PUBLIC HEALTH PAST AND PRESENT

Reinventing public health: A New Perspective on the Health of Canadians and its international impact

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Study objective: To examine the Canadian origins of the Lalonde Report and its impact on British and American health promotion activities.

Design: A brief history of the development of key Canadian documents and their use by politicians and public health activists in the United Kingdom and United States.

Setting: This paper focuses on the impact of the Canadian model on Canada, the United Kingdom and United States.

Main results: This paper argues that internal political and economic forces are as important as international trends in determining healthcare policy initiatives.

Conclusions: In the 1970s all the English-speaking developed nations were facing deficits as curative costs rose. Adopting health promotion policies permitted them to shift responsibility back to local governments and individuals while limiting their expenditures. Health and community activists, however, used this concept to broaden their focus to include the social, economic and political determinants of health and thus reinvented public health discourse and practice for the 21st century.

From 1945 to 1973, most western democracies grappled with the challenge of establishing social policies that would provide “security without stigma”.¹ Canada was no exception as it moved to develop and implement nationally funded cost-shared programmes to ensure hospital and medical care services.² The passage of the Hospital Insurance and Diagnostic Services Act in 1957 and the Medical Care Act in 1966 signalled the federal government’s apparent commitment to the piecemeal creation of a comprehensive healthcare system. Like the United Kingdom,^{3 4} the United States,^{1 5} Australia,⁶ New Zealand and western European states, Canada quickly discovered that hospital and medical costs were increasing faster than inflation-eroded government revenues. Although Keynesian economic theory had provided the justification for deficit financing during the economic boom of the 1950s, cost projections at the end of the 1960s indicated that a new approach needed to be developed.⁷

The situation was further complicated in the Canadian federation by the division of powers over health, education and social welfare services. Canada’s constitution, The British North America Act, 1867 had allocated the task of service provision to the provinces while leaving most taxation powers to the federal government. As a result, the Department of Finance became and remains one of the most powerful components of the federal administration.⁸ Indeed, from its creation in 1919 to the present, Health Canada has had a chequered career. Initially an advisory body providing shared-cost funding for provincial programmes to combat tuberculosis and venereal disease after World War I, the department was retooled as National Health and Welfare in 1944 in anticipation of a Canadian version of the National Health Service (NHS) and related social welfare programmes. Opposition from Ontario, Québec and Nova Scotia to federal intrusion in an area of exclusive provincial jurisdiction prohibited the adoption of a comprehensive system in 1945.² Instead provinces such as Saskatchewan, Alberta and British Columbia pioneered hospitalisation plans, whereas the Canadian medical profession and insurance companies created American-style medical services plans. Growing public support for universal, tax-based

healthcare reflected citizens’ increasing faith in curative rather than preventive medicine, and this view was consistently reiterated to the Royal Commission on Health Services, which began in 1961 and presented its first report in June 1964.⁹

POSTWAR PUBLIC HEALTH IN CANADA, 1945–1968

Both nationally and internationally, the focus on medical advances had overshadowed the impact of public health measures and to a degree masked the shift from infectious to chronic diseases. Through the 1950s, Canadian public health professionals emphasised health education and the development of programmes that provided services for individuals and groups such as the elderly who were not able to afford the private or employment-based hospital and medical services plans. The more forward-looking were already agitating about air pollution and other environmental issues.¹⁰ As they found themselves on the frontlines in the confrontation with the flower power generation over issues such as the public discussion of birth control or the illicit use of drugs and alcohol, and developing programmes to curb smoking and other health hazards, they were well aware that their expertise was being downgraded and that the deference to authority that had once characterised Canadian society was seriously eroding.¹⁰ They took some comfort, however, from the Royal Commission on Health Service’s Health Charter, which pointed out that “health services must be supplemented by a wide range of other measures concerned with such matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism and drug addiction.”⁹

CHALLENGE AND CHANGE: CANADIAN POLITICS IN THE 1960S

Beyond the healthcare system, change was affecting Canadian society and its politics. In addition to the arrival of the baby boom generation in the employment market, the antiwar movement, second wave feminism and Québécois nationalism

Abbreviations: NHS, National Health Service; WHO, World Health Organisation

all arose to challenge the Liberal and Progressive Conservative parties. On the left, the New Democratic Party supported a national healthcare plan and the expansion of social programmes while on the right, the Social Credit party opposed state intervention. The lack of consensus among voters meant that Canada endured a series of minority governments from 1962 until 1968 when Pierre Elliott Trudeau was elected Prime Minister. Bilingual and bicultural, Trudeau exemplified the hip, modern leader. Favouring reason over passion, he completed the reorganisation of the civil service and government administrative practices that had been introduced by his predecessor and sought to create a more rational form of policy development based on futures research and a holistic approach to the environment.¹¹ These innovations commenced just as the federal government was implementing the Medical Care Act and preparing to create a federal Department of the Environment.¹²

MODERNIZING THE FEDERAL HEALTH DEPARTMENT, 1968–1974

As a result of both the concern for rationality and worries about the cost of the “welfare state”, the new Minister of National Health and Welfare, John Munro, was asked to prepare memoranda outlining the future costs of medicare.⁸ The revelation that continuing increases would consume ever larger portions of the national budget prompted swift action. Many of the department’s mainly Anglophone senior administrators who had devoted their careers to achieving medicare were quickly retired and younger bilingual or Francophone staff, often with social science backgrounds, were hired.¹³ Foremost among these was the 40-year-old Dean of Medicine at the University of Sherbrooke, internist J. Maurice LeClair, who was appointed Deputy Minister in 1970.¹⁴ LeClair’s first task was to find a way to limit federal spending in response to double-digit inflation in both hospital and medical services costs.¹⁵ To do this he created a Long Range Health Planning Branch and chose Hubert Laframboise, a career civil servant, to head the new unit. Highly experienced and creative, Laframboise assembled a team whose mandate was to review existing programmes and make futures planning an integral part of the departmental ethos.¹⁵ With LeClair’s support and the guidance of Trudeau’s Principal Secretary, Marc Lalonde,¹⁶ the Branch produced a working document called *A New Perspective on the Health of Canadians*.¹⁸ The central argument in this green paper was that Canadians were devoting too much attention to the healthcare system and failing to recognise the importance of the three other components of the health field concept: human biology, life style and the environment. The health field concept was intended “to provide a universal framework for examining health problems and for suggesting courses of action needed for their solution”.¹⁷ By arguing for a holistic and multisectoral approach to health issues, the *New Perspective* challenged the dominance of biomedicine and opened discussion of the impact of the non-medical determinants of health, including personal behaviour.

As the concept was being developed, Marc Lalonde, who had been elected to Parliament in 1972 and appointed Minister of Health and Welfare in the Trudeau minority government, tested it on international audiences. He presented it to the World Health Assembly in Geneva in June 1973 and to the Pan American Health Organisation in Ottawa in September.¹⁸ The animated discussions that his presentations generated suggested that other health experts and politicians were seeking solutions to their rising costs and increasing concern about preventable chronic diseases and health inequalities. As John Ashton and Howard Seymour commented: “the Lalonde Report signaled the turning point in efforts to rediscover public health

in developed countries...”.¹⁹ Between 1973 and 1975, Lalonde was also attempting to persuade his provincial counterparts to accept a new funding formula for curative services. Not surprisingly, the provinces were angered by what they saw as federal downloading of an expensive social programme. When the health field concept was presented to them in February 1974, most were willing to support it because they too could perceive the benefits of making health promotion and disease prevention rather than expensive curative services the next phase of government health activities.²⁰ Therefore in April 1974 when Minister Lalonde finally tabled the document in the House of Commons, it had already begun to influence national and international thinking on the future directions of public health policy and programming.

THE LALONDE REPORT

In 76 succinct pages, the *New Perspective* challenged all Canadians to rethink their understanding of the determinants of health. Using mortality statistics to outline the extent of unnecessary disease and debility and history to demonstrate the change from infectious to chronic diseases as the leading causes of death, the Lalonde Report shattered the conventional belief that healthcare services were the foundation for future improvements in population health. Instead the report argued that more attention had to be paid to biomedical research in basic human biology, to improving the natural and built environments, and to developing an understanding of human behaviour to effect changes in what it described as “self-imposed risks”.¹⁷ The report concluded by outlining two broad objectives and five strategies to achieve them. The broad objectives were first to focus on limiting mental and physical health hazards for high-risk Canadians, and second, to ensure access to good healthcare for the disadvantaged, including the poor, aboriginals and rural Canadians. The five strategies to achieve these objectives were a health promotion strategy, a regulatory strategy, a research strategy, a healthcare efficiency strategy, and a goal-setting strategy. By health promotion, the authors meant more comprehensive efforts to improve nutrition, physical fitness and limit motor vehicle accidents, sexually transmitted diseases and the abuse of drugs, alcohol and tobacco. Under regulatory strategies they proposed interdepartmental and federal–provincial efforts to eliminate drunk driving, increase seat belt use and control environmental problems. The research and healthcare efficiency strategies were intended to develop and evaluate science-based planning and management techniques. Most ambitiously the goal-setting strategy called on all healthcare actors to work together to improve Canadians’ health and to enhance Canada’s commitment to the health goals advocated by the World Health Organisation (WHO) and Pan American Health Organisation.¹⁷

IMMEDIATE IMPACT?: THE CANADIAN EXPERIENCE

The impact of the report in Canada was surprisingly limited. The medical profession was more concerned with the threat of wage and price controls as a result of post-1973 oil crisis inflation. Public health practitioners were concerned about the growth of community health units and the loss of status as some provinces followed the British example and eliminated medical health officerships whereas others amalgamated schools of hygiene with existing medical faculties.²¹ Federal and provincial finance ministers, deeply worried about rising curative costs and inflation, implemented a round of budget cuts.²⁰ Within National Health and Welfare, champions emerged to take up the challenge. Ron Draper, the director-general of the Non-Medical Use of Drugs Section, became a leader of the activists and was named to head the government’s

Health Promotion Directorate when it was finally created in 1978.²² At the provincial level, health promotion projects and units were created as health education activities were transformed and community engagement became the new operating approach.²³ In cities such as Toronto, Canada's largest metropolis, the creation of a Health Advocacy Unit in 1980 demonstrated the changing focus of local public health.²⁴

CANADIAN CRITICS

At conferences and symposia, the Working Paper was subjected to severe criticism, particularly for its propensity to blame individuals for "risk-taking".²⁵ Critics also condemned the report for failing to recognise and emphasise the role that peer pressure, poor housing or working conditions, poverty, lack of education, etc. played in alcohol abuse, drug use and smoking. For many public health administrators, the lack of specific targets and dates for implementation left the recommendations too vague for successful introduction in an increasingly tight fiscal climate. What all of these critics did recognise was that the basis for formulating health policy had irrevocably changed.²⁶

FROM THE HEALTH FIELD CONCEPT TO HEALTH PROMOTION

Indeed, the Beyond Health Care Conference held in Toronto in 1984 prompted the European Office of the WHO to ask Canada to host the first International Health Promotion Conference in Ottawa.²⁷ This meeting not only produced the Ottawa Charter for Health Promotion but also enabled the Progressive Conservative Minister of Health, Jake Epp, to present a new and more sophisticated approach to health promotion in *Achieving Health for All: A Framework for Health Promotion*. With its matrix format and focus on "fostering public participation, strengthening community health services, and coordinating healthy public policy", it represented a logical extension of the objectives outlined in the Lalonde Report.²⁸ After sharing their expertise with WHO's European Office as it developed the Healthy Cities Project, Canadian advocates returned home to implement their own version and to attempt to persuade all levels of government to incorporate an assessment of the health consequences of their actions into economic and environmental policymaking.²⁹ Such forward-looking endeavours, however, were challenged by the need to grapple with HIV/AIDS and the continuing rise of costs for curative services and pharmaceuticals.

THE INTERNATIONAL IMPACT: THE BRITISH RESPONSE

While Canadians were digesting the Lalonde Report, British politicians were seeking to deal with longstanding problems plaguing the NHS. Lack of access in non-metropolitan areas and the pressure of cost cutting in the wake of the oil crisis prompted Barbara Castle, the Secretary of State for Social Services, to persuade her counterparts for Scotland, Wales and Northern Ireland to join in producing their own discussion document, *Prevention and Health: Everybody's Business* in 1976.³⁰ In the foreword, the secretaries noted the limits of curative medicine and pointed out that the reorganisation of the NHS to incorporate preventive activities into local health authorities had the potential to improve access, address health

inequalities, and make better use of existing funds.³⁰ In six chapters, the paper presented, first, the history of successful public health interventions in the 19th and early 20th century and then identified problems facing British society. Heart disease, cancer and stroke had replaced death from infectious disease as the leading killers and with 16% of Britain's population over 65 years of age in 1971 and a birth rate that was half what it had been at the start of the century, these problems were expected to increase greatly if new approaches were not undertaken. Without crediting the Canadian model, this document paralleled it in terms of structure and focus, emphasizing the role of personal responsibility for nutrition, leisure activities, smoking, drugs, alcohol and sexual behaviour. It moved beyond the Canadian report in asking pointed questions about the efficacy and effectiveness of mass screening, the ethical issues that would arise from genetic testing, and noted the paradox that preventing premature mortality would ultimately raise the cost of end-of-life care.²⁰ (The Lalonde Report had indicated this possibility but suggested that further improvements in curative techniques might mitigate the impact.) Given the class structure in Great Britain, Prevention and Health explicitly raised the issue of health inequalities and their role in ill health and debility. Like the Canadian report, however, this paper was for discussion purposes only and did not contain detailed recommendations for action.

As a result, it triggered the same type of negative reaction from health activists that the Lalonde Report received and was ignored by the Royal Commission on Health Services that reported in 1977.³¹ The Labour government did, however, appoint the Black Commission to enquire into health inequalities and its report, presented to Margaret Thatcher's Conservative administration in 1980, confirmed the continuing existence of significant health inequalities and recommended greatly increased national funding to expand health promotion activities and limit disparities.³¹ The monetarist and anti-statist ideology of the Conservative government prohibited much action as attention was devoted to restructuring the NHS. During the Thatcher years, however, local activists such as John Ashton emulated Canadians like Trevor Hancock in creating community-based health promotion activities that fulfilled the Healthy Cities project criteria established by the WHO.¹⁹ In 1987 Margaret Whitehead's report, *The Health Divide*, reaffirmed the conclusions of the Black Report and with other studies led the Conservative government to produce a 1992 white paper, *The Health of the Nation*, which identified improvements in rates of coronary heart disease and stroke, cancers, mental illness, HIV/AIDS and sexual health and accidents as the government's response to the WHO's *Health for All by the Year 2000* principles.³ With the election of New Labour in 1997, the "new public health" was established at the national level when the government presented its own white paper, *Saving Lives*, and appointed Frank Dobson as the first Health Secretary.³²⁻³³ Ongoing problems financing and administering the NHS have distracted politicians from pursuing sustained health promotion programmes.

THE AMERICAN REACTION

At the beginning of the 1970s, Republican Richard Nixon was President, Medicare and Medicaid costs were rising quickly, and the war in Viet Nam was distracting attention from the war on poverty. The election of Jimmy Carter and the Democrats in 1976 appeared to herald a new approach to health insurance because many Americans were finding costs unmanageable, and Senator Edward Kennedy and his supporters were arguing in favour of a universal programme similar to the Canadian single payer system.³⁴ Carter's Secretary of Health, Education and Welfare, Joseph Califano, was an advocate of universal

What this paper adds

This paper demonstrates the gradual penetration of new concepts in public health discourse and practice.

healthcare and had visited the Department of National Health and Welfare in Ottawa to discuss the situation. He became an enthusiastic proponent of the Lalonde Report and worked with the Surgeon-General, Dr Julius Richmond,³⁵ to produce *Healthy People: The Surgeon-General's Report on Health Promotion and Disease Prevention* in 1979.³⁶ Directly crediting the Lalonde Report for its inspiration to rethink health priorities by using the health field concept to dissect American mortality statistics, Healthy People argued that "50% of mortality in 1976 was due to unhealthy behavior or lifestyle; 20% to environmental factors; 20% to human biology; and 10% to inadequacies in health care".³⁶ Based on these findings, the authors stated: "we need to re-examine our priorities for national health spending" because only 4% of federal health dollars were allocated to preventive activities. Spotlighting drugs, alcohol and motor vehicle accidents for health promotion programmes, Califano used Healthy People as a springboard to get many researchers, professional organisations and non-governmental groups to work together to produce *Promoting Health/Preventing Disease: Objectives for the Nation*, which appeared in the autumn of 1980.³⁵ Unlike the Canadians and the British, the Americans actually produced targets for improvements in population health in three areas by 1990: preventive health services, health protection, and health promotion. The arrival of the Reagan Republicans in January 1980 meant that the funding for these initiatives was limited, but in 1986 the United States Public Health Service "midcourse review" predicted that 110 of the 226 objectives would be met by 1990. In general, Americans were using seat belts more, drinking and smoking less but little progress was being made against obesity and lack of exercise.³⁷

During the Clinton administration, attention focused on the unsuccessful effort to create a national health insurance system. The Department of Health and Human Services built on the success of the 1990 targets by developing additional ones for 2000 and 2010.³⁸ The focus is still on individual responsibility for action to prevent diabetes, heart disease and stroke even though non-governmental organisations such as the Institute of Medicine have published numerous studies demonstrating the ethnic, gender, environmental and socio-economic factors in ill health.³⁹ Public health activists have called for a new emphasis on the determinants of health⁴⁰ but their goals are being limited by the national focus on bioterrorism, security and pandemic planning.⁴¹

CONCLUSION

By 1974 public health authorities in Canada, Britain and the United States were well aware that their traditional duties had been superseded by new challenges. They recognised that a new approach was needed, but also wisely expressed concern about maintaining immunisation levels, effective sanitation and food quality standards and emergency preparedness. They also realised that their interests had been overlooked in the constant focus on healthcare services and rising costs. The New Perspective offered a way to regain centre stage and to make a legitimate demand for central funding for new initiatives in health promotion activities. As neo-liberal economics came to dominate the governments in the three countries, funding for both preventive and curative systems was constrained. Health inequalities were identified and new programmes to deal with child poverty, HIV/AIDS and other issues were introduced but not effectively funded. Rhetoric was far less expensive than effective central, state, provincial and local action.

Should this make researchers and administrators sceptical about new concepts? As the advocates of the "sanitary idea" in the 19th century, the germ theory, health education and centrally funded preventive services all understood, new ideas

take time to be adopted. They filter into the political system through the work of activists in the community, professional associations, political parties, and dedicated civil servants. Indeed, the speed with which these governments moved to adopt the rhetoric of the health field concept may have been prompted by the desire to cut funding but its impact is still being felt. National and international programmes to curb smoking, control drinking and driving and eradicate drug use have all evolved in the wake of the New Perspective.⁴² The greatest impact lay in challenging the hierarchical dominance of the biomedical model. By demonstrating the limitations that this posed for prevention, the Canadian document enabled the international public health movement to reinvent its role for the 21st century.⁴³

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