, former Assistant Deputy Minister, Health and Welfare Canada, 1984 to 1990, October 4, 1999.

92. Interview with Ian Schugart, September 23, 1999.

93. Interview with Ian Schugart, September 23, 1999 and Jo Hauser, September 13, 1999.

94. Interview with Lavada Pinder, September 23, 1999 and Peter Glynn, October 4, 1999

95. Pinder, *The Federal Role in Health Promotion*, op. cit., p. 100.

96. McKay, "Making the Lalonde Report," op. cit.

97. Minister Lalonde tested the Health Field Concept idea in a speech to a nurses' organization rather than to physicians. Minister Epp tested the "new health promotion" ideas at a Canadian Public Health Meeting, an organization that was already involved in the changing definition of the concept.

98. Halsall, *Vision in Progress*, op. cit., p. 64.

99. Interview with Glenn Irwin, current Director, Policy and Major Projects Directorate, July 23, 1999.

100. Ibid.

101. Halsall, *Vision in Progress*, op. cit., p. 65.

102. Interview with Peggy Edwards, Alder Group, former communications position with Health Policy and Programs Branch, September 17, 1999.

103. Interview with Tariq Bhatti, Director, Population Health Development Division, September 17, 1999.

104. Health and Welfare Canada, World Health Organization and Canadian Public Health Association, *Ottawa Charter for Health Promotion*, An International Conference on Health Promotion: The move toward a new public health, November 17-21, 1986, Ottawa.

105. Ibid.

106. Ibid.

107. Interview with Luc Goudreault, August 1998.

108. Pinder, Lavada, *The Federal Role in Health Promotion,* op. cit., p. 100.

109. Ibid.

110. Ibid.

111. There were very few consultations with the provinces or major NGOs except for the Canadian Public Health Association.

112. Halsall, *Vision in Progress*, op. cit., p. 69.

113. Ibid.

114. Health Canada, "Health Promotion in Canada," op. cit., p. 4.

115. Interview with Glenn Irwin, July 23, 1999.

116. Interview with Peggy Edwards, September 17, 1999.

117. Interview with Jim Mintz, Director of Partnerships and Marketing, Population Health Directorate, Health Promotion and Programs Branch, Health Canada, September 24, 1999.

118. Halsall, *Vision in Progress*, op. cit., p. 75.

119. Interview with Jo Hauser, September 13, 1999.

120. Pinder, *The Federal Role in Health Promotion*, op. cit., p. 101.

121. Interview with Ian Schugart, September 23, 1999.

122. Health Canada, "Health Promotion in Canada: A Case study," op. cit., p. 19.

123. Interview with Jo Hauser, September 13, 1999.

124. Health Canada, "Health Promotion in Canada," op. cit., p. 23.

125. Interview with Glenn Irwin, July 23, 1999.

126. Interview with Peter Glynn, October 4, 1999 and Peggy Edwards, September 17, 1999.

127. Interview with Peter Glynn, October 4, 1999.

128. Comments of the Policy, Planning, and Information Branch, Program Evaluation Division, *Discussion Paper on Phase I of a Study of Healthy Public Policy at Health and Welfare Canada,* November 1992, p. 24.

129. Interview with Tariq Bhatti, September 17, 1999.

130. Health Canada, "Health Promotion in Canada," op. cit., p. 23.

131. Halsall, *Vision in Progress*, op. cit., p. 83.

132. Health Promotion and Programs Branch (HPPB) contribution to the Departmental Briefing Book, December 1995. HPPB, Policy Development and Coordination Directorate, volume 1, file 300-1, 04/95 to 01/96.

133. Health Promotion and Programs Branch contribution to the Departmental Briefing Book, December 1995, page 1. HPPB, Policy Development and Coordination Directorate, volume 1, file 300-1, 04/95 to 01/96.

134 "Substudy 1: Comparative Cost Analysis of Home Care and Residential Care Services," A Report Prepared for the Health Transition Fund, Health Canada, by the National Evaluation of the Cost-Effectiveness of Home Care, Centre on Aging, University of Victoria, November 1999, p. 38.

135. Health Canada, *1994-1995 Estimates, Part III – Report on Plans and Priorities.*

136. Halsall, *Vision in Progress*, op. cit., p. 85.

137. Two stages of program review plus sunsetting programs reduced Health Canada's operating base by $174 million (approximately 8 percent overall) from 1995-96 to 1998-99. With the exception of the business line for Services to First Nations, Inuit and the Yukon, the reductions represented a loss of more than one-third of Health Canada's business line resources over three years, with the Population Health Strategy suffering the greatest loss – 44 percent over the three years. Bureaucrats warned that a long-term commitment to a population health approach might be difficult to achieve or sustain under these conditions. Sources: Health Canada Business Plan, 1996-97 to 1998-99, Draft, April 9, 1996; Health Canada Business Plan, 1996-97 to 1998-99, Presentation to Treasury Board by the Honourable David C. Dingwall, Minister of Health, Draft, June 17, 1996.

138. Robert Evans, paper prepared for the National Forum on Health, quoted in "Science and Technology Agenda for a Healthy Nation," August 30, 1995, p. 11.

139. Irving Rootman, "Developing a System for Evaluating a National Health Promotion Programme," *Health Promotion* 3(1): 101-110, 1988.

140. Interview with Glenn Irwin, July 23, 1999.

141. Interview with Jim Mintz, September 24, 1999.

142. Interview with Tariq Bhatti, September 17, 1999.

143. Interview with Glenn Irwin, July 23, 1999.

144. Canadian Public Health Association, "Perspectives on Health Promotion: Towards National Consensus," July 1995.

145. Interview with Irving Rootman, March 20, 2000.

146. Hayes, Michael V. and James R. Dunn, *Population Health in Canada: A Systematic Review*, CPRN Study No. H|01, Ottawa: Canadian Policy Research Networks, 1998, p. 8.

147. The CIAR was founded in 1982. Though financed mainly by government, its Board of Directors has consisted chiefly of corporate representatives. Poland, Blake, David Coburn, Ann Robertson and Joan Eakin, "Wealth, Equity and Health Care: A Critique of a 'Population Health' Perspective on the Determinants of Health," *Soc. Sci. Med.* 46(7), 1998, p. 785-798.

148. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 39.

149. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 3.

150. Background Paper on Health Canada's Population Health Business Line, Draft, May 21, 1996, p. 2. Population Health IRG, volume 2, file 7000-IRG, 02/96 to 07/96.

151. Thanks to Owen Adams for pointing out this oversight in an earlier draft.

152. Minutes of the 20th Meeting of the Advisory Committee on Community Health, Ottawa, November 2, 1992, p. 1.

153. Ibid.

154. The Forum held considerable clout due to its public profile and the number of experts involved. In addition to its significance to population health, recommendations such as national conferences on home care and pharmacare were followed through upon by Health Canada.

155. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 39.

156. Ibid.

157. Ibid.

158. Van de Water, Harry P. A. and Loes M. van Herten, *Health Policies on Target? Review of Health Targets and Priority Setting in 18 European Countries,* TNO Prevention and Health, Public Health Division, Leiden, the Netherlands, 1998, p. 24.

159. Diane McAmmond and Associates, *Analytic Review Towards Health Goals in Canada*, Final Report, May 1994, p. i.

160. Ibid., p. 1.

161. Ibid., p. ii.

162. Interview with Diane McAmmond, consultant to the ACPH, October 3, 1999.

163. Ibid.

164. Ibid.

165. Record of Decisions of the ACPH, Toronto, March 21-22, 1995.

166. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 6.

167. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 42.

168. DEC Presentation on an Integrated Population Health Strategy, November 27, 1995.

169. *Strengthening Our Policy Capacity,* April 3, 1995, p. 34, 36 and 37. Task Force on Strengthening the Policy Capacity of the Federal Government, submitted to the Coordinating Committee of Deputy Ministers (Policy).

170. Interview with Ian Schugart, September 23, 1999.

171. Health Canada, "Health Promotion in Canada," op. cit., p. 25.

172. Steering Committee on Integrated Population Health Strategies, meeting of November 9, 1995.

173. Interview with Jo Hauser, September 13, 1999.

174. HP Block, Ottawa Charter volume 3, 11/96-11/97, file PDCD 2000-4.

175. *Population Health: From Vision to Action*, page 16. Population Health – Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

176. Hayes, Michael and Sholom Glouberman, "Population Health, Sustainable Development and Policy Future," CPRN Discussion Paper No. H|01, Ottawa: Canadian Policy Research Networks, September 1999, p. 6 and 18.

177. Ibid., p. 22.

178. Ibid., p. 19.

179. *Population Health: From Vision to Action*, pages 3 and 4. Population Health – Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

180. Interview with Diane McAmmond, October 3, 1999.

181. Hayes and Glouberman, "Population Health," op. cit., p. 19.

182. Minutes of the Steering Committee on an Integrated Health Strategy, April 11, 1996, page 4. Population Health Steering Committee, volume 5, file 7000-SC, 03/96 to 04/96.

183. From a presentation by Michael Hayes, *What Are the Determinants of Health in Canada? Clues for Future Action,* Conference on Health for All: Setting Targets for the 21st Century, Calgary, October 7-8, 1999.

184. Just as population health was emerging in the late 1980s, a 1989-90 evaluation of the Department's Health Promotion Program recommended a further evaluation of the departmental capacity to pursue and promote healthy public policy. For Health and Welfare Canada to act on healthy public policy required assessing the impact on health of policy options while promoting healthy public policy outside the Department called for encouragement and persuasion. It was noted that the empirical basis for healthy public policy initiatives, i.e., information on the determinants of health and the impacts of public policy, needed improvement. Source: Program Evaluation Division, *Discussion Paper on Phase I of a Study of Healthy Public Policy at Health and Welfare Canada,* November 1992, p. 30 and 31.

185. Interview with Diane McAmmond, October 3, 1999.

186. The *Report of the Roundtable on Population Health and Health Promotion* (Health Canada, 1996) revealed some of the misunderstandings between proponents of the two schools of thought, and also reconciled them with a "population health promotion" model.

187. Hamilton, N. and T. Bhatti, *Population Health Promotion: An Integrated Model of Population Health and Health Promotion,* Ottawa: Health Promotion Development Division, Health Canada, 1996.

188. Hayes and Dunn, *Population Health in Canada*, op. cit., p. 53.

189. Interviews with: Tariq Bhatti, September 17, 1999; Peggy Edwards, September 17, 1999; and Lavada Pinder, September 23, 1999.

190. Health Promotion Development Division, July 1995, *Operational Framework and Workplans 1995-96*, p. 1.

191. Interdepartmental Reference Group on Population Health, Minutes of Meeting, October 16, 1995.

192. Interview with Peter Glynn, Assistant Deputy Minister, Health and Welfare Canada, 1984 to 1990, October 4, 1999.

193. January 1995 – "Discussion Papers for DEC Planning Day – *Getting from Here to There: Health Canada 1995-96 to 1998-99*."

194. Health Canada Outlook 1995-96 to 1997-98.

195. Health Canada, *Science and Technology Agenda for a Healthy Nation – August 30, 1995.*

196. Health Canada, *1998-1999 Estimates: A Report on Plans and Priorities.*

197. Health Promotion and Programs Branch contribution to the Departmental Briefing Book, December 1995. HPPB, Policy Development and Coordination Directorate, volume 1, file 300-1, 04/95 to 01/96.

198. Memorandum of September 22, 1995, from Kay Stanley, Assistant Deputy Minister, Health Promotion and Programs Branch.

199. Background Paper on Health Canada's Population Health Business Line, Draft, May 21, 1996, p. 4. Population Health IRG, volume 2, file 7000-IRG, 02/96 to 07/96.

200. Speaking Notes for Jo Hauser, Steering Committee on an Integrated Population Health Strategy, January 25, 1996, p. 1. Population Health IRG, volume 1, file 7000-IRG, 05/94 to 01/96.

201. June 29, 1995, Minutes of the Joint Meeting of the [Departmental] Steering Committee and Working Group on Integrated Population Health Strategies, p. 2.

202. Ibid.

203. One of the recommendations made by the ACPH, endorsed by the F/P/T Ministers of Health, was the development of "comprehensive intersectoral population health initiatives for a few key priorities that have the potential to significantly impact population health." To follow the recommendation within the Population Health Strategies business line, HPPB sought broader horizontal engagement and collaboration in the fall of 1995 by inviting officials from initially 15 other federal departments (18 by 1996) to join a new Interdepartmental Reference Group on Population Health (IRG). The IRG was a forum for providing advice on and sharing information about programs and policies of member departments and agencies that potentially impact the health of Canadians; as well as a forum for identifying strategic issues and opportunities for collaboration on common areas of concern as well as mutual departmental goals. The IRG's first key task was to formulate a cross-departmental perspective for Health Canada's 1997 Memorandum to Cabinet (MC) on population health. Hence the MC recommendations contained the views of the other departments and previewed other Cabinet ministers' support. However, once the MC was delivered, the IRG was without a specific task, causing the senior departmental representatives to be replaced by those more junior and the mechanism overall began to have diminishing returns. At the time of writing this paper, the IRG was inactive. Nonetheless, the engagement of other departments in population health was fruitful beyond the MC development process. For example, one of the IRG participants, the Canadian Mortgage and Housing Corporation, subsequent to the development of the MC involved Health Canada in the process of preparing a project to study the effects of housing on health. The IRG may yet be reconvened with at least those departments that have the greatest impact on determinants of health. In the meantime, no other formal program level structures for cross-departmental collaboration to advance population health thinking are in place. Source: Phone interview with Glenn Irwin, October 1, 1999; *Population Health: From Vision to Action*, p. 7, Population Health – Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97; Terms of Reference for Interdepartmental Reference Group on Population Health, May 21, 1996.

204. Population Health – Interdepartmental Reference Group, 11/96 to 7/98, volume 5, file 7000-IRG. *Strategic Action on Population Health, Draft*, no date.

205. *Global Strategic Priority Paper,* March 9, 1998. PDCD HPPB, volume 8, file 300-1, 12/97 to 03/98.

206. Fully developed population health indicators, as part of a new infrastructure, were to be treated on a par with economic indicators, with an objective being the development of a set of population health accounts similar to the overall national system of accounts to support long-term priority setting and to monitor progress by all departments and sectors that influence health. This lead to a proposal for a Commissioner for Population Health similar to the Commissioner for the Environment and Sustainable Development, although no action was taken. Source: *Advancing the Population Health Model.* PDCD HPPB, volume 4, file 300-1, 06/97 to

08/97; interview with Carmen Connolly, Director General, Major Projects Directorate (1997 to 1999), October 22, 1999.

207. *Advancing the Population Health Model.* PDCD HPPB, volume 4, file 300-1, 06/97 to 08/97.

208. Speaking Notes for Kathy Stewart, Steering Committee on Population Health, March 17, 1997, Population Health Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97; Draft Summary of Discussions, February 17, 1997, Steering Committee on Population Health; Population Health Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

209. Memorandum from Joan Simpson to the Branch Executive Committee regarding Branch Global Strategic Priorities, January 26, 1998. PDCD HPPB, volume 8, file 300-1, 12/97 to 03/98.

210. Memorandum from Hervé Leblanc to Sandra Jones re: Fiscal Environment, October 20, 1997. PDCD, HPPB volume 6, file 300-1, 10/97. The Red Book II was the federal Liberal party's electoral policy platform.

211. November 9, 1995, Meeting of the Steering Committee on an Integrated Population Health Strategy. Population Health Steering Committee, volume 3, file 7000-Sc, 11/95 to 11/95.

212. Key Decision Points to Raise [in a Memorandum to Cabinet], p. 1. Population Health Steering Committee, volume 1, 7000-SC, 1/95 to 9/95.

213. Briefing for Minister, March 28, 1996 – "A Population Health Strategy for Health Canada," p. 11.

214. Speaking Notes for Kathy Stewart, Steering Committee on Population Health, March 17, 1997. Population Health Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

215. October 12, 1995, Meeting of the Steering Committee on an Integrated Population Health Strategy. Population Health Steering Committee, volume 2, 7000-SC, 10/95 to 10/95.

216. Speaking Notes for Jo Hauser, Steering Committee on an Integrated Population Health Strategy, January 25, 1996, p. 4. Population Health IRG, volume 1, file 7000-IRG, 05/94 to 01/96.

217. Population Health Strategies: Implementation. Population Health Steering Committee, volume 2, file 7000-SC, 10/95 to 10/95.

218. Population Health – Steering Committee, volume 2, file 7000-SC, 10/95 to 10/95, Population Health Strategies Implementation.

219. Memorandum from Hervé Leblanc to Sandra Jones re: Fiscal Environment, October 20, 1997. PDCD, HPPB volume 6, file 300-1, 10/97.

220. Interview with Carmen Connolly, Director General, Major Projects Directorate (1997 to 1999), October 22, 1999.

221. Ibid.

222. Ibid.

223. The key question at present is whether it will remain as an entity within CIHI or become a research institute within the broader structure of the Canadian Institute of Health Research.

224. Interview with Carmen Connolly, Director General, Major Projects Directorate (1997 to 1999), October 22, 1999.

225. Ibid.

226. *Promoting Population Health*, HPPB, Policy Development and Coordination Directorate, volume 8, file 300-1, 12/97 to 03/98.

227. Health Canada initiatives within the National Children's Agenda are the Community Action Program for Children, the Canada Prenatal Nutrition Program, the Aboriginal HeadStart and the Centres for Excellence for Children's Well-being.

228. Under the umbrella of the "social union," First Ministers created the F/P/T Council on Social Policy Renewal in 1996 to coordinate the renewal of social programs with support from health, education, social services and justice sectors. At the First Ministers' Conference in December 1997, leaders reaffirmed their commitment to new cooperative approaches to address children's needs through a National Children's Agenda and assigned responsibility to guide and coordinate the work to the F/P/T Council on Social Policy Renewal. The first initiative implemented was the National Child Benefit in July 1998.

229. Memorandum from Joan Simpson to the Branch Executive Committee regarding Branch Global Strategic Priorities, January 26, 1998. PDCD HPPB, volume 8, file 300-1, 12/97 to 03/98.

230. Draft Presentation to the Minister, June 20, 1996, *Update on Population Health Strategy.*

231. Appendix 1: Policy Research Capacity. Admin Block DEC, volume 6, file PDCD 180, 05/98-10/98.

232. Whether such a relatively passive role can give Health Canada the leadership profile it is seeking with the population health approach is uncertain. The leadership potential may also become diffused as other levels of government and voluntary organizations become more involved in population health and evidence mounts that more and more of the determinants of health and corresponding interventions are outside the health sector. Source: "Discussion Papers for DEC Planning Day – *Getting from Here to There: Health Canada 1995-96 to 1998-99*."

233. November 9, 1995, Speaking Notes for Jo Hauser, Steering Committee on an Integrated Population Health Strategy, p. 4 and 5. Population Health Steering Committee, volume 3, file 7000-SC, 11/95 to 11/95.

234. Health Canada, *Outlook 1995-96 to 1997-98.*

235. Memorandum from Joan Simpson to the Branch Executive Committee regarding Branch Global Strategic Priorities, January 26, 1998. PDCD HPPB, volume 8, file 300-1, 12/97 to 03/98.

236. *Furthering a Population Health Approach: [HPPB] Branch Global Strategic Priority Paper*, March 9, 1998.

237. Interview with Diane McAmmond, October 3, 1999.

238. Lalonde, *A New Perspective*, op. cit., chapters 7-9.

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242. Law, Maureen, "Public Health in the 80s: A Decade of Decline or an Opportunity for Change?," *Canadian Journal of Public Health* 71 (July/August) 1980: 249-253.

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247. Notes for the Opening Address by Dr. Maureen Law, Deputy Minister of National Health and Welfare, 80th Annual Conference of the Canadian Public Health Association, June 20, 1989.

248. Ibid.

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253. Health Canada’s Population Health Business Line: Opportunities for Improving Health, Draft, February 14, 1997, p. 8.

254. *Population Health: From Vision to Action*, page 9. Population Health Steering Committee, volume 8, file 7000-SC, 01/97 to 06/97.

255. Ibid., p. 14.

256. Notes for the Opening Address by Dr. Maureen Law, Deputy Minister of National Health and Welfare, 80th Annual Conference of the Canadian Public Health Association, June 20, 1989.

257. Government of Ontario, *The Premier’s Council on Health, Well-being and Social Justice,* 1992, pamphlet.

258. Interview with Jo Hauser, September 13, 1999.

259. Interview with Tariq Bhatti, September 17, 1999.

260. Interview with Peggy Edwards, September 17, 1999.

261. “Health Goals in Canada: A Strong Legacy Continues,” *Health Targets: News and Views* 3(1) (Summer) 1999: 6-9.

List of Project Funders

Health Network

Towards a New Perspective on Health Policy Project

Max Bell Foundation
Canadian International Development Agency
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The Richard Ivey Foundation
Ministry of Health, Government of Ontario
Health and Wellness, Government of New Brunswick