MAKING THE LALONDE REPORT

Towards a New Perspective on Health Project, Health Network, CPRN
Background Paper

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Introduction

In February 1971 the Health Side of the Department of National Health and Welfare established a unit called the Long Range Health Planning Branch (LRHPB). Their most notable creation was *A New Perspective on the Health of Canadians: A Working Document*, now remembered as The Lalonde Report after then Health Minister Marc Lalonde.[1] As a green paper, the report was not a policy statement but a think piece announcing the government's perspective on health.[2] When released on May 1, 1974 in the House of Commons the paper was addressed that day and virtually forgotten. Having just received a copy, opposition parties to the Liberal government of Pierre Trudeau welcomed but mocked the paper as "solidly in the motherhood realm."[3] One member retorted that they were already aware that the minister was against sin with respect to the Canadian affliction of "spectatoritis." Another stated that it was agreed upon some time ago that it is better to be slim than fat.[4] Progressive Conservatives, New Democrats and Social Credit members also argued that if the minister was serious about the health of Canadians they should fight inflation, restore funding to the Medical Research Council and improve social security.[5]

Buried amongst other events and announcements, *A New Perspective* did not receive media attention in spite of an advertisement placed in newspapers across the country announcing the release of the report. Nonetheless, the fifty thousand copies printed in the first run for distribution to health professionals, institutions, elected officials, libraries and agencies began a slow but steady reaction. It was not the media but letters commenting on the paper and requesting copies that led over time to small quantities of re-prints ordered again and again. By the end of 1977, 140,000 copies had been printed and distributed.[6] Contrary to the pattern of most government documents, interest did not subside - it grew.[7] Hubert (Bert) Laframboise, the Director General of the Long Range Health Planning Branch from 1971 to 1975, claimed that by 1978 "the Working Document had become an integral element of health policy planning not only in Canada but in many other countries."[8] In 1984 it was heralded as a "world-class document," and "one of the great achievements of the modern public health movement."[9]

By the new millennium, *A New Perspective on the Health of Canadians* remains regarded within the health field as one of the most significant government documents produced in Canada's recent past. This is based on the view that the ideas it contained represented a "discontinuous jump" in thought.[10] The green paper provided the conceptual framework to inspire a paradigm shift by officially announcing that health was more than health care. Although health education and health campaigns had been pursued prior to this time, these efforts remained minimal relative to the early emphasis on health protection and (post-1945) on medicare. *A New Perspective* changed the orientation of federal health policy by giving birth to health promotion.

Given the role of *A New Perspective* in the history of health policy development in Canada (and abroad), this paper analyses how and why the report was written.[11] Bert Laframboise wrote two articles giving his account of the conditions that enabled the creation of the Lalonde Report. A different version of the story is told, however, in archival records of the work, thinking and role of the Long Range Health Planning Branch (LRHPB). A few key informant interviews supplement articles and historical records from the Department of Health and Welfare drawn on to examine the origins of health policy beyond medical care in Canada.[12] The majority of files reviewed consist of correspondence between the Director General of the LRHPB, Hubert (Bert) Laframboise and Deputy Minister, Dr. Maurice LeClair or documents prepared for the Policy Review Group.

Part one of this paper begins with an analysis of the role of the LRHPB, the ideas that emerged there and then tells the story of the creation of the Health Field Concept (HFC) based on archival materials from the early 1970s. Part two analyses the rationale, application and dissemination of the Health Field Concept that led to the decision to write *A New Perspective*. The paper is drawn to a close by examining the lessons learned from the making and model of the Lalonde report.

PART I Thinking about Health

The Director General of the Long Range Health Planning Branch wrote two papers on the development of *A New Perspective on the Health of Canadians* both of which emphasise the

exclusivity and rapidity of the process by which the Report was written. "Still Riding the Crest of a Wave: An Appraisal of *A New Perspective*" was written in 1978. In 1990 his article "Non-Participative Policy Development: The Genesis of *A New Perspective on the Health of Canadians*" was published in the *Journal of Public Health Policy*. The central argument in the 1990 paper is that *A New Perspective* is "an extreme, and successful, example of non-participative policy development."[13] Here Laframboise highlights the contribution of an unusual process whereby no external or internal consultation occurred. Only upon presentation of the green paper to Cabinet in January 1974 did other departments become aware of its existence and only when tabled in the House of Commons did outside groups first learn of the paper.

Archival records affirm the comparatively non-consultative process through which the document was created but show an internal process of development and refinement of its centrepiece, the Health Field Concept. From August 1972 to June 1973 versions of a paper articulating the HFC were circulated among senior staff in the department. This refinement process led to the publication of an article by Laframboise entitled, "Health policy: breaking the problem down into more manageable segments," in the *Canadian Medical Journal* in 1973.[14] Prior to the release of the Lalonde Report, the framework was also applied within the Health Side of the department as a tool of analysis for program and policy review. This process built internal support for the Planning Branch's work, complemented by public dissemination of the Concept by LRHPB members and the Minister to test stakeholder acceptance. Documents from this period shed light on the thinking behind the essence of *A New Perspective*, the Health Field Concept framework.

The Long Range Health Planning Branch

Created by directives from the Minister and Deputy Minister, the Long Range Health Planning Branch existed from 1971 to 1978. During this time, the Branch held an exceptional position in the Department of National Health and Welfare. To begin their work the Director General hired eight Policy Planning Consultants of his choice, the majority from outside government and a few from other departments.[15] Each was assigned the task of investigating a

distinct area of research. Senior management stated that the purpose of the Branch was to evaluate programs and proposals.[16] For Laframboise, this meant "to identify and assess major issues and trends in the health field which had not yet clearly emerged."[17] Describing this as "futures research" the Director argued that issues on which there was no consensus deserve attention on the basis of their potential to possess long-term health benefits to Canadians. Findings could be used as benchmarks against which to evaluate the work of the Health Side of the department. Thus, the work of reading, writing, participating in meetings and conferences, and engaging with direct contacts in the health field began. Over the next number of years, branch staff produced internal and public reports, published articles in journals and delivered lectures and speeches.[18]

At the time the LRHPB was formed, the Health Side of the Department of National Health and Welfare – which was far smaller than it is today - did not have a policy unit. The Long Range Health Planning Branch functioned separately from the medical service, health protection and health program branches.[19] In terms of the organisational structure of the department, the Branch was an anomaly. It reported directly to the Deputy Minister's office and held no operational responsibilities. Policy Planning Consultants were not obliged to fulfil any of the usual departmental requirements such as briefing notes and committee meetings.[20] Its head called himself a Director General, and related to his staff as such, yet officially held the status of Assistant Deputy Minister. This meant that he participated in senior level management meetings.

One minor role in their overall activities was a research and co-ordination function to senior management's Policy Review Group. Administrative staff ran a Planning Information Centre from 1973 onward, which produced a monthly list of departmental activities. Policy Planning Consultants conducted at least two studies to assist the Review Group's work. This constituted the full extent of interaction between Policy Planning Consultants in Long Range Health Planning and the department as a whole.[21]

In Laframboise's 1990 article, he argues that the most critical factor in their ability to produce a lasting government document was Deputy Minister, Maurice LeClair granting the Branch the role of a "free-wheeling think tank."[22] The Director General claimed that LeClair was convinced "an open mandate was more likely to produce interesting ideas than one that was

highly structured, with specific goals and outputs based on the quantitative evaluation of programs and proposals."[23] Listed in a 1990 article by Laframboise as a second factor of importance to the making of *A New Perspective* was support from the Deputy Minister and Minister. A close relationship was maintained with the Deputy Minister's office, facilitated by the close proximity of the two offices.[24]

Working relationships within the Branch were also unique. Bert Laframboise took a 'hands-off' approach to management by not ever convening a staff meeting or directing research.[25] Policy Planning Consultants were encouraged to think about the future unconstrained by any preconceived notions or short-term pressures.[26] Each Consultant read what they wished, came up with their own project ideas, proposed them to Laframboise and conducted their research usually independently of other Consultants but occasionally in pairs. The Director General would routinely write in the morning and visit each consultant during the afternoon to stay in touch with his or her work.[27] His decision to have a "flat" structure rather than a hierarchical one was also considered critical. This "served the purpose of creating a club-like atmosphere in which ideas were traded freely and in which various specialists gladly co-ordinated their particular interests without the need for direction from above."[28]

In the unpublished article of 1978, "Still Riding the Crest of a Wave: An Appraisal of *A New Perspective*," Laframboise lists three other decisions crucial to the operation of the Long Range Health Planning Branch. First, it was decided from the outset that "the system for providing personal health care would get no more than a light monitoring, on the simple grounds that there were already armies of analysts clogging the roads leading into that particular swamp."[29] Second, the Branch "would not get involved in detailed program planning, nor would it try to counter-manage those departmental programs already in operation." Third, the Branch would be very guarded about doing fundamental research. This was due to the modesty of its resources and "skepticism about the direct contribution such research could make to the formulation of significant conceptual ideas about the health field."[30]

The conjuncture of people and ideas that came together within this structure proved fruitful. Prior to the commissioning of the green paper, the Long Range Health Planning Branch produced a significant amount of research, which received a fair amount of exposure.[31] Most notable, however, is the degree of innovation that flowed from this group. As Laframboise saw

it, an inductive process of creative freedom allowed Policy Planning Consultants to arrive at new ideas of what was significant in health.

Ideas that Emerged 'Outside the Box'

In the fall of 1972, Jo Hauser, one of the Policy Planning Consultants, brought the work of Thomas McKeown to the attention of the Director General. Taking an aggregate, long-term view of health, McKeown argued that the steady decline in mortality rates in England over the last century were entirely the result of changes in living standards, not the advancement of medicine. In Laframboise's words, "his writings proved that the improvement of the health status of the people was far more a consequence of changes in lifestyle and the environment than it was a consequence of advances in medical science."[32] This radical finding had a very strong influence on the work of the branch.[33]

To illustrate the validity of McKeown's findings in Canada, in April 1973 Jo Hauser and Jean-Marie Romeder produced a graphic entitled *Panorama of Mortality in Canada, 1971*, showing the causes of mortality by sex and age group. Three professional journals published the graphic along with a weekend magazine with a readership of 5,000,000 Canadians.[34] It eventually became the insert in *A New Perspective on the Health of Canadians*. Highlighted in the panorama was the fact that twice as many men compared to women die between the ages of 15 to 69 and the striking importance of accidents and suicide for the 15 to 35 age group.[35] In Laframboise's view, "these charts...provided stunning proof that premature deaths derived principally from individually self-imposed hazards."[36] People were not dying due to a lack of access to medical care but by taking personal risks.[37] Of the dominant causes of mortality, medical intervention could do little to save victims of traffic accidents, coronary artery disease or suicide. Exploring this line of inquiry further, Jean-Marie Romeder and Gerry Hill of Statistics Canada developed the statistical indicator of Potential Years of Life Lost (PYLLs). This "formula produced a new ranking of causes of mortality that exposed the importance of self-inflicted hazards, i.e. lifestyle behaviour."[38] In October 1973 the Branch wrote a more comprehensive report in collaboration with the Health Programs Branch entitled *Hospital*

Morbidity and Total Mortality in Canada: Data for Priorities and Goals.[39] On the basis of these studies, it was concluded that what McKeown found in England was also true in Canada: health status was far more a consequence of factors such as lifestyle and the environment than advances in medical science. Curing disease through the provision of health care had reached a threshold above which it no longer contributed to improvements in health. This was a shock to health policy: "In spite of the large infusion of funds into the health care delivery system, the overall health status of Canadians did not appear to have significantly improved."[40] The realisation of a 'flattening of the curve' of health care expenditures to health status, the Long Range Health Planning Branch intuitively asked, "if this is true, what do we do to improve health?"[41]

Branch staff began re-evaluating the causes of health with a critique of the model of health held at the time. In their opinion, the conventional medical model and the public health model were deficient "in that health problems were (a) difficult to identify (b) difficult to evaluate and (c) difficult to measure program impact upon their solution, because of the size, scope and complexity of the health field."[42] This meant that "strategies which would significantly reduce the mental and physical health hazards" for high risk groups were missing.[43] It was therefore necessary to create a new model that would identify and map the health field in terms of underlying causes of ill health.

Based on the idea of "individually self-imposed hazards," "lifestyle" was a concept developed to link personal health habits to health status. As "Policy Planning Consultant, Lifestyle," Jo Hauser's work at the LRHPB contributed significantly to the inclusion of this factor as an underlying cause of health. Qualitative and quantitative research on the connections between health practices and health status began to build an evidence base. An early study on fitness led Hauser to organise the First National Conference on Fitness and Health on behalf of the LRHPB in 1972. Later he produced reports on stress, smoking and seat belts. His demonstration of a direct link between mortality and seat belt use led to the idea - novel at the time - that seat belts save lives. Attacking two other detrimental habits, Laframboise conducted a study of the impact of tobacco smoking and John Clark did a study on the abuse of alcohol. Addiction studies followed on the heels of the LeDain Commission on the Non-Medical Use of Drugs which filed its report during this time. Contributing to the uptake of the lifestyle concept was the Commission's conclusion in favour of health education and drug awareness as the means

to inhibit non-medical drug use instead of deterrence through heavy application of criminal law. In each instance, whether seatbelts, alcohol or tobacco, it was individual lifestyle choice that was seen to cause or avoid illness and death.

The very concept of lifestyle implied that behaviour was an area of self-determination that could be changed. This drew upon the liberal view of citizens as rational actors and the late 1960s idea of self-empowerment as the means for social change. Television was also recognised at this time as a powerful new tool for advertising products. In his correspondence, the DG Bert Laframboise clearly shared the view that techniques of persuasion could be employed to modify behaviour. The Deputy Minister's files contained an article on social marketing sent from Laframboise to a long list of people. Using the power of T.V., social marketing was promoted as a new hope that could change the self-destructive health habits of Canadians. A contract for research into the ability to alter the behaviour of obese people through marketing was entered into in 1973.[44] In his 1978 unpublished article, the Director General argued that the despair with which health professionals had regarded correcting lifestyle health problems was being challenged. A "growing general awareness of the consequences of destructive personal habits" and the success of programs in lifestyle problems were claimed to be changing the view that long-range health considerations always lose when competing with short-range pleasure.[45]

Secondary techniques of a range of possible behaviour modification measures could also be pursued in addition to persuasion. This included banning cigarette advertising to reduce the rate of new smokers, promoting lower cholesterol intake and pricing alcohol based on absolute alcohol content. New ideas Laframboise described as "opening up" included "largely unexplored" legislative measures such as the compulsory treatment of drug abusers and the compulsory use of seat belts.[46] "They will not prevent all people from slow self-destruction but they can reduce the number and put breaks on the process." The Director General argued that the timing was right for government action, citing the surge of interest in fitness as "further evidence of an emerging desire to break out of destructive moulds of life."[47]

Jo Hauser pursued two other areas that became underlying causes of health. First, he brought attention to the environment as another factor that influenced health following a study tour to Sweden with the Fitness and Amateur Sport Branch. What he observed was how the government provided opportunities to improve lifestyle habits by building bicycle paths and

sport facilities.[48] Second, in a completely different direction, Hauser produced a Delphi Study on the future of genetics, which predicted an explosion of interest in the micro aspects of human biology. The work of Ray Lachaine, Policy Planning Consultant, Federal-Provincial Affairs and Rachel Richard, Policy Planning Consultant, Medical Sociology are also cited in Laframboise's 1990 article as contributing to *A New Perspective*. Lachaine's compendium of health matters under federal jurisdiction became part of chapter seven of *A New Perspective on the Health of Canadians*.

In total, much of the work undertaken by the Branch fed into and fit with Thomas McKeown's findings. Although there was no grand scheme and these studies were pursued on completely separate tracks, they ended up contributing to Laframboise's vision of "an integrated approach to the health field."[49] To produce a new model of health, the DG saw that "all that was needed was a simple conceptual framework into which all the pieces could be fitted."[50] In August 1972, he wrote a working paper entitled: "A Conceptual Approach to the Analysis and Evaluation of the Health Field."[51] It was in this essay that Laframboise first articulated his idea of a 'Health Field Concept', which became the essence of *A New Perspective.* After half a year of circulation and revisions, the final version was published under his name as "Health policy: breaking the problem down into more manageable segments," (the HFC paper) in the *Canadian Medical Association Journal* in February of 1973.

The Health Field Concept

The 1973 article on the Health Field Concept was a virtual blueprint of *A New Perspective on the Health of Canadians*, tabled by the Minister in the House of Commons in May 1974. Two underlying objectives prevail throughout the five different iterations of Laframboise's Health Field Concept paper, correspondence within the department during this period and *A New Perspective*. First is to argue that health is more than health care. Second is to design the Health Field Concept to serve multiple purposes.

Discreetly critiquing the medical and public health models as insufficient, each draft of the HFC paper introduces the Concept by stating that a basic problem in analysing the health

field is the absence of an agreed conceptual framework for sub-dividing the field into its principle elements. Shifting away from the notion that 'health' refers to 'health care', the primary categorical scheme of this model is based on what were seen as the underlying causes of health presented as equal in importance. In an accessible but comprehensive manner, the framework claimed:

> To organise the thousands of pieces into an orderly pattern that is both intellectually acceptable to those who work at the frontier of change and sufficiently simple to permit a quick location, in the pattern, of any idea, problem or activity related to health.[52]

The Health Field Concept

(1) Lifestyle	(2) Environment
(4) Technology/ Research /Endogenous/Human Biology	(3) Health Care Organisation

On an early draft of the Health Field Concept paper, a chart was written in by Maurice LeClair, Deputy Minister of Health, on the bottom corner of the page. In the version in which technology was the fourth quadrant, the text reveals that Laframboise was, among other things, distinguishing each category by federal government role: "It can be further identified by its learning and teaching elements, and from its emphasis on the scientific method for progress, rather than on persuasion, legislation and re-organisation which characterise, respectively, the other three elements of the proposed framework."[53] LeClair's parallel chart identified policy instruments for progress in each health field:

Policy Instruments for Progress in Each Health Field

(1) Persuasion	(2) Legislation
(4) Scientific method	(3) Re-organisation

Although this framework of interventions is not explicitly incorporated in the HFC paper or *A New Perspective*, it is evident in the text.

With respect to health care organisation, Laframboise states in the HFC paper that this element of the health system has been receiving increasing attention. This includes what type of services are provided, how they are organised and financed. Research and re-organisation are the focus of the health care organisation description. Led by the "iron rule of data" that availability of data leads to analysis, Laframboise argues that extensive studies have been conducted on medical practice, hospitals, extended care institutions, the drug supply system, laboratories, radiology and ambulance components of the health care delivery system. In spite of extensive research, the system is largely unresponsive to recommendations for change made in six recent reports.[54] This is due to the absence of popular support for major reforms. Rapidly rising health costs are seen only by legislators and bureaucrats as a threat to other ongoing and new governmental programs. The public, health professionals and health institutions on the other hand are satisfied with prepaid hospital and medical insurance and if anything demand the extension of prepayment to cover nursing homes, optometry services, chiropractic care, drugs for the aged, dental care for the young.

In the absence of public demand, "an extraordinary amount of will power is required of governments to get reforms under way."[55] Describing an effort to fulfil the advice of the Hastings Report for reform as requiring courage, Laframboise lists eight items from that study as necessary:

- reducing hospital beds relative to population,
- reducing numbers of expensive personnel to volume of health services,
- establishing district boards and community clinics,
- finding alternatives to fee-for-service for clinic professionals,
- setting levels and standards of service,
- re-distributing physicians, and
- involving people in looking after their own health

Laframboise goes on to argue that the federal government has been reluctant to use its financing power to enforce standards other than universality, comprehensiveness and portability as required by legislation. If the proposed new cost-sharing agreements are implemented, the effect will be an abatement of the federal presence, with a net effect of greater variation between

provinces. "The question, therefore, is whether the federal government is prepared to establish minimum standards as a condition of actual or further financing, such as in the funding of community clinics."[56]

No less connected to medicine and least worked on in the LRHPB was the biology quadrant, which was difficult to pin down. The name for this field changed several times, from "technological" to "basic research and medical care research" to "basic human biology and clinical application" to "endogenous" and finally "human biology." Attempting to account for a wide range of innovations in health designed to cure illness, the first draft used the term "technological" to account for "the discovery, development, teaching and dissemination of preventive, diagnostic and therapeutic tools" ranging "from basic research into the process of life to the development of a new piece of equipment for clinical use."[57] In consultation with a Policy Review Group in November 1972, H.L. Laframboise changed the category to "basic research and applied medical care research" to include research that "cannot be related to the lifestyle, environmental and health care organisational categories."[58] Calling this a "vast and vital part of the total health field," this category was later described as the production of vaccines, antibiotics, organ transplant techniques and the use of chemotherapy in mental illness. Universities, health research foundations and pharmaceutical houses create these beneficial landmarks in "medico-technological research." Clarification of this field came through consultation with a Dr. J. Wigan who suggested that research be removed in order to apply horizontally to all four quadrants. This allowed what was called "endogenous" and then "human biology" to function as "a conceptual home for the many health conditions, good or bad, which are not a consequence of lifestyle or environmental factors" separate from the amount of study conducted in this area.[59] Thus, Laframboise included the processes of maturation and ageing, genetic inheritance, and all the complex internal body systems in this category.[60]

Similar to human biology in accounting for a different set of factors beyond the power of the individual, environment was consistently defined as "that which an individual has normally little or no free choice in avoiding."[61] Examples offered were primarily of the physical environment: clean air, potable water, protection against pollution and protection of the food and drug supply. The family was absent as a social unit in all their work, as were peer groups and

community; the only social environment problems mentioned were "rapid changes" in *A New Perspective* and the desensitising effect of advertising in the 1973 HFC paper.

Since legislation was identified as the policy instrument appropriate to the environment, government was given an important role to play in protecting "a helpless public" from environmental health hazards by such measures as quarantine control and immunisation.[62] Unlike the description given in *A New Perspective*, the HFC drafts and published paper include a section on the political difficulties of implementing environmental health protection. "Trade-offs" were identified between health protection and increases in the cost of consumer items such as cars. It is noted in the first version as favourable that governments alone hold the power to control the environment, but "unfavourable in the sense that governments are especially vulnerable to pressure groups."[63] Furthermore, health hazards of pollutants are not easy to measure which makes this field an important field for research.[64]

Leading to the overall emphasis on the Lalonde Report, each version of the Health Field Concept repeats the importance of the "personal, or lifestyle, element" on the basis that it "is one of the most neglected aspects of health."[65] Laframboise defined lifestyle as: "The agglomeration of decisions taken by individuals which have a significant effect on their health. These decisions are taken within a framework of social values, many of which have been inherited from the past but some of which are shaped by contemporary society."[66] Clearly, this was the aspect of health that the Long Range Health Planning Branch saw as having the greatest potential for change. In comparison, the paper is pessimistic about the prospects for change to health care or the environment. Identifying values as important to the lifestyle concept, Laframboise's concludes his first draft of the HFC paper idealising Sweden as a preferable model of good health on the grounds that "most Swedes are prepared to make personal sacrifices to prevent the onset of disease."[67] Unlike the North American practice of placing faith in "the restorative powers of doctors, hospitals and medical technology," discipline and sacrifice, shaped by individual and societal values are the route to good health.[68] Programs and techniques must be developed to address lifestyle, not medical care.

Part II Rationale: Expenditures and Priorities

Although mapping all "activities, problems and ideas" in the health field was offered as the rationale behind the four categories, it was the presentation of the quadrants as of equal importance and as underlying causes of health that gave the model analytical weight. In raising factors outside the cure system as important to health, the Concept as a tool of analysis and evaluation pointed health policy in a new direction.

According to this conceptual model, expenditures should be targeted at the primary cause of morbidity and mortality – from the four quadrants - rather than simply channelling funds into curing injury once the damage is done. In an early version of the HFC paper entitled "The Conceptual Model as a Tool for Analysis," Laframboise used the model to present an argument against funding research into one quadrant over others.

> Divisions chosen for the framework permit the ready use of functional matrices to depict relationships. For example, the research function can be shown as touching on all four principal divisions, i.e. lifestyle research, environmental research, health care organisational research and medico-technological research, shattering the present mind-set which tends to slot research into the medical care research element only and deprive the other elements of their just share of attention.[69]

To alleviate health problems, the "faulty values" that lead to "excessive faith placed on medical care research as a cure for all ills…and the technology which gives rise to it" must be turned around.[70] It is the underlying causes that need to be confronted, before the onset of illness.

Along these lines, the conceptual framework could also be used to guide government action to improve health status.[71] Using the *Panorama of Mortality in Canada, 1971* insert in *A New Perspective*, the HFC and the parallel chart of instruments, policy-makers move from health problems to underlying cause and from underlying cause to means for change. Goals for improving health could be established to bring the system full circle.[72] It is in identifying the extent to which each quadrant contributes to any given health problem that government can find the most effective means to its resolution. To illustrate this point, the example used in early versions of the HFC paper and in chapter four of *A New Perspective* is of deaths and injuries from automobile accidents. In this case, lifestyle choices of speeding, careless driving and seat-

belt use rank this quadrant as contributing the most. Second is the environment (automobile make and highway design) followed by health care organisation (ambulance service, treatment in emergency) and medical care/human biology research (new life-saving technology, treatment methods, attention to accidents in medical school curricula). Hence, lifestyle is the principal underlying cause of automobile accidents and the policy instrument of persuasion should therefore be used to fix this health problem. This conclusion underscored the overall emphasis of *A New Perspective* on behavioural modification.

> If, as can be foreseen, acts of individuals dominate, measures for using persuasion or coercion to alter the pattern of individual decisions can be considered as well as legislative measures for protecting an individual against himself. Here a whole array of possibilities opens up including the compulsory use of seat-belts, enforcement of traffic laws, random road-block breathalyser tests, compulsory completion of a defensive driving course before licensing and so on. These can be looked at individually as to their cost, acceptability and effect.[73]

Thus, using this method and the Health Field Concept to interpret health problems provided a rationale for using new means to change health status.

Twenty-five years later different ideas prevail with respect to causality and intervention. Other factors are now seen to function as underlying causes of mortality and morbidity beyond the four category scheme of lifestyle, environment, health care or human biology of the Health Field Concept. For this reason, few would agree to the ranking of lifestyle as the primary cause of automobile crashes. The current standard and form of evidence is also less accepting of theoretical analysis relative to quantitative analysis. Nonetheless, the method of moving from what is recorded as the official cause of mortality to an underlying cause, linked to means of intervention remains valuable regardless of the determinants and policy instruments slotted into these fields. What remains distinct to the Health Field Concept is the break from previous conceptual models that divide knowledge into asymmetrical categories of social and scientific, where only the latter contributes to health.[74] Viewing the "social" dimension of lifestyle and environment as equal to medical science work of health care and human biology research provided a different perspective of what is amenable to change in making policy choices.

Application

The Health Field Concept fit into the activities of the Long Range Health Planning Branch through the Director's participation in National Health and Welfare's Policy Review Group. Consisting of eleven senior level managers, this committee requested the branch prepare a Planning Rationale for the Health Side in 1972. The creation of the Group as well as their activities suggest that this was a period of self-examination brought on by the fiscal predicament of rising health care expenditures in the provinces over which the federal government had no means of control. This problem was no doubt heightened by a fundamental shift in the socio-political context from the 1960s to the 1970s characterised by economic downturn. Illustrating these changes, economic restraint became a caveat embedded into the mandate of a spending department during this period. For example, in 1972 an internal document stated:

> The objectives of the Hospital and Medical Care Insurance Acts are to remove barriers to the accessibility of health care and to improve the quality of that care by sharing the cost of prepaid health care plans. *A subordinate objective of growing importance is to limit the growth of federal expenditures to an escalation factor based on general economic growth and independent of the health sector of the economy*.[75]

Throughout the early 1970s the Health Side of the federal department pursued negotiations with provincial governments on the financing of medicare culminating in Established Program Financing which came into effect in 1977. In the meantime, a barrage of future planning initiatives began.[76] The aim of the Planning Rationale, requested by Treasury Board, was to provide departmental co-ordination and direction to endeavours started in each branch. Although connected only through the DG, the Long Range Health Planning Branch was given a powerful role in controlling the review system. They would maintain an inventory of plans through a Planning Information Centre, write a comprehensive Review Report on present policy and "develop health status indicators for the population at large and effectiveness indicators for assessing the effect of Departmental programs."[77]

Laframboise explained in his 1990 article that at that time the Government of Canada "was caught up in a mania for program evaluation based on the application of quantitative methods, econometric techniques, and highly structured work programs."[78] It was Treasury

Board's preference, in fact, that the LRHPB – referred to as a loose 'think tank' - be dedicated to the application of quantitative methods to evaluate existing programs and policy options.[79] But the Branch rejected this approach. In a paper entitled "A Descriptive Model of the Health Field" Jean-Marie Romeder explained their rationale for rejecting econometric models as follows:

> Briefly, we believe that a clear view of how health facts interrelate and can be functionally structured is more important than a model which attempts to foresee the evolution of several phenomena on the assumption of different mathematical hypotheses mostly unverifiable.[80]

Instead, with the support of the Deputy Minister, the Long Range Health Planning Branch developed the Health Field Concept.

> In order to do long-term planning in the health field, which means to be able to make the fundamental choices of the health services which will be offered to the population in the future, and in order to initiate new health programs or to suppress some of them, it is essential to have an overall understanding and perception of the whole of the health field.[81]

Rather than using standard categories to map actual activities or government divisions, such as medical services, health protection, etcetera, Laframboise designed a framework that was prescriptive, establishing mortality through the mediating factor of underlying causes as the benchmark against which Health Side activities should be measured. As such, the Health Field Concept provided the Policy Review Group with a basis to evaluate health expenditures which put into practice the belief that program success should be measured by health status rather than healthcare statistics. The Concept had the effect of describing what the government was doing in a way which suggested that they ought to be doing something else.

To assess where money was currently channelled, the framework was employed in expenditure analysis in the Fall of 1972. Approved B budget items were grouped together under three of the conceptual framework fields: lifestyle, environmental, health care organisation, as was requested by the Deputy Minister. The list shows the highest expenditure is health care organisation, the second highest lifestyle and the lowest environment.[82] A Policy Review Project

of the entire scope of federal activity in the health field in 1973 that used the Health Field Concept as the primary tool of analysis arrived at the same conclusion.

> This review clearly showed federal reliance on a traditional health care delivery system - costly, complex, somewhat static - concerned with adjustments to an existing system where dollar payoffs in terms of improved health status had reached a state of diminishing returns. Comparison of federal activities by using the health field concept indicated that important features in the human biology environment and lifestyle areas were receiving low priority in terms of concern and emphasis.[83]

Based on the HFC model of health problem causality, these findings pointed out a misuse of money. Chapter seven of *A New Perspective* repeated this kind of quantitative analysis to show over-investment in health care given the range of investments necessary to improve health status. It would be more efficient to re-allocate funding from health care to the other three quadrants. Given that lifestyle was presented as the most responsible for health problems and persuasion the most promising policy instrument, it was investment in this quadrant that the argument supported.

Following the publication of Laframboise's Health Field Concept article in February, 1973 and application of the Concept for planning purposes in the department, it was not long until suggestions were made that it go further. In March, 1973 J.A. Clark, Policy Planning Consultant, Medicine, wrote to Bert Laframboise stating that the Health Field Concept paper was "already beginning to have a marked effect on the way the department views provision of health care across the country not only in terms of financial resources allocated to particular elements but also in terms of priorities for assigning future efforts."[84] Referring to the use of the framework to assess the 1973-74 estimates for health expenditure, he suggests that provinces and other departments could use the Health Field Concept. "So far, however, the concept has only been used to relate to federal initiatives in the health care field...It seems to me that the Health Field Concept can have a marked and long range planning application if it is carefully exploited."[85] In April of that year Laframboise asked the Deputy Minister for his views on sending copies of the HFC to the provinces.[86] The answer was no. To avoid any disruption to negotiations on health financing the Deputy Minister, Maurice LeClair's response was that "he would prefer that the concept not be distributed to the Provinces" at that time.[87]

Sure enough, it was Established Program Financing that alleviated health care spending pressures on the federal government and allowed the department to turn its attention to implementing the Lalonde Report in 1978. This suggests that it was not endorsement of the Health Field Concept as a model of what produces health that brought about re-allocation of funding for the federal government but changes in jurisdictional responsibility for health care funding. Nonetheless, the move to reduce spending on health care found a theoretical ally in the idea that it would be more efficient to invest in underlying causes such as lifestyle. The wisdom of reducing funding for the cure system was thereby also tied to re-investment elsewhere.

Dissemination of the Health Field Concept

Through publication of Laframboise's HFC paper and its internal application, the Health Field Concept and idea of lifestyle began to spread. Policy Planning Consultants from the Long Range Health Planning Branch gave speeches on the framework and discussed it at length within the health field from August 1972 through to the end of 1973. Laframboise stated in his 1990 article that "the reception of these new ideas on how health policy should be developed was so enthusiastic that the Deputy Minister, (Maurice LeClair) convinced the Minister that the Concept...should be transformed into a green paper indicating the directions that future health policy should take."[88] In his 1978 unpublished paper, he wrote that it was the Minister who,

> ...soon realised that the ideas contained in the paper constituted a capsule statement of his own approach to health policy. The Health Field Concept put forward in the paper gradually became the principal theme around which he formulated the new directions he wanted his Department to take. This led to a full endorsement of the Concept in his speech to the Conference of the Pan American Health Organisations, in Ottawa on September 10, 1973.[89]

In June 1973 *A New Perspective* was officially commissioned.[90] Laframboise committed to a completion date of January 1974 but completed the first draft for departmental review by November. Jo Hauser reported that this was exactly Laframboise's style; his personal philosophy to always deliver early.[91]

Throughout November, the Branch received feedback from Assistant Deputy Ministers, the Principal Nursing Officer, Hugette Labelle and the Minister. The latter requested that

specific program proposals be identified and added as recommendations. In response, Laframboise maintained that there was good reason for the deliberate absence of a specific action plan. This would be pre-mature since "such a plan would be imperilled by many unknowns and dangers including: not knowing which would have the greatest pay-off, how much new money would be available, absence of input from other decision-makers in the Health Field, question of which authority should execute and finance what."[92] Advancing his desire to keep the document theoretical, he argued that "the most important outcome of the paper will likely be its influence on the actions of others including the general public, voluntary associations, provincial governments, health professions and institutions."[93] Nonetheless, a list of "action areas and possible initiatives" for nutrition, vehicle accidents, heart disease, self-imposed risks, research, marketing of social change were compiled by the Policy Planning Consultants and written as a chapter by John Bachynsky. Recommended strategies reflected the parallel chart of policy instruments with the addition of goal-setting. Health hazard reduction for high risk groups, as the first broad objective, led nicely to the preventative and educational emphasis of the seventy-four strategies.

In December 1973 the third draft was accepted by the Minister. In January 1974 the final version was put before Cabinet. Departments of Veterans' Affairs, Labour and Consumer and Corporate Affairs asked for their concerns to be included which was done by adding specific recommendations to the final chapter. To please the Department of Finance who were "very wary of Green papers that suggest an increase in federal expenditures" some parts underwent minor revision.[94] No financial commitments were made for this reason and, to reassure them, sentences were added to emphasize the importance of controlling costs. By February the changes were finalised and Cabinet gave approval. Translation and printing proceeded, the centrefold chart was updated and *A New Perspective on the Health of Canadians: A Working Document* was tabled in House of Commons on April 1, 1974. In his own writing, the former Director General emphasized the importance of speed. It was barely four months between the approval of the Minister and the tabling of the Green paper in the House of Commons.[95]

Conclusion

A close look at how and why the Lalonde Report was produced adds further insight to the place of this document in the history of health policy in Canada. It is known for shaking the view of health as health care. By presenting a persuasive argument that other factors – lifestyle, environment and human biology – are equally important to curative medicine, the Health Field Concept led to federal and provincial investment in lifestyle.

Several lessons emerge from this analysis. First is the significance of internal think tanks free from the machinery of government to do long-term research. The federal department of health has not had such a unit since the Long Range Health Planning Branch was terminated in 1978. Nor, perhaps, have they produced a document that appears as long lasting and significant in introducing new ideas since. Leading rather than following ideas of what contributes best to the health of Canadians, in response to changing morbidity and mortality trends, may require the kind of dedicated time and support given to this team of policy consultants. It is also notable that the Long Range Health Policy Branch utilised methodologies that have become less popular in public policy research. Qualitative analysis drawing on history and theories of long-term change were used first followed by quantitative methods. This approach was supplemented by remaining current with new developments in Canada's peer group countries and in national health organisations.[96]

Second, it is worthwhile to note what did not happen that could have led health policy in a different direction. Through the concept of "lifestyle," the Long Range Health Policy Branch and the Lalonde Report carved out a field within health of social phenomena amenable to change by individuals. Based on an interpretation of Thomas McKeown's work and a liberal view of human beings as independent rational actors, their analysis presented health as a matter of personal responsibility over which one could exercise control.[97] Through this lens a high degree of health problem causality was attributed to personal choice.[98] Fate was replaced by risk in conceptualising health as not what happened to a person but as something one created. Excluded was therefore anything involving collective action, such as an emphasis on the physical environment or recognition of improvements made to the lives of the working poor through

unionization.[99] To move forward on either of these contributors to health involves inspiring people working together as communities. Absent overall are any of the issues that fell into the domain of the Welfare Side (family, poverty) of the federal department. The emphasis on lifestyle thereby reflected the separation of the Health Side from the Welfare Side. In terms of the structure of federal government departments, this division has widened since. Implementation of the Lalonde Report was based on what it presented as amenable to change - lifestyle and individual persuasion – which fit within the mandate of a health department. Policies and programs aimed therefore to empower individuals to assume health as an aspect of self-determination through lifestyle choice. This change in thought formed the basis of a new optimism.[100]

Third, archival records that use the Health Field Concept as a tool of analysis for long term priority setting and funding allocation give today's health policy makers grounds for reflecting upon the conceptual models that have followed. Tied to the analytical framework of the Health Field Concept was an action framework pointing to means for change.[101] Further, this model contained a method for moving from health problems to policy that started and ended with morbidity and mortality statistics organised by underlying cause.[102] By comparison, the Epp Report (*Achieving Health for All)* and *Ottawa Charter* of the 1980s were calls to action and the Population Health model of the 1990s a compendium of underlying causes. None of these documents contain a method to determine priorities or allocate funds. Although the method for moving from ideas to policy was never adopted, the logic of moving from one point to another - health problems to underlying cause, underlying cause to means for change, goal-setting on this basis and then back to health problems to see if efforts have been effective - remains no less valuable today.

The legacy of *A New Perspective on the Health of Canadians* remains the breakthrough in thinking that health is more than medical care. As a result of this pronouncement, programs to modify behaviour through health promotion were taken up by the federal department, provincial ministries and governments abroad. The new way to invest in health put forward gave public health practitioners a role in an era dominated by non-infectious disease. It is clear based on this history that the Long Range Health Planning Branch did interesting and effective work. Nonetheless, it is also fair to say that the emphasis and implementation of the Lalonde Report

was narrow. Perhaps as a consequence, the imbalance between curative and preventative health in terms of priority, funding and political attention continues twenty-five years later. The attempt to raise investment in social dimensions of health equal to medical science have yet to materialize.[103] Two conclusions can thus be drawn: the story of the Lalonde report contains valuable lessons for the formulation of health policy today; and, the scope for investing in health, listed as seventy-four recommendations in *A New Perspective*, remains wide open.

A. National Health and Welfare Branches around 1973

Administration
Fitness and Amateur Sport
Health Programs
Health Protection
Long Range Health Planning
Medical Services

B. People

The Honourable Marc Lalonde	Minister of National Health and Welfare
Maurice LeClair	Deputy Minister, Health Side

Staff of the Long Range Health Planning Branch

Dorotheen Scott	Branch Administrative Officer
Hubert Laframboise	Director General, 1970 - 1974
Dr. W.F. Craig	Acting DG in December 1974
Thomas J. Boudreau	DG January 1975 to 1978

Policy Planning Consultants:

Jo Hauser, M.D.	Policy Planning Consultant, Lifestyle Health Problems (and environment)
Jean-Marie Romeder, Ph.D.	Policy Planning Consultant, Quantitative Methods
Ray Lachaine (from Treasury Board)	Policy Planning Consultant, Federal-Provincial Affairs
John Bachynsky	Policy Planning Consultant, Pharmacy
Rachel Paradis (clinical sociologist) (formerly R. Richard)	Policy Planning Consultant, Medical Sociology
John Clark (health care admin specialist)	Policy Planning Consultant, Hospital Management
William Craig, M.D.	Policy Planning Consultant, Medicine
Tom Owen, Ph.D.	Medical practice surveillance methodology paper

B. Studies produced by the Long Range Health Planning Branch[104]

- Cardio-vascular Disease, Bill Craig, consultant, Sept 1973
- Mental illness
- Smoking, Jo Hauser
- Stress, Jo Hauser
- Seat belts, Jo Hauser (published in: CMAJ, Halifax Journal and Washington Post)
- Alcohol Abuse
- Traffic Accident Prevention
- Delphi Study on Genetic Counselling Services, Jo Hauser, Dec 1973
- Nutrition
- Working Paper on Health Policy, reported in draft stage Nov 73
- Medical Service consumption and non-consumption by age, sex, diagnosis, and specialty of physician, Nov 1973
- National survey on health care councils[105]
- Pharmaceutical Services, reported Nov 1973
- Fitness and Amateur Sport, Jo Hauser, reported Nov 1973
- Community Health Centres, Bill Craig[106]
- Federal - Provincial relations, Ray Lachaine[107]
- Surveillance Methodology paper and project, Bert Laframboise
- Planning Rationale for the Health Side
- Statistical technique of measuring Potential Years of Life Lost, Jean-Marie Romeder, Gerry Hill, (published as *Hospital Morbidity and Total Mortality in Canada: Data For Priorities and Goals,* September 1974)
- Mortality Graphic "Panorama of Mortality in Canada" Jo Hauser and Jean-Marie Romeder, April, 1973 (published in 3 journals & reproduced in a weekend magazine with a readership of 5,000,000[108])
- *Panorama of Health in Canada* graphic, October 1974[109]
- Health Status Indicator Project, in progress in 1975
- Food Policy for Canada[110]
- Canada's Older Population
- Specialized Pharmacy Manpower Study
- Ethics of Human Experimentation
- "The Health Field Concept and Populations at Risk," November, 1973[111]

Endnotes

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[1] Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document* Department of Health and Welfare, 1974.
[2] Under the classification of government publications in the early 1970s, "orange papers" announced legislative policy in draft form, "white papers" announced government policy intentions and "green papers" (which were not usually tabled in the House of Commons) were think pieces indicating plans.
[3] 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 vol. II, p. 1918.
[4] Mr. Heath Macquarrie, Member of Parliament for Hillsborough (Progressive Conservative Party) Twenty-ninth Parliament, *op.cit.*
[5] Twenty-ninth Parliament, *op.cit.* p. 1919.
[6] H.L.Laframboise, "Still Riding the Crest of a Wave: An Appraisal of 'A New Perspective'" unpublished paper, February 12, 1978. p. 1.
[7] *Ibid.* p. 2.
[8] *Ibid.*
[9] Milton Terris, "Newer perspectives on the health of Canadians: Beyond the Lalonde Report" *The Journal*, May 1, 1984. p. 9-10.
[10] Interview with Jo Hauser, Friday, October 9, 1998.
[11] For an analysis of responses to the Lalonde Report, see Robert Evans "A Retrospective on the 'New Perspective'" *Jounral of Health Politics, Policy and Law*, Vol 7(2), Summer 1982.
[12] Interview with former Policy Planning Consultants Jean-Marie Romeder, Rachel Paradis (formerly Richard) and Jo Hauser, January 25, 1999. Former Principle Nursing Officer, Hugette Labelle, was interviewed December 8, 1998.
[13] Hubert Laframboise, "Non-Participative Policy Development: The Genesis of *A New Perspective on the Health of Canadians*," Journal of Public Health Policy, Autumn 1990, p. 317.
[14] H.L. Laframboise "Health policy: breaking the problem down into more manageable segments," *CMA Journal*, Vol. 108, February 3, 1973.
[15] See Appendix A for a list of the staff. Jo Hauser and Jean-Marie Romeder were trained as physicians at Sherbrooke University Medical School.
[16] Hubert Laframboise, 1990, *op.cit.* p. 319.
[17] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Evolution of the Working Document 'A New Perspective on the Health of Canadians'" Long Range Health Planning Branch, January 7, 1975. p.2
[18] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Update Information for Minister's Briefing Book" by the Long Range Health Planning Branch, 1975.
[19] See Appendix A for divisions within the Health Side of the Department of Health and Welfare.
[20] Interview with Jo Hauser, October 9, 1998.
[21] *Ibid.* An exception to this was Jean-Marie Romeder, Policy Planning Consultant, Quantitative Methods who participated in the Interdepartmental Committee on health statistics (HWC-Stats Can) from 1973-1977. Thanks go to Mr. Romeder for pointing this out.
[22] Hubert Laframboise, 1990, *op.cit.* p. 319. In addition and prior to Laframboise's two papers, the LRHPB wrote an internal document entitled, "The Evolution of the Working Document 'A New Perspective on the Health of Canadians,'" in 1975.
[23] Hubert Laframboise, 1990, *op.cit.*
[24] Interview with Jo Hauser, October 9, 1998.
[25] *Ibid.*
[26] *Ibid.*
[27] *Ibid.*
[28] Hubert Laframboise, 1990, *op.cit.* p. 320.
[29] H.L.Laframboise, "Still Riding the Crest of a Wave: An Appraisal of 'A New Perspective'" unpublished paper,

February 12, 1978. p.3. Laframboise wrote a paper with T.H. Owen entitled, "Surveillance methodology for the practice of medicine" *CMAJ*, vol. 105, 1972. This aimed at designing ways to monitoring the work of physicians.

[30] H.L.Laframboise, 1978. *Op.cit.* p. 3.

[31] See Appendix B for a list of studies produced by the Long Range Health Planning Branch.

[32] Hubert Laframboise, 1990, *op.cit.* p. 318.

[33] Interview with Jo Hauser, *op.cit.*

[34] Department of National Health and Welfare, *Annual Report*, "Long Range Health Planning Branch," 1973-1974. p. 23.

[35] *Ibid.*

[36] Hubert Laframboise, 1990, *op.cit.*

[37] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Evolution of the Working Document 'A New Perspective on the Health of Canadians'" Long Range Health Planning Branch, January 7, 1975. p. 2.

[38] Hubert Laframboise, 1990, *op.cit.*

[39] Department of National Health and Welfare, *Annual Report* 1973-1974. o*p.cit.*

[40] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Evolution of the Working Document 'A New Perspective on the Health of Canadians'" *op.cit.* Interview with Jo Hauser affirmed that this realization was a surprise.

[41] Interview with Jo Hauser, *op.cit.*

[42] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Evolution of the Working Document 'A New Perspective on the Health of Canadians'" *op.cit.* p.2.

[43] *Ibid.*

[44] Department of National Health and Welfare, *Annual Report* 1973-1974. o*p.cit.*

[45] PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field," Working paper by H.L.Laframboise, Long Range Health Planning Branch, August 10, 1972. p.5.

[46] *Ibid.*

[47] *Ibid.* p.6.

[48] Interview with Jo Hauser, *op.cit.*

[49] H.L.Laframboise, 1978. o*p.cit.* p. 4.

[50] *Ibid.* p. 5.

[51] PAC, Records of the Department of Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field" *op.cit.*

[52] *Ibid.* p. 1.

[53] *Ibid.* p. 12.

[54] The reports are: The Hall Royal Commission for Canada, the Castonguay-Nepveu Commission in Quebec, the Committee on the Healing Arts for Ontario, the federal-provincial Task Force on Health Costs, the Manitoba While Paper on Health and the Hastings Report on Community Health Centres. H.L.Laframboise "Health policy: breaking the problem down into more manageable segments," *CMA Journal*, Vol.108, February 3, 1973.

[55] PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field," *op.cit.* p. 11.

[56] *Ibid.* p. 12.

[57] *Ibid.*

[58] PAC, Department of National Health and Welfare, RG 29, vol. 1556, file C-1010-5-1A (1008-5-1) Memorandum from H.L.Laframboise to Members of the Policy Review Committee.

[59] PAC, Department of National Health and Welfare, RG29, vol. 1558, file 1008-5-1, pt.2 Memorandum from H.L Laframboise, DG, Long Range Health Planning Branch to Members of the Policy Review Group and Dr. J. Wiggin. Subject: "Proposed Re-write of Conceptual Paper" January 24, 1973.

[60] In the first version of the HFC paper, the author also included "genetics counseling" in this category, referring to

couples reviewing their genetic profiles to inform reproductive decision-making. This topic became an area of research by Policy Planning Consultants in the Long Range Health Planning Branch that year. (For unknown reasons, the Branch did not, however, foresee the potential danger of eugenics nor any of the ethical questions most Canadians became aware of during the consultations by the Royal Commission on New Reproductive Technology in the 1990s) PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field," *op.cit.* p. 7.

[61] H.L. Laframboise, 1973. *op.cit.* p. 388.

[62] PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field," *op.cit.* p. 8.

[63] *Ibid.* p. 7.

[64] *Ibid.* p. 8.

[65] *Ibid.* p. 2.

[66] *Ibid.*

[67] *Ibid.* p.16.

[68] *Ibid.*

[69] *Ibid.* p. 3. emphasis added

[70] H.L. Laframboise, 1973. *op.cit.* p. 389.

[71] H.L.Laframboise, 1978. *op.cit.* p. 5.

[72] This linkage back to mortality and morbidity statistics can be seen in the last chapter of the Lalonde Report under goal-setting strategy.

[73] PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) "A Conceptual Approach to the Analysis and Evaluation of the Health Field," *op.cit.* p.15.

[74] Bruno Latour *We Have Never Been Modern* Cambridge, MA: Harvard University Press, 1993.

[75] RG29, Vol. 1556, C-1010-5-1A, *A Planning Rationale for the Health Side, Department of National Health and Welfare*, second version, Long Range Health Planning Branch, June, 1972. p. 5, emphasis added.

[76] *Ibid.* p. 1.

[77] *Ibid.* p.15, 17.

[78] H.L.Laframboise, 1990. *op.cit.* p. 320.

[79] *Ibid.*

[80] RG29, Vol. 1558, file 1008-5-1, part 2, "A Descriptive Model of the Health Field in Canada" November 30, 1972, by Jean-Marie Romeder, Policy Planning Consultant, Quantitative Methods, Long Range Health Planning Branch. p. 2.

[81] *Ibid.* p. 1.

[82] PAC, Department of National Health and Welfare, RG29, vol. 1556, file C-1010-5-1A (1008-5-1) Memorandum from Mr. H.L.Laframboise, Director General and Dr. J.M.LeClair, DM, October 25, 1972.

[83] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 5 "Evolution of the Working Document 'A New Perspective on the Health of Canadians'" *op.cit.* p. 3.

[84] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 4 Memorandum from J.A. Clark, Policy Planning Consultant, Health Care Delivery, March 21, 1973.

[85] *Ibid.*

[86] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 4 Memorandum from Mr. H.L.Laframboise, Director General and Dr. J.M.LeClair, DM, March 22, 1973.

[87] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 4 Memorandum from Mr. H.L.Laframboise, Director General and Dr. J.M.LeClair, DM, April 16, 1973.

[88] H.L.Laframboise, 1990. *op.cit.* p. 319.

[89] H.L.Laframboise, 1978. *op.cit.* p. 6.

[90] Interview with Jo Hauser, *op.cit.*

[91] *Ibid.*

[92] PAC, Department of National Health and Welfare, RG29, vol. 1557, file 1008-5-1, pt. 4. "Notes on Working Paper" by H.L.Laframboise, November 17, 1973. p. 1.

[93] *Ibid.* p. 2

[94] H.L.Laframboise, 1990. *op.cit.* p. 321.
[95] *Ibid*.
[96] Jo Hauser, Policy Planning Consultant, Lifestyle, visited Sweden to return with ideas of how to change health behaviours by building bicycle paths and other facilities to support regular exercise. All Consultants regularly attended meetings of Canadian health organizations. Interview with Jo Hauser, *op.cit.*
[97] McKeown's view that living standards contributed most to improvements in health was interpreted by the LRHPB as lifestyle and environment of which they chose lifestyle as the more important factor. The idea of "lifestyle" reflected the liberal view of human beings as individual rational actors with choices. By contrast, the definition of self-care in the 1986 document *Achieving Health for All* as "decisions *and actions* individuals take in the interest of their own health," views human behaviour as the result of decisions taken by the rational mind *as well as* simply reactions. Thanks go to Jean-Marie Romeder for affirming my analysis and noting how the understanding of human behaviour changed in the next decade. National Health and Welfare, *Achieving Health for All: A Framework for Health Promotion*, Ottawa, 1986.
[98] Lifestyle as the underlying cause of automobile accidents is a good example.
[99] An awareness of the physical environment was emerging at the time due in large part to Rachel Carson's groundbreaking book *Silent Spring* on environmental degradation, published in 1962.
[100] Policy Planning Consultants aimed to create a model for a new optimism. Interview with Jean-Marie Romeder, January 25, 1999.
[101] Jean-Marie Romeder who reviewed an earlier draft of this paper made this observation.
[102] During this period and after the release of *A New Perspective*, the HFC was used to guide policies and funding within the department. For example, the Health Programs branch planned to do a project entitled "Development of a guide to community health" under a Working Group of the Federal-Provincial Advisory Committee on Community Health starting in May 1974. This guide was to take "a broad approach to planning for community health services, which will include human biology, life style, and environment as well as the more traditional health care organization. It will set out the framework for assembling an argument for accepting a range of community services that will both encourage and support the population in attaining or maintaining optimum health levels, and in guiding the appropriate use of health care resources." Planning Information Report" of February, 1975 by the Long Range Health Planning Branch, National Health and Welfare. p. 20 (RG 29, Volume 1733, file no. 6670-16-1). After 1974 an implementation committee, the "Working Group on priorities and strategies," designed a conceptual framework inspired by the Lalonde report to decide which recommendations to prioritize. (This framework was applied to smoking and hazardous drinking and showed that 18% of the premature mortality (between ages 1-70) in Canada was attributable to these two risk factors. Ouellet, B.L., Romeder, J.M., Lance, J.M. "Premature mortality attributable to smoking and hazardous drinking in Canada," *American Journal of Epidemiology* 109: 451-463, 1979.) This framework indicated a need to increase preventative health interventions. Interview with Huguette Labelle, December 8, 1998.
[103] In fact, the health field of human biology which was considered "nature" that had to be accepted, has possibly received the most investment, primarily from the private sector.
[104] Internal Reports referred to in archival records. Most are described by the Branch as "state of the art" briefing papers on major national health problems. Information Letter No. 14, November 23, 1973 by the Long Range Health Planning (RG29, Vol. 1557, file 1008-5-1 vol.3)
[105] Report on developments in all provinces towards establishing regional or district councils responsible for providing health care in given geographic areas. RG29, V. 1557, file 1008-5-1, pt. 5 "Update Information for Minister's Briefing Book, Long Range Health Planning Branch"
[106] Bill Craig worked for the Non-Medical Use of Drugs Directorate. Interview with Jo Hauser, Friday, October 9, 1998.
[107] Interview with Jo Hauser, Friday, October 9, 1998.
[108] RG29, V. 1557, file 1008-5-1, pt. 5 "Update Information for Minister's Briefing Book, Long Range Health Planning Branch"
[109] Shows principal data and indicators for each province and Canada as a whole. RG29, V. 1557, file 1008-5-1, pt. 5 "Update Information for Minister's Briefing Book, Long Range Health Planning Branch"

[110] Food Policy (about nutrition), Canada's Older Population, Pharmacy Manpower and Ethics of Human Experimentation (referred to under the Health Programs Branch - unclear whether it proceeded) were referred to in the 1975 Planning Information Report as "Long Term Innovative Activity" produced by the LRHPB. Planning Information Report" of February, 1975 by the Long Range Health Planning Branch, National Health and Welfare. (RG 29, Volume 1733, file no. 6670-16-1)

[111] "This paper describes the work done in the Long Range Health Planning Branch in using and disseminating the Health Field Concept." Information Letter No. 14, November 23, 1973 by the Long Range Health Planning (RG29, Vol. 1557, file 1008-5-1 vol.3)