CHANGING APPROACHES TO HEALTH:

THE HISTORY OF A

FEDERAL/PROVINCIAL/TERRITORIAL ADVISORY COMMITTEE

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In a federation where health policy cuts across federal and provincial responsibilities, there is a real need for a co-ordinating agent. In Canada, this task falls to a system of federal-provincial-territorial advisory committee(s) on health. This inter-jurisdictional committee apparatus of senior bureaucrats was established in 1973 to serve a co-ordination and advisory role to the Conference of Deputy Ministers of Health who in turn advise the Conference of Ministers of Health. Committees consider emerging issues, exchange information, conduct research, coordinate joint programs and make recommendations with the aid of a secretariat housed with the federal government. The Deputy Minister of each province, territory and the federal government designates one member to each committee.[1] Committee Chairs are selected by a liaison Deputy Minister for two year terms. While the number and mandate of the committees have shifted over the past twenty-seven years, at least one was consistently devoted to health matters other than curative services. The changing nature of this committee, referred to as the health – not health care – committee, is the subject of this paper.

Changes to the health committee over the last quarter century reflect and have shaped the direction of health policy in the country. This report tracks the history of this committee as a means to document how the subject of health policy, and, the ways in which it is pursued have changed. Many issues could be considered matters of importance to "health." Three variables seemed to determine the ebb and flow of the domain of the committee: the conceptualisation of health; the relative dominance of particular groups of professionals and relationships among groups; and, the nature of intergovernmental politics. In taking a longer view of changes in health problems and shifts in the role of the committee, what becomes apparent is the rise and fall of ideas about health. The original contribution of this research is thus to look beyond the life course of one manifestation of the committee to track the patterns that have formed over the last three decades.

This paper is based on primary data collected from archival documents for the early years and meeting minutes for committees in the 1980s and 1990s (Appendix A provides a tabulation of what topics were discussed in the minutes and when). The limitation of this research is that the minutes do not report on the substantive debate in the meetings.[2] This means that only an overview is possible based on the topic headings recorded in committee minutes. Also, the inability to review the records from other committees limits the findings to what falls within the

domain of the health committee rather than what was and was not discussed within the committee structure. Key informant interviews for the *Towards a New Perspective* project and secondary sources are used to supplement the archival research where appropriate.

"Changing Approaches to Health" is divided into three sections with the core of the paper focused on two major transitions in health policy – the introduction of health promotion and population health – as turning points in the history of the committee. Section one is an overview of changes to the committee structure from 1973 to 2000. Section two considers the rivalry between public and community health with health promotion from 1973 to 1984. Section three compares the Advisory Committee (AC) on Community Health to the Advisory Committee on Population Health, covering the period of 1984 to 2000. To conclude, observations and insights are raised to offer directions to the current committee based on its history.

1 Overview

During the public health era and advent of medicare, the Dominion Council of Health facilitated federal-provincial collaboration for health and social welfare. This advisory body included ten provincial Deputy Ministers of Health and five non-governmental members "representing various aspects of the population," led by the Federal Deputy Minister of Health.[3] They met 100 times from 1919 to 1973. 126 federal-provincial committees supported their work.

In 1973 a Federal/Provincial Advisory Committee (AC) structure was struck to assist meetings of the Conference of Deputy Ministers of Health.[4] Non-governmental members were removed and subject areas divided into four: Health Manpower, Health Insurance, Health Standards and Community Care (changed at the first meeting to Community Health Services).

1973
Federal Provincial Advisory Committees:

Health Manpower
Health Insurance
Health Standards
Community Health Services

The mandate given to the committee contained broad terms of reference. Members were instructed to conduct:

> Consideration of all matters relating

1977
Federal Provincial Advisory Committees:

Health Manpower
Institutional Care Services
Environmental and Occupational Health
Community Health Services
Health Promotion

to the promotion, protection, maintenance and restoration of health of the people of Canada, by joint federal - provincial action and initiation of recommendations to federal and provincial Ministers of Health, the Conference of Health Ministers, and other appropriate bodies on health related matters.[5]

In a pattern that was to recur, this move "substantially reduced and rationalised the number and nature of the various kinds of committees reporting to [the Conference of Deputy Ministers]."[6] After several years, a number of structural and operational problems led to a review in 1977. This, in turn, led to a re-organisation of the structure to five advisory committees and six sub-committees. With the directive to be more responsive to the objectives of the Deputy Ministers, the advisory committees were divided into Health Manpower; Institutional Care Services, Environment and Occupational Health, Community Health Services, and Health Promotion.

In 1981 an Ad Hoc Committee on National Health Strategies was established by the Conference of Deputy Ministers of Health "to review health status, identify priority problem areas, and propose goals and strategies for meeting those goals."[7] Seven health problems were identified as priorities in the report produced:

- accidents
- arthritis and joint disorder
- cancer
- cardiovascular and cerebrovascular diseases
- maternal and infant health problems
- mental disorders
- respiratory diseases

Six major strategies were identified to tackle these problems based on a process-model:

- health risk reduction
- early detection of health problems
- treatment
- rehabilitation
- research
- evaluation and data collection

At the March 1982 Conference of Deputy Ministers of Health meeting, advisory committees were directed to carefully review the report and restructure all activities to bring them in line with the National Health Strategies report. A detailed workplan and timeframe for their future activities were to be submitted by November 1982 in the priority areas outlined in the report.[8] At this time each advisory committee was also assigned a liaison deputy minister from one of the provinces or federal government. This was to establish an intermediary between the work of the committee and the Conference of Deputy Ministers of Health.

1984
Federal Provincial Advisory Committees:

Health Manpower
Institutional Care Services
Environmental and Occupational Health
Community Health

In spite of these changes, the committee structure came under review again only two years later in 1984.[9] The major change that occurred at this juncture was the amalgamation of community health services and health promotion into the Advisory Committee on Community Health (ACCH). This reduced the number of committees from five to four.

In June of 1986 the Task Force on Program Review (Neilsen Task Force) recommended the Conference of Deputy Ministers undertake a critical review of the on-going necessity and mandate of the advisory committee system. According to a 1991 Descriptive Inventory of the committee structure, a "Report on the Federal-Provincial -Territorial Advisory Committee Structure," was presented to the Conference in February 5-6, 1987 and accepted as submitted.[10] However, the content of this report has not been made available. By 1987 it appeared the committee structure was as follows:

1987
Federal/Provincial/Territorial Advisory Committees

Health Human Resources
Institutional Care Services
Environment and Occupational Health

Community Health
Mental Health
Alcohol and other Drugs

The profile and work of two standing committees of Community Health - Mental Health and Alcohol and Other Drugs – had expanded to raise the number of advisory committees from four to six. Health Manpower was also renamed Health Human Resources. Between 1978 and 1984, the Yukon and Northwest Territories began sending their own representatives to the advisory committee meetings. Consequently, the name of the committee structure changed.

1992
Federal/Provincial/Territorial Advisory Committees:

Health Services
Health Human Resources
Population Health

In the fall of 1992, another restructuring reduced the number of advisory committees to three. The work of previous committees was considered not well integrated.[11] Some of the work of the Environment and Occupational Health Advisory Committee was moved to the federal Health Protection Branch. Institutional Care Service was renamed Health Services and retained. Mental Health, Alcohol and Other Drugs, remaining issues from Environment and Occupational Health and the Community Health Advisory Committee were rolled into the Advisory Committee on Population Health (ACPH). A fourth committee, the Advisory Committee on Health Infostructure was added in 1999.

The pattern of name changes and re-organisations among advisory committees can be seen to reflect one of three factors. First is the ongoing challenge of establishing and maintaining a highly effective organisational structure. Second are shifts in jurisdiction. Health Insurance, for example, is a committee that was disbanded in 1977 coincident with the federal and provincial governments implementing the Established Program Financing Act. Substantive discussion regarding health care coverage then moved to the AC on Institutional Care Services. Third, changes to the advisory committees parallel shifts in approaches to health. If the non-medical committees are isolated from the rest, we see a change from:

1973	Community Health Services
1977	Community Health Services and Health Promotion
1984	amalgamation to Community Health
1987	Community Health, Environment and Occupational Health, Mental Health, Alcohol and Other Drugs
1992	Population Health

To gain insight into the dynamics behind this stream of committee structure changes, we can examine the changes that took place in the shift from community health services to health promotion to population health.

2 1973 – 1984: Including a New Approach

Of the first set of advisory committees struck in 1973, the Advisory Committee on Community Care was established to address health concerns beyond the institutions, arrangements and standards of medical care. At its first meeting, the committee immediately changed its name to Community Health Services. This move was a signal in support of broadening the view of health as more than health care. Community health professionals emerged between the longstanding tradition of public health (medical officers of health and home nursing) and clinical or hospital based medical professionals. The mandate of the committee was "to advise Ministers and Deputy Ministers of Health on the planning, development and evaluation of community health and care services, including alternatives to institutional care."[12] "Health and care services" captured the preventative and continued care aspects of maintaining the health of the population that work around hospitalisation. Although distinct, the complementarity between the two groups came in sharing a focus on individual health in relation to the population. Both approaches formed arms extending from the medical clinic to different levels of surveillance – community, provincial or national. Areas of concern and intervention for the Advisory Committee on Community Health Services included: immunization, disease prevention, epidemiology, community health services and population groups: children, seniors and immigrants.[13]

Over the course of the century, disease prevalence had changed. In 1900 pneumonia/influenza, tuberculosis and diarrhoea/enteritis were the three leading killers,

accounting for nearly a third of all deaths.[14] Public health was designed to control infectious disease by isolating individuals for medical treatment, regulating food production (and later pharmaceuticals, medical devices and blood) and changing the conditions of the environment. By 1970, diseases of the heart, malignant neoplasm and cerebrovascular diseases – all chronic diseases – were the three top killers, accounting for two-thirds of all deaths.[15] With this change, community health continued to address communicable disease prevention but added education to the range of interventions possible in clinical settings. For example, a project pursued by the AC on Community Health Services in the early 1980s sought to add preventative advice to nurse and physician fee schedules.[16] This would encourage physicians to look for signs of oncoming disease and prescribe preventative measures instead of waiting for the onset of illness. The committee also aimed to replace the routine annual check-up with a periodic health examination based on specific risk in certain populations at different stages of human life.[17]

The 1974 document *A New Perspective on the Health of Canadians* (the Lalonde Report) released by Health and Welfare Canada spoke to the shift in causes of mortality from infectious to non-infectious diseases (known in development theory as the health transition). Since health problems were not contagious, causality was not attributed to dangers in the environment but to personal choices. Health was thus conceptualised as a matter of self-determination rather than fate. This was a critique of faith in the "fix-it" curative system but also, more subtly, of public and community health. To protect and improve the health of the population, preventative efforts had to go beyond education and the clinic. Health promotion thus declared it the appropriate role of government to use social marketing techniques of persuasion to modify the behaviour of Canadians. Offering a new optimism, the problems identified were primarily addictions that contributed to chronic disease, for example smoking and cancer. Based on behavioural science research, which was popular within academic circles at the time, health promotion created a "new" public health for an era dominated by non-infectious disease.

Creation of an Advisory Committee on Health Promotion in 1977 thus emerged from the adoption of the new approach. In response, European governments and several provincial health ministries established health promotion units, followed by the federal department in 1978. This committee was given the mandate "to advise the federal and provincial ministers and deputy ministers of health on ways and means for individuals, groups, and society to modify or sustain

lifestyle plans to insure better health." Sub-committees on Nutrition and Alcohol and Other Drug Problems were formed along with working groups on Emotional Well-being (1977-1982), Co-operative Problems, Child Safety and Smoking. Meetings were held twice a year, chaired jointly by the Director General of the federal Health Promotion Directorate and Director of Health Promotion for Saskatchewan. Reports from each sub-committee and Fitness Canada were given at each meeting along with information exchange of developments and trends in each jurisdiction.

In 1980 a "Health Promotion Planning Framework" emerged from community and working group deliberations. The task of this work was to resolve the fundamental problem facing the Advisory Committee that "health promotion" lacked clear definition. A priority setting exercise helped clarify the role of the new committee by identifying health problems and program priorities.

Priority health problems:	Program priorities:
• nutrition • smoking • alcohol abuse • safety • emotional well-being	• physical activity • fluoridation • cardiovascular disease and blood pressure (heart-lung health) • resource exchange

Prenatal and adolescent age groups were selected as the target population groups to focus the work of the committee.

Thus from 1977 to 1984 two committees on health existed offering two different approaches to the question of how to improve the health of the population.[18] The AC on Community Health Services and AC on Health Promotion shared a position of response to the expressed need to reduce health care costs. Their answer overlapped by pointing to education but differed in terms of its form and relation to medicine. Terms of reference, responsibilities and activities of each committee illustrate the differences between these two groups.

AC Community Health Services	*AC Health Promotion*
<u>Mandate:</u> "To advise Ministers and Deputy Ministers of Health on the planning, development and	<u>Mandate:</u> "To advise the federal and provincial ministers and deputy ministers of health on ways and

evaluation of community health and care services, including alternatives to institutional care." Responsibilities: 1. Identify community health needs and the various ways of meeting them 2. Propose policies and programs for the development of community health services and recommend on the development or modification of appropriate federal or provincial legislation 3. Advise on federal-provincial collaboration efforts in community health services 4. Advise on priorities and resource allocation within the field of community health services 5. Advise on roles of health and related agencies in collaborative efforts in the development of community health and care services and systems 6. Review progress and advise on reassignment of priorities in community health services to reflect changing circumstances 7. Advise on development of standards 8. Advise on financial implications of proposals[19]	means for individuals, groups, and society to modify or sustain lifestyle plans to insure better health." Responsibilities: 1. To advise on ways to encourage the reduction of self-imposed risks resulting from personal decisions and habits that are bad, from a health point of view 2. To advise on the harmful effects on health of the social environment, including the rapid changes in it; and to advise on measures to influence the lifestyles by manipulating the built environment 3. To advise on all matters related to development and implementation of health promotion activities which are aimed at increasing awareness and motivating adoption of personal, family and community responsibilities for healthy lifestyles and maintenance of good health 4. To advise on development of standards 5. To advise on financial implications of proposals[20]
List of Activities and Issues: National Immunization Policy Disease Prevention Public Health Services (accreditation) Epidemiology (Community) Health Information Role of the Physician in Public Health Cardiovascular Disease Prevention (1978) School Health Services review (1980) Health Surveys Geriatric Community Services Home Care Immigrant Health (health care payment and public health disease control) National Committee on Immunization Policy Advisory Committee on Epidemiology Technical Advisory Committee on Public Health Laboratories	List of Activities and Issues: Information Exchange of Campaigns on Nutrition, Fitness and Smoking Health Promotion Planning Framework Provincial Summaries of School Health Education Self-Care Discussion Document Special Report on Alcohol Statistics National Planning Committee on Training in Addictions Alcohol Use Among Adolescents and Young Adults, 1982 Data Element Definition (alcohol statistics) Central Nervous System Prescription Drugs Canada's Food Guide Handbook Introductory Guide to Evaluating Nutrition Projects Nutrition Recommendations for Canadians[21]

A key difference between the two committees was the centrality of the problem of addictions to health promotion. This focus contributed to the work on the non-medical use of drugs emanating out of the LeDain Commission Report of the early 1970s. Persuasion towards healthy choices was the preferred approach recommended as appropriate to a liberal democracy instead of stringent criminalization. Health promotion was the means to this end, aiming to encourage individuals to make healthy choices about long-term health consequences based on access to information. Another difference was that the AC on Health Promotion did not possess comparable status or power to Community Health Services. Members of the Health Promotion committee came from lower ranks in the government hierarchy and the committee did not report directly to the Conference of Deputy Ministers of Health.[22]

2.1 Amalgamating Community Health Services and Health Promotion

The presence of two committees on health was not a problem for Health Promotion but it was for Community Health Services. The perspective of the latter was that their educational activities to prevent disease amounted to health promotion and thus ran directly into the jurisdiction of the other committee. Moving ahead with the educational component of the periodic health exam, for example, required consulting the AC on Institutional and Medical Services and the AC on Health Promotion. To start an awareness program on Cardiovascular Disease Prevention, the same problem of overlap arose.

From the outset therefore AC on Community Health Services sought to absorb the AC on Health Promotion. At the founding meeting in September 1978 concern was expressed that its responsibilities and interests overlapped with those of the AC for Environment and Occupational Health and Health Promotion.[23] It was decided therefore that the Chairperson, Dr. M. Law, ADM of Health Services and Promotion Branch, National Health and Welfare, propose two actions to the Deputy Ministers. One, that the terms of reference for the AC on Health Promotion and AC on Environment and Occupational Health be clarified; two, "that the Advisory Committee on Health Promotion become a Sub-Committee on the Advisory Committee on Community Care."[24] At the second meeting of the committee in 1979, this matter was postponed for further study.[25] Unable to change the committee structure, it was proposed at the third meeting that the two committees hold a joint meeting at the end of the year.[26]

Consequently, the two committees did co-operate, finding ways to communicate on an issue-by-issue basis, particularly for programs with an educational component. For example, an agreed upon division of labour was struck for an awareness program on Cardiovascular Disease Prevention initiated by Community Health Services. Detection in primary care settings, nutrition services and compliance would be retained as AC on Community Health Services responsibilities, while the educational efforts to promote health were designated for the AC on Health Promotion. For a School Health Service review conducted by the Community Health Services in 1980, it was found to be "difficult to delineate responsibilities for clinical services and health promotion services."[27] But the two committees worked together: one collecting medical service information and the other educational service information.

Meanwhile, the AC on Community Health Services continued to pursue its preference to subsume health promotion. In May of 1983, a motion on the matter was moved:

> Because of anomalies in roles, membership and resources of the Advisory Committees on Health Promotion and of Community Health, be it resolved:
> i) that the Advisory Committee on Health Promotion be restructured as a standing sub-committee of the Advisory Committee on Community Health
> ii) that the Federal support resources (manpower) to the two present Advisory Committees be redeployed to form a strengthened, better co-ordinated support to the proposed simplified advisory structure.[28]

Arguments in favour included the difficulty drawing the line between prevention and services; a duplication of functions; and, difficulties communicating despite on-going exchange of reports, all of which pointed to a need for greater interrelationship between the two committees. The lone dissenter from this motion noted that Deputy Ministers had rejected similar recommendations made at different points in time deciding instead "to establish and maintain the F/P/T Advisory Committee on Health Promotion."[29] Nonetheless, the motion carried and was recommended to Deputy Ministers. This time, they listened and agreed.

The following year, 1984, the AC on Health Promotion was officially amalgamated with the AC on Community Health Services to become the Advisory Committee on Community Health. This action was interpreted by some as a *de facto* take-over that lessened the role of health promotion within inter-governmental channels.[30] On the grounds that it held a "broader future orientation," it was argued that Health Promotion should have absorbed Community

Health Services.[31] Amalgamation was a loss for this approach since the absence of a specific committee left health promotion without an inter-jurisdictional body to act as an advocate. A contrary view was based on the perceived unwillingness of health promotion to work with medicine as a flaw in the health promotion approach.[32] A third view saw the merger as natural given the mutual interests of the two groups.[33]

As one committee, the mandate agreed upon by the AC on Community Health was "to deal with community health and health promotion issues…and not to deal with jurisdictional issues."[34] With respect to prevention, the intention was to take "a very broad perspective to include prevention or reduction of institutionalisation, where appropriate, or loss of independence in the community."[35] At the first meeting held September 12-13, 1984 Dr. Boyd Suttie's introductory remarks "indicated that this Committee has a new opportunity to reconcile policy in its definition of workplans and priorities."[36] Forging the two groups together through amalgamation may have, therefore, facilitated the transition to what came to be known as the "new" public health by dissolving the rivalry.

3 1984 – 2000: Community Health to Population Health

The next major transition for the advisory committee on health did not come until the 1990s. Leading up to this point, the Advisory Committee on Community Health integrated the work of community health, public health and health promotion albeit without necessarily addressing each area equally. This section describes the issues raised by this committee, while comparing the work under ACCH from 1984 to 1992 with that of the ACPH from 1993 to 1999.[37] A major difference from the 1980s to 1990s is a change in the role of the committee from co-ordination to advocacy.

3.1 Advisory Committee on Community Health

From 1984 to 1992, the Advisory Committee on Community Health held twenty meetings in total – usually two per year, but there were three in each of 1985, 1986 and 1987 (see Appendix A, page 29). At the first meeting, the title of Community Health was chosen on the basis that it "describes the primary thrust of the Committee and also encompasses health

promotion issues."[38] At this time, the members decided what work from the two former committees would be carried forward. Sub-committees selected were as follows:

Initial ACCH Committees	**Origin**
Standing Committee on Alcohol & Other Drug Problems	Health Promotion
Standing Committee on Nutrition	Health Promotion
Standing Committee on Home Care	Community Health Services
Working Group on Community Health Information	Community Health Services
Working Group on Periodic Health Examination	Community Health Services

Related to these sub-units, a list of priorities was identified by the Advisory Committee on Community Health: [39]

- Smoking
- Nutrition (Elderly; Maternal; Preschool; Labelling)
- Immunization
- Environmental & Occupational
- Alcohol and Drug Abuse
- Fitness
- Non-Communicable Disease – Hypertension
- Maternal & Infant Health
- Lung Cancer
- Accidents
- Mental Health
- Structures for delivery
- Information
- Standards
- Committee structure

The Deputy Ministers of Health chose three primary areas of concern from this list: smoking, cardiovascular disease and mental health. The status of mental health was debated until it was moved to a specific Advisory Committee on Mental Health in 1986. Addictions – to nicotine, alcohol and drugs – remained and took a central role in the work of the committee. With the approval of the Deputy Ministers, one of the main tasks of the ACCH from 1984 to 1992 was to co-ordinate the National Strategy to Reduce Tobacco Use. From 1984 to 1987, another major focus in the work of the ACCH was Alcohol and Other Drug Problems. Cardiovascular disease prevention was addressed through the study of hypertension and a cholesterol strategy, and remained a consistent focus from 1984 to 1991.

There are different ways to divide and examine the topics addressed by the Advisory Committee on Community Health. Based on the volume of agenda items per year, it is clear that the committee hit a peak in 1986 and 1987. This coincides with the 1986 release of the second

report on health promotion, *Achieving Health for All* (the Epp Report) as well as the *Ottawa Charter*. The proportion of topics addressed suggests that community health and public health issues dominated the agenda. Based on the weight of issues rather than frequency of discussion suggests, however, that there was more of a balance, especially since the top priority item of smoking entailed a health promotion strategy. Beyond the top areas of concern, other topics consistently raised include:

- Poison Control Program (1984-1991)
- Nutrition (1984-1990)
- Community Health Information (1984-1990)
- Home Care/Long Term Care (1985-1990)
- Adolescent Reproductive Health (1986-1990)
- Community Health Intervention Monograph (1986-1992)

Topics consistently addressed for three years or more include:

- Immunization (1984-1986)
- Periodic Health Examination (1984-1986)
- Health Promotion Survey (1984-1986)
- Federal Program on Child Sexual Abuse (1986-1988)
- Public Nursing Consultants (1988-1990)
- Advisory Committee on Epidemiology (1988-1990)
- Dental Directors Health Council (1988-1990)

In the second half of the 1980s, new health problems were added to the agenda of the ACCH. For example, AIDS first appeared in 1985, broadening by 1987 into several agenda items such as the Canadian Public Health Association Awareness Program, as well as federal and provincial activities. Recognising the scope of this disease as a new epidemic, a separate Advisory Committee on AIDS formed reporting through the ACCH to the Conference of Deputy Ministers. Cancer appeared in 1988 and remained on the agenda until 1991. An advisory committee on epidemiology was discussed in 1988, 1989 and 1990. Issues of social and health inequality also began to emerge related to specific groups: women, adolescents, sexually abused children, immigrant and visible minority women (see Appendix A).

In 1987 the committee engaged in another priority setting exercise resulting in a new set of activities to be addressed in the coming year:

- Cardiovascular Health
- Reproductive Health
- Home Care
- Smoking
- Alternative Health Delivery Strategies
- Health Information Clearinghouse(s)[40]

The breadth of the ACCH domain was relatively wide throughout the life of the committee as it engaged in issues pertinant to the community health, public health and health promotion fields. Health problems tended to be those individuals were seen to be able to prevent if given proper information or services or means to function better within their community. What stands out in reviewing how problems were addressed is the emphasis on co-ordinated programs and services. The National Strategy to Reduce Smoking was a perfect example. Health promotion was the central technique used to change the lifestyle habits of the population. Provincial action was co-ordinated and supported by the federal government for national consensus on specific issues and projects. Research, policy discussion and information sharing was also part of the work of the Advisory Committee.

3.2 The Shift to Population Health

At the twentieth meeting of the Advisory Committee on Community Health, in November 1992, it was announced that the Conference of Deputy Ministers of Health had decided to restructure the advisory committees. Based on a proposal to the Deputies, conveying the argument that the concept of health was "more and more driven by determinants of health," it was decided to terminate the ACCH to form a Population Health Advisory Committee (ACPH).[41] To better integrate the work of all the committees and ensure that they address the real questions pertaining to strategic directions and cost effectiveness of interventions, it was decided that the ACPH should "play a co-ordination role and be strategic in its thinking."[42]

From March 1993 to February 2000, the ACPH met nineteen times. The frequency of meetings began to accelerate in 1995, to three per year plus an average of six teleconference calls per year over the next five years (see Appendix A, page 29). Workload and budget for the committee grew substantially over this period as well. In reviewing the work of the ACCH (and several standing committees – AIDS, Mental Health, Alcohol and Other Drugs and Community

Health – that by 1987 had shifted to the status of advisory committees), it was suggested in 1993 at the first meeting of the ACPH that "a high profile be given to health promotion activities such as Healthy Communities."[43] Instead, the new committee took a distinct turn from its main predecessor and immediately set to work on two major initiatives: a) national health goals, b) a health strategies report.

The health goal approach was chosen as the tool to set priorities and a policy agenda.[44] Decisions on continuing the work of committees on Mental Health, Alcohol and Other Drugs, Women's Health and Health Promotion from the ACCH were deferred until the completion of a National Health Goal Setting Exercise by a Task Group on Health Goals. A Disparities in Health Status Task Group was also struck but failed to reach consensus on future policy directions. This groups was therefore rolled into the effort to establish National Health Goals which was then linked to a *Strategies for Population Health* paper. By the third meeting of the ACPH in 1994, it was stated that "further attention to this area [disparities in health status] may be appropriate once the Committee selects population health strategies to work on."[45] In the meantime, the Task Group on Health Goals produced an internal working paper entitled *Analytic Review Towards Health Goals for Canada*.[46] The ambitious framework for setting national health goals in the document required a level of consensus that would be difficult to attain, particularly when setting corresponding indicators, quantified targets, measurement and monitoring components sensitive to the uniqueness of each jurisdiction.[47] Thus, instead of forging ahead with health goals, the framework developed was moved to the *Strategies for Population Health* document as a population health framework. The two initiatives thus converged into the report released by ACPH in February 1995 as *Strategies for Population Health: Investing in the Health of Canadians*.

When the report gained the approval of the Conference of Deputy Ministers and Ministers of Health, population health was publicly declared the new paradigm for health policy. Releasing the *Strategies* document also signalled that the Advisory Committee on Population Health had embraced a new approach to health and took on the role of advocate. *Strategies for Population Health* was a public endorsement of the work of the Canadian Institute for Advanced Research, a think tank that created the concept of population health through a series of meetings and writings in the late 1980s and early 1990s.[48] The ACPH translated this into an approach

(also known as the determinants of health approach) by arguing that conducting research through this lens and using these findings in public policy would improve the health of the population. Thus, instead of addressing particular health problems like the ACCH, the ACPH chose to articulate a way of thinking about health.[49]

To illustrate the utility of population health, the approach was embedded into every aspect of the work of the committee. Other than specific public health problems discussed on an issue-by-issus basis, the only strategy carried forward from the ACCH was the National Tobacco Strategy, mentioned once in 1999 (see Appendix A). Health promotion activities and work on addictions and were dropped as all efforts concentrated on advancing the population health approach through a) education and b) research. A Working Group on Determinants of Health was struck and a public education strategy embarked upon in March 1995 with its first task to revisit/clarify the definition of population health.[50] Major projects worked on from the inception of ACPH to February 2000 include:

- Report of the Health of Canadians (1993-1999)
- Women's Health (1994-1997)
- Cross Sectoral Strategies /Collaboration Intersectoral Action (1995-1999)
- Population Health Strategy (Strategic Directions/Indicators) (1995-1999)
- Healthy Child Development – National Strategy (1995-2000)
- AIDS (1997-2000)

Topics addressed consistently for three years or more include:

- Environmental and Occupational Health Committee (1994-1996)
- National Forum on Health (1995-1997)
- (WHO) Renewal of Health for All Strategy (1995-1997)
- Population Health Research – RFP (1995-1997)
- Quality of National Vital Statistics (1998-2000)
- National Children's Agenda (1998-2000)

Overall, an emphasis was placed on achieving understanding and support for the population health approach from the public, government and private partners.

Research to provide the evidence for population health interventions was also pursued. The ACPH aided the development of population health research centres as well as producing and analysing data in numerous documents of their own. Part research, part advocacy, the following

policy reports produced by the ACPH are arguably the primary outcome of their efforts to advance a new paradigm for health.

ACPH Documents	
Strategies for Population Health: Investing in the Health of Canadian	1995
Report on the Health of Canadians	1996
Building a National Strategy for Healthy Child Development	1998
Quality of National Vital Statistics: Report of the ACPH Working Group	1999
Intersectoral Action: Towards Population Health	1999
Investing in Early Child Development: The Health Sector Contribution	1999
Towards a Healthy Future: Second Report on the Health of Canadians	1999
New Directions for Tobacco Control in Canada: A National Strategy	1999
Intergovernmental Collaboration on HIV/AIDS	1999

The reports consist of a theoretical framework and compilation of statistical correlations demonstrating that various determinants influence health. Offering information on trends in health status through the population health lens is intended to educate people about the approach and guide health intervention. Nine determinants are divided into the following framework of categories (sometimes referred to as a framework for action):

- personal health practices
- individual capacity and coping
- social and economic environment (living and working conditions)
- physical environment
- health services

Using this schema of underlying causes, statistics are presented for each and comparisons made to other countries or between provinces or using other distinctions in the Canadian population such as age, gender, Aboriginal and recent immigrant. Listed at the end are “health challenges” or “priorities for action,” where possible health status improvements are identified. In offering several areas for improvement, the reports generally leave considerable room for discretionary decision-making. This implicitly acknowledges that each federal, provincial and territorial jurisdiction may select a different determinant to design programs for or address first. It also leaves unaddressed what policy instruments are available to achieve health status improvements. Acknowledging that most determinants of health lie outside of the health sector, several reports

call for inter-sectoral collaboration. Contained in these documents is the premise that theory translates into action first by producing the evidence-based research on determinants, followed by securing inter-departmental, inter-jurisdictional and private sector support to fund programs.[51]

The ACPH resumed efforts to develop national health goals from 1996 to 1998, but again abandoned this work (see Appendix A). Jurisdictions were instead asked in 1998 to seek endorsement for five broad strategic directions "which could provide a strong basis for inter-jurisdictional and inter-sectoral collaboration."[52] Based on a population health perspective, the statements were given the title National Health Strategies and endorsed by the Conference of Deputy Ministers of Health. Provinces could use this as a framework 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.

Representatives from ACPH would also contribute to an overall accountability framework for Regional Health Authorities developed by a working group of the Advisory Committee on Health Services. In the process of working on and eventually giving up the health goals exercise, the commitment to include health promotion and focus on disparities in health status appears to have been lost. While inequality takes a central place in the theory of population health, only once was the issue of economic inequality/poverty explicitly addressed at the ACPH over the course of the 1990s.[53] The decision to advance a paradigm for health rather than address specific problems to guide health intervention may have hindered the ability of the committee to initiate programs. Of the ambitious list of determinants, the two issues developed into national strategies were Immunization and Healthy Child Development.

3.3 Comparison of ACCH and ACPH

Unlike the integration process of the early 1980s, which diffused the rivalry between different approaches, the move from Community Health to Population Health was in many ways abrupt. While supporters of public and community health largely accepted population health,

adherents of health promotion did not. By simply dropping issues (such as addictions) that health promoters took to be serious health problems, the contribution of these professionals appeared to be dismissed. Population health reasserted the connection of health to medicine by supporting scientific research rather than building upon the socially oriented work that dominated the decade before (which fell in the fields of social work, sociology and social or behavioural psychology). As the new paradigm took over, two competing factions developed. The mandate and core work of each committee illustrates the difference in the two approaches to health.

AC Community Health	*AC Population Health*
Mandate: 1. It was agreed that the Advisory Committee's mandate is to deal with community health and health promotion issues; in the case of prevention, with a very broad perspective to include prevention or reduction of institutionalisation, where appropriate, or loss of independence in the community, and not to deal with jurisdictional issues.[54] Priority areas: 1. Smoking 2. Cardiovascular Disease 3. Mental Health Key Issues Addressed: National Strategy to Reduce Smoking Alcohol and other Drug Problems Cardiovascular Disease Health Promotion Survey Public Health Issues: Immunization, Periodic Exam, Poison Control Program, Information and Training for Community Public Health Nutrition Primary Health Care Liaison to WHO (Integrated Program on Non-Communicable Diseases) and CPHA Long Term Care, Home Care Family Planning	Goal: "To improve the overall health of the population and reduce disparities experienced by certain groups of Canadians, within a determinants of health framework."[55] Mandate: "To address major issues that affect the health and well being of Canada's population as a whole, as well as groups with less favourable health status. The Committee will make recommendations based on analysis of population health data, as well as factors which influence health, in the context of finite resources." Role: "To advise the F/P/T Conference of Deputy Ministers of Health on national and interprovincial strategies that should be pursued to improve the health status of the Canadian population and significant sub-populations, and to provide a more integrated approach to health." Four Key Areas of Focus (1994): • Education and Communication • Health Information and Research • Cross-sectoral Consultation and Collaboration • National Population Health Strategies

The main distinction from 1984-1992 to 1992-2000 in what is important to "health" and how the committee did its work can be characterized as a change from following to leading health policy. The ACPH has become a major player in setting policy direction based on their success as a primary force in a) mobilizing the federal and provincial governments to adopt a population health approach, b) launching a new academic discourse and c) re-orienting health research in the country through funding centres and producing their own policy documents. There is a notable shift from a focus on addictions to one on evidence and advocacy. The main work of the ACCH was to oversee national strategies to reduce the prevalence of health problems that were socially caused and/or infectious. The main work of the ACPH has been articulating what population health is and advocating its adoption as an approach.

After amalgamation with Community Health Services in 1984, health promotion did not have an advocate within the advisory committee structure. Consequently, health promotion was reduced from a guiding philosophy to a programming technique.[56] The grassroots and values orientation was set aside but social marketing accepted and used as a means in programming by public health, community health and population health. What distinguishes the latter three health fields (to varying degrees) from health promotion is a link to medicine through the privileging of scientific evidence. In fact, it could be argued that a critical dimension of the population health approach is to prove that social phenomena are biologically based. The premise is that only upon the discovery of positive knowledge will government intervention take place, and, be appropriate.

In sum, advocacy and evidence production to set a new health policy agenda based on the population health approach replaced the co-ordination of national strategies to alleviate specific health problems. The current health committee thus became less of a vehicle to initiate and oversee inter-jurisdictional action. Reports gave health ministers a resource to draw on that presents good news on progress made while identifying areas for improvement. No theoretical links are made between the compilation of statistics broken up into the determinant categories or to other theories regarding class, gender, the environment or economy. Where the approach leads in policy terms is therefore unclear. Although some ACPH reports employ the language of rights, the underlying debate over the appropriate role of government relative to the private sector is avoided.[57]

In spite of the stated goal of the ACPH to reduce disparities in health status, the ACCH spent more time addressing issues of inequality. This was done on an ad hoc basis, as the public became aware of specific problems: child sexual abuse, the health of immigrant and visible minority women, and the long-term needs of seniors and the disabled (see Appendix A). The ACPH's work on its goal statement – "to improve the overall health of the population and reduce disparities experienced by certain groups of Canadians" – appears to have been derailed by concentrating on the latter half of the statement: "within a determinants of health framework." It is notable, however, that since health promotion strategies tended to be most effective for main stream society, neither committee appears to have found ways to address the health of Canadians with the least favourable health status.

Finally, the changing nature of Canadian federalism plays an important part in accounting for the shift in role from the ACCH to ACPH. Key political events during this period are as follows:

1980	Québec Referendum
1982	Repatriation of the Constitution
1987	Failed Meech Lake Constitutional Accord
1992	Failed Charlottetown Constitutional Accord
1993	Election of the Bloc Québécois and Reform Party to the House of Commons
1995	Québec Referendum

Constitutional tensions in the early 1990s led to further decentralization of the federation, and then rules governing federal funding for national programs also changed with the introduction of the Canadian Health and Social Transfer in 1995. Rather than conditional funding, the block transfer allowed provinces greater autonomy in program spending. While this change in jurisdictional relations has put the ACPH in a position of far greater influence, it may also have led to a focus on evidence building and general recommendations instead of action.

4 Conclusion

Three conclusions can be drawn from this survey of the changes to the health committee(s) over the last twenty-five years.

- Medicine remains a thorn in the side of other means to improve health. The relationship between biological and social causality of health problems needs to be reconciled and acknowledged.
- A related matter is the need to link social and economic policy to health status. At the federal government, these two areas have only moved further apart in dividing the Department of Health and Welfare into Health Canada and Human Resources Development Canada. This is contrary to the knowledge regarding health articulated by health promotion and population health.
- The impetus behind the transitions is notable. The first transition to integrate health promotion with public and community health was driven largely by a change in disease prevalence. The second transition from community health to population health was driven primarily by a change in health politics as resources shifted from interventions in the form of national strategies to research and advocacy. This may reflect fiscal problems in all twelve governments and/or resistance to national strategies on the part of the provinces.

Finally, two comments on the history of these committees. The current Advisory Committee on Population Health is defined by and committed to a particular approach to health. In contrast, the Advisory Committee on Community Health through amalgamation had less allegiance to a particular approach. History shows that committee names and mandates evolve with major changes over four to eight-year lifespans. It would, therefore, not be unreasonable to expect a change in the work of the ACPH in the near future. It should also be noted that the irony of the thinking about health in the 1990s is that during a period in which inequality was much discussed, it has arguably become worse. As levels of inequality fluctuate as a function of economic trends and social structures, the success of the population health approach may depend upon variables that the current health committee acknowledges are beyond its mandate to control. It is perhaps for this reason that the ACPH has thus far demonstrated an ability to measure but not prevent poor health, particularly for groups with less favourable health status.

Appendix A									
ACCH									
Issue	**Timeframe**								
	1984	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**
1. **Smoking**									
SC/WG National Strategy to Reduce Tobacco Use	1984	1985	1986	1987	1988	1989	1990	1991	1992
Smoking in the Work Place			1986	1987					
Special Request from Physicians for a Smoke-free Canada			1986						
Alcohol and Other Drug Problems	1984	1985	1986	1987					
Health and Safety Relating to the Use of Alcohol in the Workplace			1986						
National Consultation on Women and Drugs			1986						
2. **Cardiovascular Disease** – hypertension, blood cholesterol (WG)	1984	1985	1986	1987	1988	1989	1990		
Cholesterol Strategy						1989		1991	
High Blood Pressure		1985		1987					
3. **Mental Health**	1984	1985							
Nutrition	1984	1985	1986	1987	1988	1989	1990		
Group on Nutrition						1989	1990		
Home Care/Long-Term Care	1984								
Steering Group on Psychogeriatrics						1989			
Federal Seniors Initiatives					1988				
SC/WG on Home Care/Long Term Care		1985	1986	1987	1988	1989	1990		
Subcommittee on Continuing Care								1991	1992
Community Level Health									
WG Community Health Information	1984	1985		1987		1989	1990		
Accreditation of Community Public Health Programs	1984	1985							
Fed/Prov Consultation on Community Approaches to Rehabilitation		1985							
Community Health Services/Provincial Visits				1987					
Community Health Services Guide for Hard to Reach Youth				1987					
Report on CPHA "Strengthening Community Health Services"				1987					
Strengthening Community Health Programs						1989	1990		
Manpower Planning S&D for Local Public Health Physicians			1986						
Community Health Evaluation and Needs Assessment (CHENA)					1988				
Community Risk Factor Survey						1989			
Revisit Priorities in Community Health						1989			
WG on Community Health Intervention Monograph			1986	1987	1988	1989	1990	1991	1992
Traditional Public Health									
Immunization (WG)	1984	1985	1986						1992
Periodic Health Examination	1984	1985	1986						
WHO programme on communicable disease	1984								
Communicable Disease Control								1991	
National Committee of Food and Regulatory Health Officials	1984	1985							
Proposed Provincial Action Regarding Availability of the New Haemophilus Influenza b Vaccine			1986						
Manpower Planning Supply and Demand for Local Public Health Physicians			1986						
Status of LCDC			1986						
Development of a Community Health Intervention Monograph			1986						
Vaccine Compensation Issue			1986						
Group on Public Nursing Consultants					1988	1989	1990		
Future Need for Schools of Public Health in Canada						1989			
Canadian Association for School Health							1990		
Community Health Evaluation and Needs Assessment							1990		
CPHA-CEIC Study on Public Health Personnell								1991	1992

Health Care									
Primary Health Care			1986						
National Task Force on the Role of the Nurse in Reproductive Care			1986						
Report on Provincial Rehabilitation Services				1987					
Future Directions for Health Services					1988				
Alternative Health Delivery Strategies					1988				
Scoliosis Screening				1987					
Cancer									
Cervical Cancer						1989	1990		
Early Detection of Breast Cancer (Screening)					1988	1989	1990	1991	
Cancer 2000							1990		
Family Planning	1984								
Clearing House on Adolescent Sexual Health				1987					
WG on Adolescent Reproductive Health			1986	1987	1988	1989	1990		
Health Promotion								1991	1992
Health Promotion Survey	1984	1985	1986						
Health Promotion Contribution Program				1987					
Provincial Participation to Inter Regional Conference on Health Promotion			1986						
Private and Public Sector Cooperation in Health Promotion				1987					
Health Promotion and Disease Prevention Policy			1986		1988				
Achieving Health for All				1987	1988				
(Sep-Prov consultations); July88-Framework									
Federal Knowledge development: Health Promotion Framework					1988				
National Health Goals						1989			
AIDS									
Report on AIDS		1985	1986		1988	1989			
CPHA AIDS Awareness Program (briefing)				1987					
Update on federal AIDS activities/provincial discussion				1987		1989			
AC on AIDS				1987	1988	1989			
Injuries									
Childhood Injury Surveillance Program							1990		
National Symposium on Injury Prevention									
Prevention of Injuries								1991	1992
Other									
Federal Program on Child Sexual Abuse			1986	1987	1988				
Guidelines for Community Health Workers on Child Sexual Abuse				1987					
Canadian Public Health Association		1985							
Poison Control Program	1984	1985		1987	1988	1989	1990	1991	
Child Health Record	1984			1987					
Occupational Health Programs	1984								
WHO Integrated Program on Non Communicable Diseases		1985	1986						
Maternal and Child Health			1986	1987					
Family Functioning			1986						
Advisory Committee review				1987					
Reporting Mechanism of Substructures on ACCH			1986						
Liability Issues (Blood)				1987					
Proposal for the Creation of a SC on Tuberculosis				1987					1992
Health Concerns of Immigrant and Visible Minority Women				1987	1988				
Nobody's Perfect (mental health or smkg?)				1987					
Advisory Committee on Epidemiology					1988	1989	1990		
Ultraviolet light – Tanning Booths						1989			
Ontario's Office for Women's Health						1989			
National Health Information Council						1989	1990		
Dental Directors Health Council					1988	1989	1990		
Wilks Task Force							1990	1991	
Impact of the Environment on Human Health								1991	
Task Force on the Treatment of Obesity								1991	
Children and Youth									1992

ACPH								
Issue	**Timeframe**							
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
National Health Goals	1993				1997			
Vaccine Preventable Disease Goals				1996				
National Population Health Goals (WG)				1996	1997	1998		
Strategies for Population Health Paper	1993	1994	1995					
Report on the Health of Canadians	1993	1994	1995	1996	1997	1998	1999	
Second Report on the Health of Canadians							1999	2000
Disparties Task Group		1994						
Women's Health		1994	1995	1996	1997			
Gender and Health					1997			
Environmental and Occupational Health Cttee		1994	1995	1996				
National Accord on Health and the Environment				1996				
Principles of Co-operation amg Health and Environment					1997			
Population Health Intelligence Network		1994	1995					
Canadian Institute on Health Information		1994						
Round Table/Inventory of F/P/T Pop H Initiatives		1994						
Inventory of Pop Health Activities			1995	1996				
Policy Analysis of the Barriers to Advancing PH				1996				
Population Health - Public Education Strategy			1995	1996				
Public Perception of Determinants of Health (WG)					1997	1998		
Population Health - definition					1997			
Population Health Index			1995					
Population Health Strategy(Stategic Directions/Indicators)			1995		1997	1998	1999	
HC's Population Health Strategy (Consultations)					1997	1998		
Strategic Futuring Exercise								2000
Population Health Research - RFP			1995	1996	1997			
Creation of a Population Health Studies Program								
Cross Sectoral Strategies/Collaboration Intersectoral Action			1995	1996	1997	1998	1999	
Health Promotion				1996				
CPHA - Perspectives on Health Promotion			1995	1996				
WHO Health Promotion Strategy			1995	1996				
(WHO) Renewal of Health for All Strategy			1995	1996	1997			
Health Promotion/Population Health								
National Forum on Health			1995	1996	1997			
Review of AC Structure			1995					
Axworthy Initiative			1995					
Hepatitis C			1995					
Child Health Strategy			1995					
Healthy Child Development -Nat'l Strategy			1995	1996	1997	1998	1999	2000
Centres of Excellence for Children's Well-Being						1998		
National Children's Agenda						1998	1999	2000
Early Child Development Paper							1999	
Investing in Early Child Dev: The Health Sector Contribution							1999	2000
Healthy Adolescent Development Paper							1999	2000
Canadian Health and Social Transfer (CHST)			1995					
Diabetes Council of Canada			1995					
Two Dose Measles			1995					
Prevention of Neural Tube Defects				1996	1997	1998		
WHO Updates				1996				
Infant Mortality				1996				
Infant Mortality and Low Birthweight					1997			

Health Monitor Survey Results				1996	1997			
WG on Public Health					1997	1998	1999	
Public Health Goals				1996				
Canadian Contingency Plan for Pandemic Influenza							1999	2000
Nat'l Strategies for Immunization							1999	2000
National Framewk for Injury Prevention and Control							1999	2000
Injection Drug Use paper							1999	
Public Health Infrastructure Initiative							1999	
Harm Reduction Paper							1999	
Anti-Microbial Resistance							1999	
Cancer Control Initiative								
Influenza Crisis								2000
National Health Surveillance Network							1999	2000
Review of Public Health Capacity in Canada								2000
Strategies to Reduce Harm Associated with Injection Drug Use								2000
Canadian Strategy for Cancer Control								2000
ACPH Website					1997			
AIDS					1997			
F/P/T AC on AIDS					1997	1998	1999	2000
AC on Fitness and Recreation					1997			
Population Health Policy Framework					1997			
Tobacco Issue					1997			
F/P/T Tobacco Strategies					1997			
National Tobacco Strategy							1999	2000
Folic Acid Pilot					1997			
Canadian Health Information System (CHIS)					1997			
Canadian Foundation for Innovation					1997			
Sustainable Development and Global Change Program					1997			
National Roundtable on Recreation								
Population Health Institute					1997	1998		
National Population Health Clearinghouse (HC)						1998		
Health Transition Fund						1998		
Quality of National Vital Statistics						1998	1999	2000
Canadian Population Health Initiative (CPHI)						1998	1999	
CIHI Update on Roadmap							1999	
Policy Research Committee Report						1998		
Canadian Health Network						1998	1999	
Economic Inequality/Poverty							1999	
Millennium project							1999	
Health Information Roadmap							1999	
Self-care/Tele-care							1999	
National Varicella Consensus Conference							1999	
CPHA 2000							1999	
F/P/T Infrastructure							1999	
Canadian Health Network (CHN)								2000
ACHI								2000
Canadian Community Health Survey (CCHS)								2000
Strategic Reflection								2000

					ACCH				
20 Meetings:									
	1984	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**
	Sept	Jan	Feb	Feb	July	April	May	July	July
		April	June	June	Oct	Oct	Oct	?	Nov
		Sept	Sept	Sept					
					ACPH				
19 Meetings:									
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	
	March	May	March	March	Jan	Jan	Jan	Feb	
		Oct	June	May	April	April	April		
			Oct	Oct	Oct	Oct	Oct		
Teleconference Calls			3	5	9	7	6		

[1] Members of the current health committee, the Advisory Committee on Population Health do not have fixed terms nor criteria for selection other than holding a position at the Assitant Deputy Minister (ADM) level responsible for population or public health. The ADM of Population Health and Public Health at Health Canada designates the federal representative. The Chair also has the support of an associate. Interview with Pierre Génier, Manager, Development and Project Management Section, FPT ACPH Secretariat. January 16, 2001.

[2] All advisory committee meeting minutes prior to 1994 did include minimal remarks, including quotations. After the second meeting of the Advisory Committee on Population Health meeting minutes were replaced by a record of decisions noting only the agenda and decisions made.

[3] Health and Welfare Canada, "Federal Provincial Territorial Advisory Committee" Descriptive Inventory, June 1991. Introduction, p. 1.

[4] When the territories gained independent governing status the federal government no longer represented them. A representative of the Yukon and Northwest Territories was therefore added in the 1980s and the committee title changed to Federal/Provincial/Territorial Advisory Committee (FPTAC). After 1999 a representative of Nunavut was added.

[5] "Federal - Provincial Advisory Committee on Health Promotion: History, Terms of Reference Activities and Accomplishments," revised September 1983.

[6] "Federal Provincial Territorial Advisory Committee" Descriptive Inventory, June 1991.

[7] "Federal - Provincial Advisory Committee on Health Promotion" 1983 *op.cit.* p. 6.

[8] *Ibid.*

[9] The Conference of Deputy Ministers had become concerned about the number of federal/provincial advisory committees.

[10] "Federal Provincial Territorial Advisory Committee" Descriptive Inventory, June 1991. Introduction p. 1.

[11] Minutes of the First Meeting of the Federal-Provincial-Territorial Advisory Committee on Population Health, Toronto, Ontario, March 25, 1993.

[12] Minutes of the First Meeting of the Federal-Provincial Advisory Committee on Community Health Services, September 20-21, 1978, Ottawa.

[13] *Ibid.*

[14] Rick J. Carlson "Business as Usual?" Richard H. Egdahl and Paul M. Gertman (eds.) *Technology and the Quality of Health Care* Germantown, Maryland: Aspen Systems Corporation, Boston University Health Policy Institute, 1978. p. 48.

[15] *Ibid.*

[16] Report of the Meeting of the Federal - Provincial Advisory Committee on Community Health Services, April 22 and 23, 1981, Ottawa, Ontario. p. 3.

[17] Report of the Meeting of the Federal - Provincial - Territorial Advisory Committee on Community Health Services, November 3-4, 1982, Ottawa, Ontario p. 9.

[18] At this time, the Chairperson of the AC on Community Health was Dr. M. Law and Co-chairperson of the AC on Health Promotion was Ron Draper. Both federal civil servants, Draper was the Director General of the Health Promotion Directorate from 1978 to approximately 1987. Law was a Assistant Deputy Minister on the Health Side around this time.

[19] Minutes of the First Meeting of the Federal-Provincial-Territorial Advisory Committee on Community Health Services, September 20-21, 1978, Ottawa.

[20] Appendices, "Federal - Provincial Advisory Committee on Health Promotion" *op. cit.*

[21] *Ibid.* Appendix titled "Major Accomplishments" p. 29-36.

[22] Lavada Pinder "The Federal Role in Health Promotion: Art of the Possible" Pederson, A., O'Neil, M., and Rootman, I. (eds.), *Health Promotion in Canada*, Toronto: W. B. Saunders, 1994, p. 99.

[23] Proceedings of the First Meeting of the Advisory Committee on Community Care, Ottawa, Ontario, September 20-21, 1978. p. 2.

[24] *Ibid.*

[25] Report of the Second Meeting of the Federal - Provincial Advisory Committee on Community Health Services, March 21-22, 1979, Ottawa, Ontario, p. 3
[26] Report of the Third Meeting of the Federal - Provincial Advisory Committee on Community Health Services, October 31, 1979, Halifax, Nova Scotia. p. 14.
[27] Report of the Meeting of the Federal-Provincial-Territorial Advisory Committee on Community Health Services, April 22-23, 1981, Ottawa, Ontario.
[28] Moved by Dr. Suttie, Ontario, and Dr. Walker, Saskatchewan. Report of the Meeting of the Federal - Provincial - Territorial Advisory Committee on Community Health Services, May 30-31, 1983, St. John`s, Newfoundland. p. 20.
[29] *Ibid.* Stated by Mlle Gareau, Co-Chairperson, National Health and Welfare.
[30] Lavada Pinder, 1994. *op.cit.*
[31] *Ibid.*
[32] Interview with Dr. Jo Hauser, former director in the Department of Health and Welfare, September 13, 1999.
[33] Interview with Gerry Dafoe, CEO, Canadian Public Health Association, August 1999.
[34] Minutes of the First Meeting of the Federal-Provincial Advisory Committee on Community Health, September 12-13, 1984, Ottawa, Ontario. p. 1
[35] *Ibid.*
[36] *Ibid.*
[37] Note that only a brief description of agenda items was recorded in ACCH minutes. ACPH records contain only agenda items and no substantive discussion.
[38] Minutes of the First Meeting of the Federal-Provincial Advisory Committee on Community Health, September 12-13, 1984, Ottawa, Ontario. p. 1
[39] *Ibid.* Appendix IV p. 21
[40] Minutes of the Tenth Meeting of the Federal-Provincial Advisory Committee on Community Health, September 23-24, 1987. Agenda item: Priority Setting
[41] Minutes of the Twentieth Meeting of the Advisory Committee on Community Health, Ottawa, Ontario, November, 1992.
[42] First Meeting of Advisory Committee on Population Health, Toronto, Ontario, March 25, 1993.
[43] *Ibid.*
[44] Health Goals was an idea discussed once in 1989 at an ACCH meeting.
[45] Record of Decisions, Third Meeting of the Advisory Committee on Population Health, Toronto, Ontario, October 5-6, 1994.
[46] Diane McAmmond and Associates, *Analytic Review Towards Health Goals in Canada*, Final Report, May 1994.
[47] Interview with Diane McAmmond, consultant to the Advisory Committee on Population Health, October 3, 1999.

[48] See 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.
[49] *Ibid.* p. 6.

[50] Record of Decisions, Fourth Meeting of the Advisory Committee on Population Health, Toronto, March 21-22, 1995. Note that this is an exercise the Advisory Committee on Health Promotion underwent in 1980 (see page 9).
[51] *Report on the Health of Canadians*, Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of Ministers of Health, Toronto, Ontario, September 10-11, 1996. p. 76.
[52] Record of Decisions, Thirteenth Meeting of the Advisory Committee on Population Health, Vancouver, January 29-30, 1998.
[53] Record of Decisions, Sixteenth Meeting of the Advisory Committee on Population Health, Edmonton, January 28-29, 1999. Agenda item "Inequality/poverty" (see Appendix A, page 28). The main message of population health, also known as 'inequalities in health' is that there is a gradient correlating poor health status with socioeconomic status, with the lower income group showing poorer health, earlier death, etc.
[54] Terms of Reference, Minutes of the First Meeting of the Federal - Provincial Advisory Committee on Community Health, Ottawa, Ontario, September 12-13, 1984. p. 4.

[55] Advisory Committee on Population Health, Terms of Reference, (version written after March 1998).
[56] See Labonte, R. "Population health and health promotion: What do they have to say to each other? *Canadian Journal of Public Health* 86(3): 165-168, 1995 reviewed in Hayes and Dunn, *op.cit.* p. 31.
[57] See Michael V. Hayes and James R. Dunn, 1998. *op.cit.* for a overview of the work of R.G. Wilkenson and R. Labonte in critizing the CIAR's model of economic growth.