

CONSTRUCTING VULNERABILITY:
A FEMINIST ANALYSIS OF HEALTH CANADA'S
POPULATION HEALTH STRATEGIES

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by

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ABSTRACT

In recent years, the activities of Canadians have become a major focus of Health Canada and other regulatory agencies, and significant resources have been allocated to examining and modifying people's lifestyles and behaviour patterns. Diet, fitness, exercise, friendship patterns, sexual behaviour, educational experience, drug and alcohol use, community involvement, political behaviour, and so on, have all fallen under intense scrutiny. This scrutiny has resulted in the creation of a multitude of programmes, policies and interventions designed to target specific 'vulnerable populations' and limit what are seen as 'high risk' behaviours. In particular, the perceived links between gender, risk and vulnerability have become key concerns of both policy makers and feminist researchers and activists in the field of health care. Indeed, many feminist researchers and activists have applauded this population health approach as a practical tool for reducing gender disparities in health status. Unfortunately, despite this growing interest, the political ramifications of targeting specific 'vulnerable' populations and 'at-risk' behaviours in the context of health and health care have not been given sufficient scholarly attention. Through an interrogation of the publicly accessible population health documents produced by Health Canada this grounded theory study investigates (1) how the definitions of vulnerability and risk have evolved over time, as demonstrated by the public documents produced by Health Canada, and to what extent these terms are gendered, (2) to what extent health promotion can be seen as a political act that affects women, and, (3) what sort of power relations valuations of lifestyles and behaviours

create between citizens, between citizens and the State, and particularly between women and the State. The overall concern of this thesis is to explore the implications that the population health approach has for women with regard to their expectations for full membership in the polity. The findings suggest that, far from being a 'common-sense' approach to removing health disparities, the population health approach has severe political implications for women and other vulnerable populations. A key finding of this study is the link between the development of the population health approach and the expansion of an active federal presence in the management of health and health care in Canada. In this context, the categories of vulnerability and risk appear more as a means of expanding federal regulative practices than as a component of a social justice project. Thus, this grounded theory study argues that the use of predefined categories of vulnerability and risk, the negative valuations of behaviours and lifestyles that are embedded within these categories, and the persistent link between vulnerability, risk and targeted populations operate as a subtle exclusionary process wherein women, and other identified vulnerable populations are disenfranchised.

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Table of Contents

Abstract	ii
Acknowledgments	iv
Chapter 1 Introduction	1
Chapter 2 Literature Review	9
The Population Health Approach	9
Research Supporting the Population Health Approach	16
Critiques of Health Promotion and Population Health Strategies	25
Feminist Response to the Health Promotion and Population Health Strategies	29
Conclusion	38
Chapter 3 Theoretical Perspectives	40
Poststructural Feminist Theory	41
Social Contract Theory	47
Chapter 4 Health Canada - A Genealogy and Document Analysis	53
Genealogy of Health Canada and the Population Health Approach: 1919- Present	55
Population Health Strategy - Document Analysis	70
<i>A New Perspective on the Health of Canadians, 1974</i>	75
<i>Achieving Health for All: A Framework for Health Promotion, 1986</i>	80
<i>Strategies for Health: Investing in the Health of Canadians, 1994</i>	87
<i>Towards a Common Understanding: Clarifying the Core Concepts of Population Health, 1996</i>	93

<i>Taking Action on Population Health, 1998</i>	97
The Population Health Approach in the Twenty-first Century	101
Chapter 5 Discussion	103
Heath Promotion as a Political Act	104
The Social Construction of Acceptance	112
Beyond Exclusion	115
Chapter 6 Conclusion	124
References	127
Appendix A	137

Chapter 1

Introduction

Like most women's studies graduate students, I came to my master's thesis with an interdisciplinary background. My undergraduate work was in political science and women's studies. Thus, coming up with a thesis topic began as an intellectual task in which I was readily able to draw on my academic background, particularly with regard to feminist theory and notions of political power and citizenship. This work was augmented in many ways by my job as a researcher with the Newfoundland and Labrador Women's Health Network. During my tenure at the network, I began to see a disconnect between the women's health projects we were working on and the feminist calls for substantive change. At the time, knowing that I could put this thinking to good use in developing a thesis proposal, I saw the disconnect as calling for a feminist interrogation of these health projects. At no time during that period had I given much thought to the actual lived experiences of those women targeted by the projects.

My naivete came to a cruel and abrupt halt on January 3rd, 2006, when my partner, Lynda, was diagnosed with Stage 3 breast cancer. Putting my intellectual project on the back burner was necessary for a while, and indeed, I found it quite impossible to even let it simmer there. Instead, my energy became devoted to managing Lynda's treatment, with its many painful trips to physicians, surgeons, oncologists, radiation therapists, and emergency rooms. Immediately following her diagnosis, Lynda's treatment seemed to follow its own internal schedule - decisions that needed to be made

immediately, information that needed to be absorbed, services that we needed to find, and so on. In the short term, we were inexorably caught up in the need to make informed decisions regarding the immediate aspects of treatment and there was little time (or energy) left to reflect on the process in its totality. We had no complaint with the doctors or surgeons who were compassionate and highly skilled and, in fact, went out their way to provide us with information and show respect for our decisions. They seemed also to understand the effect of the diagnosis on our lives as a whole. As Lynda's treatment progressed, however, we began to become aware of, and indeed frustrated with an underlying process of behaviour management, which manifested itself in some subtle, yet insidious ways. We were surprised, for instance, by the attention to Lynda's so-called "risk behaviours." She was told that, as a lesbian smoker, she had placed herself at increased risk of breast cancer - this, in spite of the lack of any clinically proven connection between smoking, sexuality and breast cancer. As we reflected on this, we became more aware of the environment, that is the cancer clinic itself, and the attitudes of the nurses, volunteers and support staff. What initially struck us as individualized homophobic attitudes began to take a new meaning, surrounded as it was by a kind of trite, almost simpering sort of emotional "help," mostly expressed through such things as angel posters and cross-stitched messages of hope, all done in a kind of Hallmark-version of religiosity. It was as if there was an informal regulation of our behaviour throughout the treatment, as if there was some ideal model of how a cancer patient should behave. When we stepped out of that model (which we did with great regularity), for instance, by

sharing irreverent jokes during chemotherapy sessions, by showing affection to one another in the clinic, and by apparently not treating the cancer issue with the gravity it deserved, most others in the clinic began to physically distance themselves from us, by moving chairs, by closing curtains, and so on.

All of this meant that when I returned to the back burner to pick up what remained of my intellectual project, I found that what had started for me as an abstract academic debate had taken a turn. Women's health hit home in a way that no amount of reading could instill. I began to look at the disconnect between women's health projects and feminist calls for change with new eyes. I knew then that the disconnect was part of a much larger political project of the management and regulation of women.

Returning to the books with these new eyes, it soon became apparent that in recent years, the activities of Canadians have become a major focus of Health Canada and other regulatory agencies, and large amounts of resources have been allocated to examining and modifying people's lifestyles and behaviour patterns. Diet, fitness, exercise, friendship patterns, sexual behaviour, educational experience, drug and alcohol use, community involvement, political behaviour, and so on have all fallen under intense scrutiny. This scrutiny has resulted in the creation of a multitude of community programmes, policies and interventions designed to limit what are seen as 'high risk' behaviours. A preliminary perusal of the organizations that have received funding from Health Canada, Population Health Branch indicates that these programmes are often guided by feminist principles and are sponsored by feminist organizations (Public Health

Agency of Canada, 2006). Between 2002 and 2004, a total of \$1,970,000.00 was spent by the Population Health Fund¹ (PHF) alone on national youth focused research and programmes, constituting a total of 33 short-term regional youth projects (Health Canada, 2003; Health Canada, 2004). These projects were conducted by non-governmental, community-based organizations. Although only a minority of the projects specifically targeted young women, there were no projects specific to young men. It is also important to note that the PHF is only one of the federal funding organizations mandated to support community-based population health initiatives.

While it seems to go without saying that some of these ‘high risk’ behaviours² are arguably destructive, I question whether this is the central or only issue. First, I wonder to what extent the focus on risk behaviours is generating a public sense of crisis about what constitutes appropriate lifestyles and behaviour. Second, perhaps more importantly, I am concerned that what appears to be a common-sense health issue is actually fraught with politics and may be creating a new, and more stringent definition of citizenship, namely one that links health and civic duty. Clearly, it is hard to argue against improving the health of Canadians; however, it is imperative to question the extent to which this

¹ The Population Health Fund is one of Health Canada’s funding branches and is responsible for supporting community-based population health research and programmes.

² As noted, these high-risk behaviours include, among others, smoking, poor nutrition, drug and alcohol use, etc. As will be demonstrated throughout the document analysis within chapter 4, each has been defined in specific ways and for specific purposes by Health Canada.

new focus could result in a situation where some citizens are considered more worthy than others, in effect, redefining the boundaries of Canada's political community. What is at issue is not so much that the boundaries are being redefined, but the fact that this is happening under the guise of improving health, without discussion or consideration of the political consequences, particularly for the newly defined vulnerable populations, for example, women, youth, Aboriginal peoples, seniors, and so on.³

The purpose of this research is to interrogate the relationship between the social construction of vulnerability and risk, and the boundaries and definitions of 'good' citizenship within the context of health promotion, for example, the valuation of a healthy/unhealthy citizen's worth and the informal designation of rights, duties and responsibilities. The nature of this relationship, as demonstrated in the following literature review, has been largely overlooked by feminist thinkers who have instead focused on either the need for more targeted programmes for women and girls or, conversely, on the problems associated with the over-management of women and girls. More specifically, this study is guided by the following research questions:

1. How have the definitions of "vulnerability" and "risk" evolved over time, as demonstrated by the public documents produced by Health Canada, and to what extent are these terms gendered? This question is intended to interrogate the political processes

³ See, for example, *A New Perspective on the Health of Canadians* (Lalonde, 1974) which highlights such factors as income, rurality, air quality, housing, social change and working conditions in order to identify specific 'at-risk' or vulnerable populations to be targeted by policy and legislation.

by which these terms have been developed and marketed for acceptance by the public.

Specifically, the question asks:

- How are vulnerable populations defined and categorized by Health Canada?
- Do the definitions of vulnerability and risk, and categories of vulnerable populations promote valuations of lifestyles and behaviours, and if so, how?
- Within the context of government-initiated preventative health strategies, what are the implications of being labeled 'vulnerable' or 'at-risk'?

2. To what extent can health promotion be seen as a political act that affects women?

This question is aimed at pulling debates about women's health out of the usual context of access and exclusion. Instead, the question is concerned with the following issues:

- What are the implications of health being considered as a 'collective good'?
- What are the implications of the provision of healthy bodies being a governmental function?
- What are its implications regarding the informal, that is non-codified, designation of rights, duties and responsibilities?
- How, under what conditions, and in what form has the jurisdiction of Health Canada been (re)defined and expanded? What other forms could this have taken? What is excluded, included and highlighted?

3. What sort of power relations do valuations of lifestyles and behaviours create between citizens, and between citizens and the State, and particularly between women and the State? This question is designed to go beyond the processes outlined in the first two

questions to consider the more theoretical issue of how these regulatory processes are situating women as citizens.

What these questions call for is an analysis of (i) the development of our national system of health care over time; (ii) an interrogation of the federal population health strategy; and (iii) the political links between the two. In this thesis, I present the findings from a two-part grounded theory study. I begin by developing a genealogy of Health Canada, from its inception in 1919 to the present. Then, using the genealogy as a context, I conduct a content analysis of the publicly accessible documents produced by Health Canada from 1974 through to the end of the century, when the vision of the population health approach began its implementation. Both methods are in keeping with a feminist poststructuralist approach, which I draw on for my analysis and discussion. In addition, I draw on concepts from social contract theory in order to consider the political ramifications of redefining health care as a collective ‘good’ and explore its implications for women with regard to their expectations for full membership in the polity.

This thesis contains six chapters. In the following chapter, I provide a review of the pertinent literature, namely a description of the population health approach, the research in support of the approach, and selected feminist critiques. In chapter 3, I outline the theoretical perspectives, including social contract theory and feminist poststructuralism, providing the rationale for drawing on both perspectives. In Chapter 4, I outline the methods and findings of this study by first presenting a genealogy of Canada’s national health care system, from 1919 to the present, and by discussing Health

Canada documents as they relate to this historical context. In Chapter 5, I provide a broader, theoretical discussion of the links between gender, health care and citizenship. It is in this discussion that I provide a full interrogation of the processes illustrated by the production of documents and the engagement with its related activities over time and how they are marked mainly by the active silencing of a wide-ranging national debate. I argue that while operating under the guise of improving national health status, the population health approach has been essentially used as a vehicle to redefine federal and provincial jurisdictions, to create ideological shifts regarding the freedom of choice, to expand what legitimately falls within a public domain, and to change the balance between individual and collective needs, wants and desires. I claim that what is particularly noteworthy is the employment of gender broadly and the women's movement more particularly to consolidate these ideological, economic and political shifts. I discuss these understandings by considering the extent to which we may see a relationship between the social construction of vulnerability, risk, and good health, and the non-codified boundaries of citizenship. More specifically, I focus on the more theoretical question of whether health promotion may be seen as a political act which disenfranchises women, promotes valuations of lifestyles and behaviours, and links gender to definitions of vulnerability and risk. The attempt here is to make visible the power relations that operate through the valuations of gender, lifestyle, and behaviours to define the boundaries between citizens, and between citizens and the state and particularly between women and the state. The thesis concludes with Chapter 6.

Chapter 2

Literature Review

In exploring the evolution of Health Canada's population health approach, and the adequacy of current feminist thinking in relation to it, in this chapter, I examine three bodies of literature: literature which describes the population health approach; research pertaining to advocacy of the approach; and selected feminist critiques.

The Population Health Approach

The current governmental focus on limiting high-risk behaviours among young women as evidenced by the plethora of funding, projects and policies (Health Canada, 2003, Health Canada, 2004, PHAC, 2004, PHAC, 2006, Women's Health Bureau, 2002), falls within the broader policy context of health promotion and population health strategies. While the link between health care policy and young women's behaviour may seem vague, it is necessary to recognize the combined effects that broader conceptions of health, the shifts away from treatment toward prevention and the goal of reducing the strain on primary health care resources have on our perceptions regarding the possible negative outcomes of young women's high-risk behaviour. Based on the assumption that lifestyle and behavioural patterns are learned early in life and form the basis for later decisions, Health Canada has, from the onset of the population health approach, placed a great deal of emphasis on promoting healthy lifestyles in youth (Lalonde, 1974). Within the category of youth, girls and young women have been specifically targeted by

programmes and services - due in part to the increasing rate of young women's involvement in high-risk behaviours in relation to that of young men, and the recognition of gender as a determinant of health (University Health Network Women's Health Program, 2000, p. 5-8; Women's Health Bureau, 2002, p. 8-10).

In recent years, health promotion and population health approaches have featured prominently at provincial, national and even international levels of government and, in many cases, have become the standard for measuring the effectiveness of health care systems (World Health Organization, 2004). Health promotion and population health strategies have been adopted at a global level and there is a burgeoning of literature examining this approach to the conceptualization of health and the delivery of health services.⁴ The trend that is, perhaps, most readily apparent is the delegation of responsibility for maintaining and/or improving health and well-being to individuals and their communities. By linking specific 'at-risk' behaviours with specific causes of morbidity, national health authorities are able to cast individuals as the primary players in the quest for improved health status.

What is key to population health strategies is that they fall outside of the traditional medical field and health care organization and target areas such as education, social policy, employment and labour relations, personal lifestyle choices, and sexual

⁴ For example, a simple "google" search for the term "population health approach" turned up more than 43 million sites. A similar wikipedia search produced 11,400 English population health sites. The popularity in Canada of the population health approach since 1974 is demonstrated in the description of the document search which follows in Chapter 4.

behaviour to name a few (Ratcliff, 2002). Programmes designed to educate individuals on particular individual and social risk factors are now present in settings ranging from classrooms to board rooms, and legislation - based upon the desire for healthy physical environments - now exist to limit personal risk behaviours (e.g., anti-smoking legislation and seat belt laws). In 1974, Canadian health authorities began to move away from medical definitions of health and adopted the broader conception of a 'health field.' Prior to 1974, health was seen to be a function of the absence of disease. Subsequently, the primary focus of health care services was on providing first-class, timely medical interventions (Lalonde, 1974). One of the more notable features of this conception was the promotion of the idea that improving the overall health of Canadians would require the removal of historical social and economic inequalities (Lalonde, 1974). This approach dictated that, for the goal of improved health status to be realized, radical change would have to occur - a prescription that has long been advocated by feminist organizations.

In 1974, the Department of Health and Welfare set out four determinants of health: human biology, lifestyle, environment and health care organization (Lalonde, 1974). These determinants of health were defined as follows:

- *Human Biology*: "all those aspects of health, both physical and mental, which are developed within the human body as a consequence of the basic biology of man [sic] and the organic make-up of the individual" (p. 31).
- *Environment*: "includes all those matters related to health which are external to

the human body and over which the individual has little or no control” (p. 32).

- *Lifestyle*: “consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control” (p. 33).
- *Health Care Organization*: “consists of the quantity, quality, arrangement, nature and relationships of people and resources in the provision of health care” (p. 32).

In 1994, this list of social determinants of health was expanded to nine different categories, namely:

1. *Income and Social Status*: Health status shows a positive relationship to an individual’s income and social status, with those in a higher socio-economic position possessing a better health status than those in a lower socio-economic position (Health Canada, 1994).
2. *Social Support Networks*: Those who have an integrated support network have a better health status than those who do not (Health Canada, 1994).
3. *Education*: Health status has a positive relationship with education, with those who have a higher level of education experiencing a better health status than those with a lower level of education (Health Canada, 1994).
4. *Employment and Working Conditions*: Those with more control over their working environment have a better health status than those who have less control over their workplace (Health Canada, 1994).
5. *Physical Environments*: An individual’s health status is shaped by the physical environment in which they live and work (Health Canada, 1994).

6. *Biology and Genetic Endowment:* Health status is related to an individual's biology and organic make-up. This includes genetic endowment, the functioning of body systems, and the processes of development and aging (Health Canada, 1994).
7. *Personal Health Practices and Coping Skills:* Personal practices have a large impact on health status. Practices such as smoking and the consumption of alcohol and other drugs have a negative impact on an individual's health while, conversely, practices such as engaging in regular physical activities have a positive impact on an individual's health status (Health Canada, 1994).
8. *Healthy Child Development:* Prenatal and early childhood experiences are closely linked to an individual's health status in later life (Health Canada, 1994).
9. *Health Services:* Access to health services, and in particular those services intended to promote health and prevent disease are linked have a positive relationship with an individual's health status (Health Canada, 1994).

Two years later, in 1996, Health Canada finalized the list, expanding the social determinants of health to twelve (Health Canada, 1996):

1. *Income and Social Status:* Health status is related to an individual and a group's income and social status, with marked differentiations between individuals and groups being exhibited at every gradient on the hierarchy (Health Canada, 1996).
2. *Social Support Networks:* Health status is positively affected by supportive

networks of friends and families. These networks are central to helping individuals solve problems and maintain control over their situations. As such, supportive social networks act as a buffer against poor health outcomes (Health Canada, 1996).

3. *Education:* Health status is related to an individual's level of education, with marked differentiations between individuals being exhibited at every gradient on the hierarchy (Health Canada, 1996).
4. *Employment and Working Conditions:* Individuals with control over their work and/or workplace have a better health status than those who do not. Unemployment, underemployment and unsafe working conditions are major causes of poor health (Health Canada, 1996).
5. *Social Environments:* The broader community setting has an impact on health status, with areas that are vibrant and prosperous being conducive to improved health status (Health Canada, 1996).
6. *Physical Environments:* Toxic physical environments have a profound impact upon health status and can lead to a variety of negative health effects including cancer, birth defects, respiratory ailments, and so on (Health Canada, 1996).
7. *Personal Health Practices and Coping Skills:* The ability to perform 'self-care' relates directly to an individual's health status. Healthy lifestyle choices result in an improved ability to address problems, and to be more self-reliant. The ability to make these choices are not only an individual capacity but are also linked with

socioeconomic factors (Health Canada, 1996).

8. *Healthy Childhood Development*: One's health status in later life, is, to a large extent, dependent upon their health status in early childhood and the resources to which they had access as a child (Health Canada, 1996).
9. *Biology and Genetic Endowment*: Health status is also dependent upon one's natural resources in regard to their physical endowment (Health Canada, 1996).
10. *Health Services*: An individual's health status is related to their ability to access first-class health services, not only in relation to medical care, but also in relation to preventative treatments (Health Canada, 1996).
11. *Gender*: Gendered norms influence the health system's practices and priorities. Many health issues are a function of gender-based social roles (Health Canada, 1996).
12. *Culture*: Some individuals may have a reduced health status due to their membership in cultural groups that are marginalized, or stigmatized (Health Canada, 1996).

Within the current mainstream health discourse, these social determinants of health, both individually and collectively, serve to outline the factors that influence an individual's and a group's health status. It is hoped by many policy makers that using these social determinants of health to inform research, and policy and programme development will result in substantive improvement in the overall health status of Canadians (PHAC, 2004).

What is most obvious from the shift in the social determinants of health between 1974 and 1996, as outlined above, is the expansion of determinants. Perhaps more importantly, however, this expansion was accompanied by attention to the notions “risk” and “vulnerability,” defined by Health Canada as populations who are at risk because they are “vulnerable to environmental risks as a result of physical differences, behaviours, location and/or control over their environment” (Health Canada, 2007, p.1), along with attention to specific target groups, for example, children and pregnant women, aboriginal peoples, and seniors (Health Canada, 2007, p.1). As will be shown in the document analysis to follow in Chapter 4, the expansion of the social determinants of health was accompanied by an expansion of the categories of populations considered to be vulnerable and at risk, and this linking was accomplished at specific times for specific purposes.

Research Supporting the Population Health Approach

There has been a flurry of research activity in support of the population health approach. Much of this research takes as its initial presumption the positive aspects of the tenets of the approach and thus focuses on their applicability to a variety of health contexts.⁵ What is immediately apparent is how these presumptions may be seen as prompting research across sectors and across academic disciplines. Even a cursory perusal of research cited by Health Canada (2007a) indicates that research based on these

⁵ See, for example, Ratcliff, 2002.

presumptions has been conducted in the fields of medicine, climatology, sociology, education, policy analysis, economics, and so on (pp. 1-2).

A first example of employing the tenets of the population health approach to the systematic development of broad national projects is Wolfson's (1994) argument for a national system of health statistics. Noting that Canada has "inherited a hodgepodge of limited data collection systems that are seriously limited with respect to current thinking" (p. 181), Wolfson advocates for a broader vision of health information, that is a system of health statistics, that is "in line with emerging views on the determinants of health" (p. 181).

In keeping with the presumed applicability of the determinants of health to national concerns, Hancock (1999) argues for a "bottom-down" (p. 417) approach to health care reform in which the household is considered to be the primary source of good health and health care. Such a system "would see the hospital become once again the place of last resort (but still a potentially important partner in creating healthier communities) and would focus instead on how to provide health promotion and health care from the household level up" (p. 417).

In addition to its use as a tool for informing research on broad national policy and projects, the population health model has also been employed by researchers as a means of evaluating health care services, programmes and policies. The discussion by Cameron, Manske and Brown (2007) of the School Health Action Planning and Evaluation System, uses a population health model as a tool for evaluating the integration

of public health policy, practice, evaluation, surveillance and research related to population-level interventions. With this system, local data can be collected from a school's students and "used to produce computer-generated school 'health profiles,' " (p. 648) which can then be used to inform "intervention planning, evaluation, surveillance and research across Canada" (p. 648). As Cameron et al. argue, these systems can "contribute substantially to evidence-informed public health practice, public engagement, participatory action research, and relevant, timely population intervention research" (p. 648). The focus on developing a systematic approach to research, surveillance, management and evaluation to inform interventions with specific populations illustrates the unquestioning acceptance of the tenets of a population health approach.

Related to using a population health model as a tool for evaluating the effectiveness of a given intervention, Lavis, Ross and Stoddart (2003) use the model to grade the commitment that Canadian civil servants have to the health of the population. In this study, federal and provincial civil servants in the departments of finance, labor, social services, and health were surveyed about their awareness of, attitude toward, and self-reported use of ideas about the determinants of health. The majority of civil servants, with the exception being those employed in the department of finance, felt that the determinants of health had been integrated into policymaking in their sector. In addition, most reported the need for "more information about the health consequences of the policy alternatives their departments face" (p. 658). Lavis et al. concluded that there is a need to develop "accountability structures for health, and researchers should consider

producing and transferring more policy-relevant research” (p. 658). Again, the population health model and its identified determinants of health are taken up unquestioningly by these researchers.

The basic tenets associated with the population health approach have also been employed extensively by researchers as a means of establishing and exploring the links between health and various targeted populations. Focusing on the under-use of formal health care services of rural families caring for seniors with dementia in Saskatchewan, Morgan, Semchuk, Stewart and D’Arcy (2002) inquire into the barriers to accessing care services in rural settings. Through the use of a community-based application of the population health framework, Morgan et al. identify “eight barriers to the use of formal services” (p. 1129), describe “the consequences of low service use,” (p. 1129) and suggest strategies for improving the accessibility of rural health services.

As another example of research on targeted populations, Dunn and Dyck (2000) focus on immigrant populations, examining in particular “differences in health status and health care utilization between immigrants and non-immigrants, immigrants of European and non-European origin, and immigrants of < 10 years and > 10 years' residence in Canada” (p. 1573). They also evaluate the utility of large-scale databases, drawing upon a population health perspective, suggesting that “most important antecedents of human health status are not medical care inputs and health behaviors (smoking, diet, exercise, etc.), but rather social and economic characteristics of individuals and populations” (p. 1573). What they conclude, interestingly, is that there is “no obvious, consistent pattern

of association between socio-economic characteristics and immigration characteristics on the one hand, and health status on the other” (p. 1573). While these researchers discuss the limitations of cross-sectional survey data, they do not challenge the basic tenets of the population health approach.

Also focused on immigrant populations is a research report by Hyman (2003). In this case, Hyman investigates the reasons “why immigrant women to Canada come to the country with superior health to the native-born population, and then lose this health advantage over time” (p. 31). Her findings indicate that “policies and programs are needed that focus on the key determinants of immigrant women's health” (p. 33), a view that may be interpreted as acceptance of the presumptions of the population health strategy as an a priori aspect of the research.

This focus on target populations is extended to other ‘vulnerable’ groups. For instance, Wilson and Rosenberg (2002) explore the determinants of health for First Nations peoples in Canada. What Wilson and Rosenberg have attempted is the integration of the determinants of health with a “set of measures of traditional activities” (p. 2017). Their use of the Aboriginal Peoples Survey, along with their attempt to statistically measure cultural traditions is premised on an unquestioning acceptance of the population health framework and its accompanying notions of risk, targeted populations and the necessity of evaluative measures. What is most interesting is the notion that cultural traditions can be measured and whether, if they can be measured, how they may be seen as an integral causal component of good health. It is an awkward integration,

perhaps illustrating just how accepting these researchers are of the tenets of the population health approach.

This acceptance by researchers is similarly indicated in research by Newbold (1998), who uses the population health approach as a framework for exploring the health status of Canadian Aboriginals. In this case, “comparisons were made with respect to group identity (North American Indian, Metis and Inuit) and geographic location (reserve, urban, rural and North) and across a series of health status and health care use indicators” (p. 59). While Newbold is clear that his findings suggest that geographic location features more than aboriginal identity as being linked to health status, he maintains that the results of his analysis “tend to reinforce the determinants of health framework” (p.59). What Newbold does not address are the ways his findings challenge the way aboriginal identity is used within the determinants of health to demarcate the boundaries of a vulnerable population. That is to say, within the determinants of health approach, aboriginal populations are not seen to be at risk because of their location, but rather as a result of their identity as aboriginals (Health Canada, 2004a)

The focus on targeted populations is also present in the Birch, Jerrett, and Eyles (2000) study on heterogeneity in the determinants of health and illness. Concerned with the persistence of systematic variations in health and illness among social groups, this study used a logical regression analysis based on the 1992-93 Santé Quebec survey data to explore the “smoking-health relationship between social groups” (p. 307). The findings indicate: first, smokers were much more likely than non-smokers to report their

health as poor or fair; second, the reported differences were much greater among groups with low incomes and/or employment, but were less among sub-groups with lower levels of education. Birch et al concluded that the variations in health and illness could be reduced through an expansion of the determinants of health to include attention to the “interface between social, behavioural and clinical determinants of health” (p. 307). Thus, while these researchers recognize some of the limitations of the determinants of health they remain committed to them overall.

The commitment by researchers to the population health model is demonstrated as well by Kosteniuk and Dickinson (2003), who trace the social gradient in the health of Canadians by focusing on the relationship between primary and secondary determinants of health. Primary determinants include socio-economic and demographic indicators; secondary determinants include stressors, control, self-esteem, social support, and social involvement. Using these indicators coupled with data from the Canadian National Population Health Survey, Kosteniuk and Dickinson found a positive relationship between primary and secondary indicators, noting a link between good health and high socio-economic standing. What stands out most about this study, apart from its attachment to indicators pre-defined by the health strategy, is the operationalization of statistical measurements of the determinants of health in a population's health status. Indeed, the authors suggest the continued replication of this research in order to be able to measure improvement or decline in a population's health status.

In terms of targeted populations, gender is also a key focus of research. Avison

and Davies (2005) focus on single parenthood and health over the life course. This research employs the Canadian National Population Health Survey data to identify “the effects of single parenthood on parental health and determine whether such effects are similar for all single parents or whether there are variations by gender among young, middle-aged, and older adults” (p. 113). Finding an association between female single parents and elevated psychological stress and alcohol consumption, and only some indication of elevated stress among young single fathers, they conclude that “the relationship between family structure and psychological distress and alcohol consumption varies by lifestage” (p. 115), with the negative effects decreasing with advancing age. In addition, they advocate for a follow-up study on women and single parenthood to better understand “the ways that gender, family structure, and stress produce varied consequences for the health of parents” (p. 116).

Gender differences in health is the primary focus of the Denton, Prus, and Walters (2004) study of the psychosocial, structural and behavioural determinants of health in Canada. This study used a population health approach and the Canadian National Population Health Survey data to identify and examine gender differences in mental and physical health. Finding that “social structural and psychosocial determinants of health are generally more important for women and behavioural determinants are generally more important for men” (p. 2585) due to “differential vulnerabilities to social forces between men and women” (p. 2585), Denton et al. conclude that models need to include a wide range of health and health-determinant variables and that gender differences in

health warrant further study.

Taking a more focused approach to young women and experiences of previous abuse and violence, Henderson and Jackson (2004) examine the potential for processes of restorative health. While advocating “certain rights-based principles” (p. 794) in interventions with this group, it is interesting to note that Henderson and Jackson do so in ways that are based on “social determinants of health” (p. 794), and particularly the idea that “restorative health can be operationalized through the provision of adequate services and resources to disadvantaged and vulnerable young girls” (p. 794). In so doing, the authors do not challenge the definitions of ‘vulnerable’ population, nor do they discuss the implications of operationalizing conceptions of health that are intended to alleviate previous hurts. Finally, while ostensibly feminist, the researchers do not question the use of the social determinants of health in assigning definitions of loss and vulnerability. Thus, while their goal is to ameliorate the long-term effects of children’s exposure to violence and abuse, they do not recognize the young woman’s agency in seeking restitution. Indeed, their reliance on definitions of health and vulnerability that are defined prior to the girls’ involvement may be in effect replicating the processes of exclusion and disempowerment that they purport to be challenging on the girls’ behalf.

The literature I review here is by no means exhaustive. However, what this review makes clear are the variety, and number of studies informed by the population health model. As illustrated, the population health approach and the subsequent focus on the social determinants of health and targeted populations have provoked health research

on a broad range of social health issues. These issues include national population health statistics, health care reform, programme evaluation, human resources, rurality, immigrant populations, aboriginal peoples and culture, smoking, social gradients, gender and violence and abuse. This review is only a small sample of the research that has been generated by the population health approach.

These studies underscore how categories of vulnerability and risk have become so deeply embedded in our consciousness, and institutionalized and reinforced through research and programme and policy development and evaluation. In this way, the population health approach, with its focus on linking determinants of health with specific target populations becomes a litmus test for the effectiveness of national strategies. Particularly noticeable is the introduction of varying systems of measurement in an attempt to establish gradients of health. What is overlooked is a discussion of the assumptions underlying the premises of the social determinants of health, or the demarcation of vulnerable groups and the linking of the two for the purposes of research, policy and programme development. The result is, minimally, the reinforcement of stereotypes, accomplished through the institutionalization of categories of risk and vulnerability. Clearly, larger issues of power need also to be addressed since these unquestioned assumptions suggest the insidiousness of these categorizations and their effects.

Critiques of Health Promotion and Population Health Strategies

Although there is a dearth of literature that interrogates the assumptions embedded within the population health approach, Labonte (1997) began to challenge the use of the term 'population' in what he defined as critical health research. More specifically, he was concerned with how the term was used to stand in for the term 'public.' In his view, 'population' connotes a statistical measure, whereas the term 'public' denotes attention to rights and responsibilities. He argued that the resulting effect was a masking of the political agenda and the political challenges associated with removing health disparities and the spectrum of inequalities.

While his initial critique might have provided the basis for an expanded critique of health care as a vehicle for social change, Labonte, as evident in his more recent work (Labonte, 2005) shifted his focus toward developing an operationalized conception of population health as an analytic practice. Instead of his previous project of exploring the political implications of using statistical language to describe social health status, Labonte shifts his critique to focus upon the ways in which the population health model can be modified to improve its ability to remove socially derived inequalities in health status. To this end, Labonte argues for what he describes as a "critical population health model" (p. 6) as a framework for conducting health research. This model would be characterized by attention, not only to the social aspects of health, but also to their underlying causes. As Labonte (2005) argues

The twinned goals of critical population health research, then, are (1) a thorough going deconstruction of how historically specific social structures, economic relationships and ideological assumptions serve to create and reinforce conditions that perpetuate and legitimize conditions that undermine the health of specific

populations; and (2) a normative political project that, as a result of deeper understanding, seeks the reconstruction of social, economic and political relations along emancipatory lines (p. 10).

Thus, Labonte's critique is a limited one, particularly in its continued linkage between socially derived health effects and specific groups. Nowhere does he problematize this link, or discuss the political implications of creating analytical categories of belonging. Nor does he question the possible effects of having this amount of research focused on certain populations.

In keeping with Labonte, Cohen (2006) provides a similarly limited critique of the use of population health as an epidemiological tool, citing its lack of emphasis on social change and the absence of "values of equity" (p. 1576). Cohen thus echoes Labonte's call for research on the social and economic causes and consequences of health inequalities, but goes further to require practical application of what she terms a "critical population health practice" (p. 1576), stating that this would be:

...an approach [that] would not only link what is known about societal determinants of health with action strategies to address these determinants but also focus all decisions related to public health program planning, delivery, and evaluation and staff development through an equity lens (p. 1576).

Beyond Labonte's initial questioning of the statistical language of the population health approach as a discourse which masks its political nature, critiques of the federal strategy have been largely limited to other analytic and methodological concerns. As an example, the work of Mikhalovski and McCoy (2002) is noteworthy. These researchers focus on a particular analytic concept, which they term "health work" to explore the work that

people living with HIV/AIDS do to take care of their health. More importantly, the concept of “health work” is employed as an analytic tool to raise awareness of the power of the population health approach, and its accompanying changes in the organization of hospital services, to create “[a shift in] the burden of care onto the shoulders of individual PHAs [people living with HIV/AIDS], their partners, friends and family members” (p. 22). At the same time, the potential of this concept to develop such a critique was limited by the researchers’ rapid shift to methodological concerns once they took up their work in the field. These methodological issues came into play when the project funder, (the Positive Action Fund, Ontario Ministry of Health) expressed concerns regarding community-university partnerships, effectively changing the focus from the concept of “health work,” and its potential for critique, to a more limited analysis of the technical aspects of health care provision in the limited context of emerging antiretroviral therapy.

While our initial plan to focus on hospital restructuring and the transfer of care onto individuals was of interest to the people we spoke with, more pressing for them were concerns about how to support PHAs in the context of new combination antiretroviral drug therapy that had been introduced at the time (p. 23).

Also critical in a limited way of the population health approach is the work of Coburn, Denney, Mykhalovskiy, McDonough, Robertson and Love (2003). These authors begin with the argument that the population health approach “is flawed because of assumptions in its perspective that limits analysis of determinants of health at the macrolevel; because it excludes, at the microlevel, the local context in which the health of real people is shaped; and because it fails to adequately conceptualize possibilities for

change” (p. 392). The authors’ concerns focus primarily on technical and methodological issues, however, as evidenced by their argument that the specific disciplinary framework of the dominant population health approach employs the wrong actors, that is, “change is brought about by social scientists and the governments they inform, rather than by classes, social movements or communities” (p. 393). Thus, their critique is not aimed at the population health approach, as such, but instead raises concerns about the technical aspects involved in developing appropriate methodologies for its implementation. Again, the potential for a far-reaching political critique, in keeping with Mykhalovskiy and McCoy’s shift, is overlooked in favour of a focus on the limited context of implementation. In both cases, the question of concern to the researchers seems somehow to be reconceptualized in ways that support the social definitions of health.

Feminist Response to the Health Promotion and Population Health Strategies

Feminist critics have provided much in the way of critiques of medicine. Some early examples include: de Beauvoir (1952), Firestone (1972), Boston Women’s Health Book Collective (1973), Ehrenreich and English (1974) Crawford (1980). These critiques, while substantial and important, by and large, focus on the ways in which women’s bodies have been expropriated by the field of medicine to support the relegation of women to the status of ‘other.’ This literature clearly attends to the political and social valuations that are embedded in the dominant medical discourse. More current feminist

discourse has taken up the challenges identified by these early feminist scholars and has focused more clearly on exploring and understanding the socially derived nature of women's health status.

Prominent among the issues which are taken up is the social construction of the body (Frank, 1991; Shilling, 1991, 1993, 1997; Featherstone, 1993; Grosz, 1994; Turner, 1996; Kirk, 2002; Tinning and Glasby, 2002). Another key issue is the discursive production of health (Evans, 2006; George and Rail, 2005; Moulding, 2007). A third issue that stands out in the literature is the link between health and identity and the body and identity (Featherstone, 1993; Lupton, 1996; Howell and Ingham, 2001; Kehily, 2007). While all of these issues are critical to understanding the relationship between health, culture, identity and women's continued subordination within medical discourses, what is missing is a full exploration of the relationship between the formal political application of health policy and the issues identified in these bodies of literature, an issue which is the central focus of this thesis. Thus, although all of work cited above provides a substantial discussion of women's health and the informal application of political and social valuations, I do not provide detail within this literature review. Instead, I move on to discuss some of the features of the literature that pertains more directly to the population health approach itself.

Overall, the feminist literature is critical of particular aspects and applications of the population health approach. At the same time, while some other feminist writers such as Mohanty (2003), Holloway (2006) Calhoun (2001) have raised questions

pertaining to the identification of women as a categorically important group these questions appear to have been ignored by many feminist critics in the field of health (a field which, as shown, not only categorizes women as an homogenous group, but as a group which is particularly vulnerable to poor health effects). This tendency becomes immediately obvious through the topics which are being addressed and the emphasis on Gender-Based-Analysis (GBA), developed by the Women's Health Bureau of Canada in 1999 as part of the National Women's Health Strategy.

What is most striking about this research, apart from the fact that the GBA approach itself has been critiqued only in a very limited way, is that much of the feminist critique takes up an issue-group approach.⁶ This is perhaps best illustrated with the list which follows. Note that this list represents only a partial selection of topics drawn from a periodical keyword search of "women and health," and "feminist," as well as the keywords "feminist critique" and "health".⁷

- rural women's health issues (Leipert, 2005)
- support for rural girls (Varpalotai, 2005)
- HIV and sex trade workers (Keeping, 2004)
- colonialism, racism and sexism and aboriginal women (Bourassa, McKay-

⁶ Here, I have coined the term "issue-group approach" in order to highlight that health research projects employing the GBA tend to couple health issues, for example, breast cancer, with a targeted group, for example, lesbian women.

⁷ The list I present here is a partial one because of the large number found in the peer-reviewed database. While only 21 records turned up with a search of "feminist critique" and "health," 237 peer-reviewed articles appeared with the search of "women and health" and "feminist." Taking both searches together, I judged more than 25% to fall into the category of "issue-group" approach as I have described it above.

McNabb, and Hampton, 2004)

- two-tiered recreation and poor women (Reid, Frisby, and Ponio, 2002)
- HIV and women (Connell, 2001)
- health-seeking behaviour and women (Currie and Wiesenberg, 2003)
- women and social support (Hurdle, 2001)
- smoking and adolescent girls (MacDonald and Wright, 2002)
- physical activity and adolescent girls (Brooks and Magnusson, 2007)

The list provides a clear indication of how particular health issues are linked to specific target groups identified by the population health approach, for example smoking and adolescent girls and HIV and sex trade workers. Again, what is missing from this type of research is any analysis of the analytical limitations of this method of inquiry, namely the ability of the approach to address the heterogeneity of experience or effect *within* categories of groups and health effects, or the homogeneity of experience *between* categories of groups and health effects. In other words, whenever there is an example of plurality within a category, a new category is developed. Conversely, examples of homogeneity between categories are simply overlooked. Also missing, is a discussion of the political implications of relying on categories of identity to examine health effects. Moreover, this research direction not only takes for granted the finite and inflexible nature of categories of identity, but also asserts their inherent utility in exploring questions surrounding gender and health and developing strategies for change. The prevalence of this style of inquiry is perhaps most evident in a special issue of *Canadian*

Woman Studies v.24 no.1 (Fall 2004) which was devoted to women's health and well-being. This issue provides numerous examples of the issue-group approach, and highlights the perceived utility of the Gender-Based-Analysis (GBA) to social health issues that underlie women's health status. This situation precludes any interrogation of either the categories themselves, or the valuations embedded within them.

Feminist critiques of gender-based analysis are limited to an evaluation of its acceptance by policy-makers.⁸ An article by Hankivsky (2006) provides a recent example. Viewing the adoption of the national Women's Health Strategy in 1999 as a major victory for the women's health movement, Hankivsky is critical, not of the gender-based analysis itself, but rather the lack of consistent adoption of the gender-based analysis by policy makers. According to Hankivsky, it is the uneven implementation of gender-based analysis that is the primary cause of continued gender inequalities in policy, programmes and services for women and girls.

The vision was both progressive and congruent with international objectives and priorities in the area of women's health. From the very outset, however, there were no mechanisms put in place for operationalizing, monitoring, or evaluating the Women's Health Strategy, including the key objective of GBA . . . (p. 51).

Hankivsky goes on to argue that while the Women's Health Strategy and the gender-based analysis approach is being ignored by "many policy makers" who "simply do not recognize the relevance of gender-based analysis and resist having to undertake any additional work that they perceive is associated with a gender analysis" (p. 52).

⁸ If additional feminist critiques of the GBA exist it is possible that they are being subsumed under the plethora of issue-group research that characterizes the majority scholarly work on women and health.

A notable exception to this approach, and perhaps more pertinent to the analysis I conduct in this thesis is work done by a number of feminist critical scholars who focus more clearly on the implications of the population health approach for the management of women's and girls' risk behaviours.. Harris (2003, 2004), for example, focuses on the (over)management of young women's behaviour. Although, as Harris argues, 'growing up right' has always been a highly managed process for girls, our current process of regulation has unique characteristics and implications for young women (Harris, 2004). According to Harris, our contemporary conceptions of girlhood and young women's adolescence are intimately intertwined with our notions and images of modernity. In this context, images of outgoing and successful girls and young women have become synonymous with ideas of progress. Depicted as the inheritors of the legacy of the women's movement, successful girls and young women (what Harris defines as the 'can-do' girls) are now seen as possessing unconstrained freedoms and opportunities. Parallel to the images of success are the perceptions of girls as being 'at-risk' or 'risk takers'. The category 'at-risk' is most often used in relation to young women who are seen to be vulnerable due to their circumstances. As Harris (2003) argues, "Those who lack the flexibility and resilience to achieve success are often seen to suffer from personal problems that have led them to unfortunate, risk-taking behaviour" (p. 39).

As Harris argues, both the 'can-do' and the 'at risk' young women have become the subjects of regulatory programmes and interventions. Within the 'can-do' category of young women, programmes and interventions operate as a means to prevent young

women from failing to meet the extraordinary expectations of success that have been placed upon them. For young women who have been defined as being 'at-risk', these programmes operate to facilitate their movement into the 'can-do' category. While there are distinct differences between the two styles of interventions, they share a tendency to individualize the problems experienced by young women. In both the 'can-do' and 'at-risk' cases, the results of structural inequalities are redefined in terms of poor personal choices and laziness. In making her point about this tension, Harris cites McRobbie, who argues:

Girls, including their bodies, their labour power and their social behaviour are now the subject of governmentality to an unprecedented degree'. The cultural fascination with girlhood and the modes of governmentality by which their bodies, labour and behaviour are regulated have been organized primarily around two images: 'girlpower' on the one hand, and 'girls as risk-takers' on the other" (McRobbie, 2001, p. 1, as cited in Harris, 2003, p. 40).

In addition to masking structural inequalities and supporting a two-dimensional depiction of young women, Harris (2003) argues that these programmes and interventions have a much more ominous effect on young women and their potential to challenge biased institutions. Programmes and interventions designed to manage young women's 'negative' behaviours are structured in ways that, at least superficially, mirror feminist styles of consciousness raising. Like feminist forums, these programmes encourage young women to speak about the challenges that they are experiencing. However, unlike feminist models which focus on participant driven dialogue, critique and action, these programmes operate in a top-down fashion with the objectives predefined by the host organization and the larger social and governmental institutions

(Harris, 2003). Thus, while young women are being encouraged to speak, the parameters of discussion have already been defined. As Harris states, "Young women are encouraged to speak their stories and provide narratives of their experiences, but at the same time they risk these narratives being scrutinized, interrogated, appropriated and depoliticized" (p. 44). When examined from this angle, it is apparent that this incitement to speak actually functions to silence young women and appropriates the discursive spaces where young women could come together to develop strategies for resistance, for example, to the regulation of their behaviours. This description of silencing is particularly interesting when seen against the backdrop of the feminist advocacy of women-centred health programmes and policies (Thornham, 2000). That is to say that while women-centred health programmes and policies appear consistent with feminist agendas in the field of health, the social, political and cultural contexts in which they operate to redefine these projects in ways that are easily integrated into the status quo and which re-enforce practices of dominance and subordination.

In another critique, Shoveller and Johnson (2006) address the concept of risk in the context of youth sexual health, claiming that the population health approach practice of modifying sexual risk behaviour articulates an "unrealistic set of assumptions about the level of agency and control that is afforded to many young people" (p. 47). The initial focus of their work contains a valuable deconstruction of the concept of risk, particularly as it has been employed within the population health strategy. Their contention is that the notion of risk has been used by various actors in various ways to

create binary evaluations of sexual behaviour among young people, and that these evaluations have been employed in very specific ways for specific purposes. This deconstruction highlights the ways in which the concept of risk has been developed by focusing on the shift away from risky groups to risky behaviours and then to low self-esteem. What this deconstruction shows, then, is how the essentializing characteristics of risky groups have been reintegrated into the current discourse on self-esteem, effectively masking the political nature of these evaluations, while according young people little in the way of agency and control. As well, the authors demonstrate how this shift has been accomplished through the deployment of additional actors, such as peer educators. As such, they put forward a substantial critique of the population health approach by unpacking the underlying assumptions that segregate groups and behaviours into worthy or unworthy. What the authors neglect, however, is the opportunity to take this critique further into a full analysis of the political implications of viewing youths' sexuality as worthy of public scrutiny and policy development. Instead, they put forward a "critical public health approach" that advocates little more than "new directions for public health research and practice in the area of youth sexual health that move us away from risk-factor models and towards approaches that consider, respond to and potentially transform youths' social contexts and structures" (p. 56). The goal of "producing long-term sexual health improvements at the population level," (p. 56) a main feature of the population health approach, is again, accepted without question, effectively cutting off further critique.

Conclusion

As illustrated in this review of the literature on population health, the population health approach and its related policies, programmes and procedures have amassed a great deal of support from researchers, policy makers and activists. What this review makes apparent is the degree to which researchers in the field of health care have relied on, and continue to rely on the linking of risk behaviour to group membership in their attempts both to understand the social causes of poor health effects and to ameliorate health disparities. In some of the research reviewed here, namely Wilson and Rosenberg (2002), Dunn and Dyck (2000), and Newbold (1998), this reliance on the population health model was so entrenched that the researchers refused to dismiss the model even when their findings suggested that there was no link between group membership and poor health effects. Another aspect of the literature that was highlighted is the apparent acceptance of the population health model, and its related methodological tool, Gender-Based-Analysis, by feminist researchers in the field of health. With some notable exceptions, feminist researchers have demonstrated their acceptance of the population health approach through the plethora of health research that relies on an issue-group approach to understanding poor health effects and health disparities. This largely unquestioned reliance on the population health model and the subsequent issue-group linkages needs to be interrogated in ways that make visible the political nature of the process. It is to this task that I turn next.

Chapter 3

Theoretical Perspectives

In this chapter, I turn to some of theoretical understandings related to the analytic tasks of this thesis, which I see as being twofold: first, the task of deconstructing the population health approach as it has been developed and institutionalized in Canada; and second, of examining its implications for women with regard to their expectations of full citizenship in the polity. As illustrated in the literature review, in the field of health the tenets of the population health approach have been accepted, almost unquestioningly, by researchers who are concerned with increasing collective understandings of the social aspects of health disparities and removing their subsequent effects on health status. This acceptance of the population health model has taken place across academic disciplines and sectors, and has been employed, in very similar ways, by researchers, activists and policy-makers who may be seen to possess very different political agendas. Indeed, the only substantive difference that feminist researchers display in the field of health promotion has been with regard to methodology and their collective tendency not to rely on a meta-analysis derived from national statistics such as the National Population Health Survey. What is of particular interest is the overwhelming approval this approach has received from feminist researchers and activists, who have described the broad acceptance of the population health approach as an unprecedented success of the women's health movement - a causal relationship that has also been identified by government departments in their marketing of the approach (Bureau of Women's Health

and Gender Analysis, 1999). The plethora of feminist research that reflects an issue-group approach is indicative of the broad acceptance of the model's utility for incorporating gender into mainstream health discourse and in developing pragmatic strategies for removing health disparities. Understanding the implications of the widespread acceptance of the population health approach suggests two related projects, as noted above. To accomplish these tasks, I turn to two theoretical perspectives, namely poststructuralist feminist theory and social contract theory.

Poststructural Feminist Theory

The first task, that of deconstructing the population health approach, would suggest the benefits of applying a poststructural feminist theoretical perspective, because of its emphasis on a critical gaze at how categories and concepts become constructed and operationalized. As Rosenberg (2004) argues, "the categories and concepts that most usually organize our world are worth a careful look" (p. 36) and not just as categories and concepts but also in how they produce and confine critical engagements and subsequent possibilities for change. It can be argued that nowhere is this need for a 'careful look' more apparent than in the institutionalization of the population health model, both within feminist approaches to health and mainstream approaches to health policy development, and the subsequent operationalization of categories of vulnerability and risk. What is of concern here is not whether or not Canada's health care system is reflective of all of the needs identified by all of its constituents, but, rather, the power relations and processes

that have gone into the institutionalization of the social aspects of health and the operationalization of categories of identity and behaviour into policy and programme development. In other words, the key question within this first project, is not whether the health care system adequately reflects the needs of, say, lesbian women, but, rather the discursive mechanisms by which the categories of 'lesbian' and 'woman' are asserted and naturalized, rendering 'lesbian women' as analytically relevant categories of investigation and management. This is clearly different from approaches which question whether or not the categories accurately reflect needs, a question which is focused more on the programming requirements of health interventions than on the processes by which categories are constructed and naturalized. If, as argued in the literature review, the categories are constructed without the recognition of heterogeneity within categories, or homogeneity between categories, then it would be impossible for the categories to accurately reflect the identified needs of its constituents. That said, the question is really beside the point, as the focus of this thesis is to examine how these categories were constructed, by whom, for what purposes, and with what effect to members of the constructed categories. To conclude, then, an interrogation of discursive mechanisms is one of the primary strengths of feminist poststructuralist theory, and therefore, ideal for this first task.

Feminist poststructural theory, with its rejection of the structural tenets of 'rational man,' the unitary character of power, and objective consensus-building and decision-making, provides a framework that goes beyond questions of access to permit a

discussion of the micro-events that contribute to the production and re-production of relations of power. Unlike structuralist theories, feminist poststructural theories attempt to theorize “the relation between language, subjectivity, social organization and power” (Weedon, 1987, p. 12). Thus, by taking as their starting point that there is no fixed objective reality (as in ‘a healthy person,’ for instance), but instead a reality that is subjective, contradictory and negotiated through language (as in ‘at risk behaviours’), they permit a consideration of the ways in which certain articulations of reality or truth come to be accepted and enforced as The Truth. What is of particular relevance to this study is the process of open-ended interrogation and critique of “the practices of producing and representing knowledge that are more usually taken for granted and taught as ‘the right way’” (Rosenberg, 2004, p. 39). This process is key, since the tasks here are to question the parameters of the population health approach, and to complicate the apparent acceptance by many feminists of the compatibility of the approach with the dictates of social justice and the overall goal of improving the status of women. Moreover, it permits an investigation of the language of social justice as one of the central practices of reproducing these ills and creating new ones. In other words, while the Health Canada documents appear to be couched in the language of empowerment and equality, two of the basic tenets of social justice, it is not clear to what extent women may be actually empowered by these policies. As Rosenberg argues:

...the point is not to endeavour to answer such questions definitively, but to work with them as openings onto prevailing feminist explanations and political strategies, and to deliberate on how assumptions and concepts previously taken as foundational (meaning no longer open to inquiry) may be supporting not only

productive but also limiting analyses and possibilities for change (Rosenberg, 2004, p. 41).

This argument is echoed by Mueller, who exhorts us to remember that,

When the issues and political aims of the women's movement become knotted up with the ruling apparatus, it is no longer on the side of women in the Third World *or* the First World . . . this is not a condemnation of feminism as in itself imperialist, but a recognition of the power of ruling forces to appropriate our topics, our language, our action for imperialist purposes which can never be our own (Mueller, 1989, p. 6 as cited in Escobar, 1995, p.180).

A key analytic tool for raising the kinds of questions that Rosenberg and Mueller's ideas compel, and for de-centering the population health approach is the development of a genealogy, that is a "history of the present . . .that is structured by conclusions and considerations already established concerning present practices and institutions" (Henriques, Jackson, Urwin, Venn and Walkerdine, 1984, 101). In this case, the present is considered to be the accomplishment of incorporating population health approach and gender-based analysis into the ruling apparatus of health promotion, policy and programme creation. A genealogy allows for an examination of the mechanisms of discursive practices at the micro-level, and of the detailed calculations that go into the construction of discourses and practices. It permits an exploration of the development of the health care system without necessarily predicating a feminist critique on questions of access, and without relying on the dualisms of bio-medical intervention versus social aspects of health. What this permits, more particularly, is a focus on the health care system and population health approach as products of particular discursive enterprises, making more visible the specificity of their construction. Also essential to the first task

(deconstructing the population health approach) and related to the uses of a genealogy, is an examination of the ways in which categories of identity have been shaped in very specific ways, for very specific purposes and how these categories have been accepted by the feminist community. As Mueller suggests, these categories, and their subsequent acceptance need to be interrogated in order to understand how they may in fact represent an appropriation of feminist topics and language, in the absence of a feminist agenda, and, perhaps more importantly, how this appropriation has come to be enacted by feminist researchers and activists.

Another useful analytic tool provided by feminist poststructuralism is a blurring of the boundaries of binary oppositions. Fundamental to the task of deconstruction is to interrogate the definitions of health, and more particularly with regard to health promotion, the definitions of healthy choices. Since the concepts of risk and vulnerability are tied to the definitions of health, and more particularly to the binary oppositions of "good/poor health," "healthy/unhealthy choices," exploring how the boundaries have been established, accepted and operationalized is critical. As Fuss (1991) describes it:

The figure inside/outside cannot be easily or finally ever dispensed with; it can only be worked over and worked over - itself turned inside-out to expose its critical operations and interior machinery. To the extent that the denotation of any term is always dependent on what is exterior to it (heterosexuality, for example, typically defines itself in critical opposition to that which it is not: homosexuality) the inside/outside polarity is an indispensable model for helping us to understand the complicated workings of semiosis. Inside/outside functions as the very figure for signification and mechanisms of meaning production. It has everything to do with the structures of alienation, splitting, and identification which together produce a self and an other, a subject and an object, an

unconscious and a conscious, an interiority and an exteriority (pp. 1-2).

Essentially, feminist poststructuralism enables this examination of the healthy/unhealthy dichotomy and its connection to risk and vulnerability through the recognition that words have no fixed meanings, but are instead contextual and historical (Scott, 1994). Thus, for example, notions of health, and being healthy may be seen in this way as arising out of particular kinds of relations of power, language, and historical processes. Similarly, vulnerable populations, or at-risk behaviours may be looked at through the feminist poststructuralist lens.

Related to this is the formulation, within poststructuralism, of subjectivity, which holds some significance for how external definitions of vulnerability and risk come to be internalized, and how the behaviour modifications that are informed by these definitions are accepted. As Weedon (1987) states,

For poststructuralist theory the common factor in the analysis of social organization, social meanings, power and individual consciousness is *language*. Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity is *constructed*. The assumption that subjectivity is constructed implies that it is not innate, not genetically determined, but socially produced. Subjectivity is produced in a whole range of discursive practices - economic, social and political - the meanings of which are constant struggles over power. Language is not the expression of unique individuality; it constructs the individual's subjectivity in ways, which are socially specific. Moreover for poststructuralism, subjectivity is neither unified nor fixed. Unlike humanism, which implies a conscious, knowing, unified, rational subject, poststructuralism theorizes subjectivity as a site of disunity and conflict, central to the process of political change and to preserving the status quo (p.21)

This notion of subjectivity permits an examination of the inter-subjective processes by

which the population health model has been able to take hold. Additionally, it allows this examination without relying on notions of socialization, passive acceptance, or relegating Health Canada to a position of complete autonomy. Thus, this particular notion of subjectivity denotes a recognition that power is enacted through the relationship between Health Canada and the population as a whole, including those who are externally defined as vulnerable. This relationship is complicated, as well, by the collusion of feminist researchers and activists. This point becomes clear when we consider Lather's (1995) question: "How do our very efforts to liberate perpetuate the relations of dominance?" (p. 169). Ryan (2005), talking about critical educators, offers a partial answer by suggesting that too often these educators are caught up in the hegemonic "web of power structures that they purport to reject and challenge" (p. 2).

Taken as a whole, then, this first task, that is the deconstruction of the population health approach, is well served by feminist poststructuralist theory.

Social Contract Theory

As a theoretical framework guiding this thesis, however, feminist poststructuralism has its limitations, particularly in relation to understanding how broader social rights and duties are framed. As demonstrated in the literature review, there has been widespread use and acceptance of feminist research which gives emphasis to an issue-group way of conceptualizing a critique of women's health. By and large, this issue-group approach has been informed by the tenets of feminist poststructuralism, and a

focus on micro-events as well as subjectivity, agency, resistance and so on. By identifying and exposing biases, particularly as they relate to vulnerable populations, researchers working within the feminist poststructuralist paradigm may be overlooking opportunities for a broader discussion of the implications for women with regard to their expectations of full-membership in the polity, the second task I have identified here. Indeed, the presence of the issue-group approach, with its intense sub-categorization of vulnerable populations, is indicative of the need for a different framework, or perhaps an additional framework with which to engage broader questions of gender, health and citizenship.

The second task, as I have described it above, is to examine the implications of the population health approach for women with regard to their expectations of full citizenship in the polity. This task reflects my argument that the deconstruction of the population health approach is a necessary activity, but is insufficient in explaining how women's positioning within the health care system under the population health approach undermines their positions as full citizens within the polity. In taking up the second task, I am trying to avoid getting bogged down in a continuing process of interrogation that is limited to identifying the power relations that are involved. What is necessary, in my view, is to go beyond deconstruction to formulate some ways of thinking that permit a critical evaluation of the identified processes. To this end, I draw on some useful concepts from social contract theory.

Social contract theory dates back to the Enlightenment and is engaged with

questions regarding the origins of legitimacy within political institutions (Buckler, Hill, & McKay, 1995). The assumption is that individuals gather together to form social units aimed at some collective purpose, for example, protection of the group. The alternative is to remain individually independent, but without the protection of the other members of the group. Thus, in order to maintain individual security, individuals actively agree to enter the group and relinquish or modify their own independence, aspirations, autonomy and so forth, and to become subject to governance by the dominant authority, that is the will of the majority. The social contract is the articulation of this consent and outlines the rights and duties of all members of the political/social community. Within this articulation, legitimacy and executive power are accorded to governing bodies only inasmuch as necessary to achieve the aims of the original group, that is the protection of self and property and the right to an independent adjudicator (Locke, 1988). This notion begins with the basic premise that governments are only legitimate, or able to act legitimately, when (1) there is an appropriate balance between individual rights and collective responsibility; and (2) the limitations of rights are equally shared by all members of the political community (Rawls, 1999). Thus, the legitimacy of governing bodies within such a community resides in its ability to engage its participants actively in the moderation of their individual rights for the good of the group.

Since the central concern of my second task is not to judge whether health is a social product, but rather to understand how the adoption of social health as a political agenda relates in broader ways to the informal designation of the rights and duties of

citizenship, social contract theory provides a useful set of constructs. These constructs permit me to go beyond the question of how the population health approach has been constructed as both social and political, to consider the broader political implications for those labeled as vulnerable within it.

Because social contract theory speaks to the heart of questions about collective ‘goods,’⁹ as opposed to individual ‘goods,’ it provides some useful analytic tools which may be applied to my second task. Specifically, it permits questions concerning the links between being healthy individuals and the duty to be healthy citizens. Moreover, it allows us to look at health promotion as a political act, rather than confining it to a medical discourse. It is very hard, for instance, to argue against keeping people healthy. At the same time, it is necessary to look at the political ramifications of pursuing health as a collective ‘good,’ because of its direct links to the relinquishment or modification of individual rights and autonomy. However, as many feminist thinkers have already pointed out, social contract theory has its limits, particularly with regard to questions of gender (Pateman, 1988; Held, 1993; Phillips, 1991). While superficially gender-blind, social contract theory locates “economic man” or “rational man” as its primary actor. Exclusion of women is the inevitable result. This exclusion may be particularly evident within the Health Canada documentation, since all women are defined by Health Canada as a vulnerable or at-risk population, along with overlapping categories such as seniors, aboriginal people, disabled persons and youth, and so forth. The vulnerability label is

⁹ Collective goods may be defined as those aspects of the social contract that are collectively agreed upon as those that should be provided by the government.

perhaps enough on its own to disengage women from the political sphere as defined by the social contract, simply because the term vulnerability may be seen as denoting irrationality or an inability to make appropriate (healthy) decisions, or at least in a particularly dependent relationship to the state. While recognizing the value of these feminist critiques, I maintain that to dismiss social contract theory as a framework for questioning health as a collective good would be premature, since social contract theory allows us to consider the extent to which individual women are truly consenting to the modifications promoted by Health Canada, or whether there is some consideration of implied consent.

Although it would seem that social contract theory and feminist poststructural theory stand in opposition to one another, both offer an entry point into discussions of health promotion and gender. This is because the organization of governance under the social contract paradigm may be seen as a discursive framework, within which questions of the legitimacy of social policy are negotiated. Thus, while I have set the two tasks as separate projects, the first guided largely by feminist poststructuralist theory, the second by social contract theory, the concepts within both theories may be seen as complementary and therefore useful for the analysis as a whole.

Having outlined the benefit of drawing on both feminist poststructuralism and some aspects of social contract theory, I am left with an, as yet, unresolved theoretical dilemma. One of the foundational tenets of feminist thinking and action is that 'the personal is political,' a tenet which compels a blurring of the distinction between political

and private acts. Yet, in the theoretical formulation I have put forward here, I argue, first, that without maintaining this public/private split, we would be unable to discuss the established rules for engaging within either sphere or understanding the implications of a 'good' moving between spheres, and second, that we would be unable to evaluate the legitimacy of the behaviour modifications imposed by the population health strategy. While I believe that this theoretical split is necessary for my work, I recognize that I have drawn a somewhat arbitrary line between the personal and the political. While this issue deserves much more by way of feminist theorizing, it is beyond the scope of this thesis, other than to suggest that the findings from my research may help inform this thinking.

Chapter 4

Health Canada - A Genealogy and Document Analysis

Having discussed the lack of critical research into the development and operationalization of the population health approach and its political implications for the status of women, I will now provide a description of the study and the key findings. Generally speaking, this grounded theory study is concerned with two related projects: first, to deconstruct the population health approach as it has been developed and institutionalized in Canada; and second, to examine its implications for women with regard to their expectations of full-membership in the polity. As argued, one of the more notable features of the federal population health approach in Canada, has been its acceptance by the majority of feminist researchers and activists in the field of health as an appropriate model for understanding the relationship(s) between gender, race, class, sexuality, culture, and so on, and health status. Moreover, this perceived compatibility between the federal strategy and feminist health agendas has been referenced by policy-makers at all levels of government as one of the most beneficial aspects of the application of the population health approach. It is this expressed link that is one of the primary concerns of this thesis. In broad terms, this thesis is concerned with the questions that this link raises, namely, how has the population health model been developed, how has it been linked to feminist discourse and strategies for change, and to what degree is it compatible with the advancement of women? As noted earlier, this involves three main issues: how the definitions of vulnerability and risk have evolved over time; the extent to

which health promotion can be seen as a political act that affects women; and what sort of power relations valuations of lifestyles and behaviours create between citizens, and between citizens and the State, and particularly between women and the State (see Introduction for a fuller description). I conduct my examination of these issues through a two-part analysis: a genealogy of Health Canada and the population health approach; and a document analysis of the key public documents produced by Health Canada.

In this chapter, I present the findings of this research, along with a description of the methods of analysis. I begin with a historical account of the development of Health Canada, beginning with its inception in 1919 at the close of World War I. In this account I provide as much detail as possible with regard to the conceptual development of various population health strategies and the tensions involved in the development of a national health care system. As will be shown, these tensions centre primarily around political and economic tensions between the federal and provincial governments. What becomes evident throughout this descriptive analysis is an historical context in which the health of the population has been inexorably linked with ideas surrounding good citizenship in relation to both national security and prosperity. It is clear that social issues or concerns, while receiving much rhetorical attention have been secondary in the establishment of national health care systems and preventative health strategies.

Following the historical account, I present a detailed description and analysis of the documents pertinent to the current population health strategies. What this analysis brings into focus is the continuing conceptual attachment of good health and good

citizenship as defined by the nation's need for international economic competitiveness. Also evident in these documents is the current expropriation of social justice and feminist language and discourse to promote the acceptance of population health strategies while effectively preventing debate on the principles underlying our current health care system. More specifically, this analysis will indicate how women have been cast into the dual role of client or dependent population and provider of good health to others.

Genealogy of Health Canada and the Population Health Approach: 1919- Present

As one of the key tasks of this thesis is to deconstruct the population health approach as it has been developed and institutionalized in Canada, this study begins with a construction of a genealogy of Health Canada. It is imperative here to complicate the accepted history of the population health approach as being a 'natural evolution' of the Canadian health care system. Following Henriques, et al. (1984), precepts for a genealogy are that it be a "history of the present precisely to the extent that it is structured by conclusions and considerations already established concerning present practices and institutions" (p. 101), this genealogy is informed by the assumptions that: (1) Health Canada, and its subsequent strategies including the population health approach, were actively constructed in very specific ways for very specific purposes; and (2) that the construction of Health Canada was informed by and delineated through the participation of broader social, political and economic practices and concerns. Following these assumptions, this genealogy presents a history of the construction of Health Canada

beginning with the establishment of the first federal department of health in 1919 and presents its future development in relation to broader national and international contexts. To this aim, the genealogy presents a contextual history of Health Canada that is developed through the integration of federal-provincial health related financial transfers, federal governing parties, federal-provincial jurisdictional changes and conflicts, related national health care legislation and other events, for example, the Second World War, Trudeau's invocation of the War Measures Act, and so forth.

Methodologically, this involved creating a chronology of the major events that occurred throughout the development of a national health care system in Canada. These events were tagged by date, document title, governing party, department structure, funding and other events. The following sources were used in the compilation of the chronology. The full chronology is included in Appendix A.

Department of Finance (2007) *Federal transfers to the provinces and territories: a brief history of the health and social transfers*. Retrieved May 2, 2007 from www.fin.gc.ca/FEDPROV/hise.html.

Government of Canada (2007) *1957 - Advent of medicare in Canada*. Retrieved June 5, 2007 from www.canadianeconomy.gc.ca/english/economy/1957medicare.html.

Health Canada (2006) *Timeline - Canada's health care system*. Retrieved June 5, 2007 from www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2005-hcs-sss/time-chron_e.html.

Health Canada (2007b) *Canada's health infostructure: history*. Retrieved May 2, 2007 from www.hc-sc.gc.ca/hcs-sss/ehealth-esante/infostructure/hist/index_e.html

Parliament of Canada (2006) *History of departments: 1967 to date*. Retrieved May 2, 2007 from www2.parl.gc.ca.

I would like, at this time, to remind the reader that this history is directed by the

assumptions outlined above, and, as such represents but one of a number of possible histories of the development of Health Canada and its related projects.

While the right of universal access to timely, first class medical services has become embedded within the national character of Canada, the process of establishing health care as a federal responsibility has not been without conflict. As will be illustrated in this genealogy, the establishment of federal guidelines for the provision of health services and the formulas for funding these services has been an evolving process that has required the renegotiation of federal and provincial jurisdictions. In addition, this process has evolved in a specific manner and has been constructed in such a way as to address very specific concerns that are only tangentially related to health and welfare.

Under the British North American Act (BNA Act) of 1867, health care was defined as being predominantly within the jurisdiction of the provinces who were given the responsibility of establishing, regulating and/or maintaining hospitals, asylums, charities and charitable foundations (BNA Act, 1867, 92 (7)). Within the field of health care the federal government was only responsible for aboriginal health services, marine and veterans' hospitals and quarantine regulations (BNA Act, 1867, 91(7, 11, 24)). The federal government was also allocated the majority of the taxation rights as outlined in the Act, thereby providing it with an increased ability to raise taxation revenue in relation to that of the provinces (BNA Act, 1867, 91(3)). The increasing cost of providing health care services, the fiscal imbalance between the national and provincial governments, and the subsequent demands of the provinces for the federal government to shoulder more of

the costs of providing health care, have resulted in a blurring of jurisdictions within the field of health care which has allowed the federal government to take an increasingly active role in establishing national health care policies (Chenier, 2002).

Although health care is now a major source of contention between the federal, provincial and territorial governments, it only emerged as an area of public concern in the early 20th century. Prior to 1919, federal health responsibilities were managed by the Federal Department of Agriculture and were seen as an area of minor concern (Health Canada, 2006). In 1919, the federal government established the first federal Department of Health (Health Canada, 2006). The new department was mandated “to direct national legislation, collect and disseminate information, educate the public, stimulate baby hygiene, establish nursing systems, look after immigrant inspection and equip health research laboratories” (Bryce, 1919, 650).

This redefinition of health care as an area of national concern was inspired greatly by the events of the First World War. In his address to the Canadian Medical Association in June 1919, Dr. Peter Bryce, the Chief Medical Officer of the Canada Immigration Service explicitly linked the national health with national defense, and stated “Today there can be no doubt but that the direct effect upon what we call the manpower of the country is the motive influencing action with a view to the saving the lives of the citizens who are the source of power whether for national defense or economic progress” (p. 650). He goes on to state the concerns surrounding the development of national health objectives should “take their place amongst the modern questions

affecting national prosperity equally with conscription, submarines, aeroplanes and dreadnaughts, since upon the health and hygiene of the army depends the effective use of all other destructive agencies” (p. 650). The connection between health and national defense and prosperity is further emphasized in his treatment of mothering and child welfare, as he cites the need for mothering supports and improved child welfare services to improve the health status of the “potential soldier” and “producer of wealth” (p. 652). Bryce goes on to highlight the need for federal action as a result of a ‘moral deficit’ arising out of an increasingly complex society stating:

It [the federal department of health] can cooperate in measures intended to deal with health conditions growing out of our complex life tending to disseminate diseases of a peculiarly social character. Indeed, experience shows that such measures must be yet more refined and comprehensive demanding the education of a too often unwilling public involving as they do ethical principles adopted only gradually (p. 651).

As documented by Health Canada (2006), the 1920s and 1930s also saw a similar focus at the provincial level on developing and expanding health care services. During this period, Manitoba, Saskatchewan and Alberta established municipal hospital plans. In 1921, British Columbia established a Royal Commission on Health Insurance. In 1936 British Columbia and Alberta both passed health insurance legislation although neither province established an operating programme to oversee the provision of primary health services. These initiatives were solely provincial undertakings and bore little relation to either the objectives outlined by the new federal Department of Health or those of the other provinces. Moreover, as a result of the limited ability of the provincial governments to raise tax revenue, these initiatives were limited to offsetting some of the

individual costs of accessing medical services. In 1937, the Rowell-Sirois Commission was established to re-evaluate the economic basis of Confederation and to begin to address the imbalances between provincial legislative powers and the ability of the provinces to generate the revenue needed to finance these increased services (Savoie, 2003).

With the outbreak of the Second World War, the federal government took a renewed interest in national health and health care and began to take a more active role in shaping Canada's health services. In 1940, the Federal Dominion Council on Health was created, which was followed in 1942 with the creation of the Federal Interdepartmental Advisory Committee on Health Insurance. These initiatives were designed to identify areas in which federal involvement would be possible and to define the parameters of future national health policies (Health Canada, 2006).

The post-WWII period witnessed an ever-increasing focus by both provincial and federal government on providing publicly funded health services. Instead of simply offsetting the individual costs of accessing health services, both levels of government began to develop public health programmes. On January 1, 1947, Saskatchewan, under Premier Tommy Douglas initiated a province-wide public hospital insurance plan (Government of Canada, 2007). In 1948, the federal government established the National Health Grants Programme. This programme was designed to provide grants to the provinces and territories to support health-related initiatives, including hospital construction, public health, professional training, provincial surveys, and public health

research. This new funding structure allowed both British Columbia (1949) and Alberta (1950) to establish limited hospital insurance plans. Newfoundland, joining Confederation in 1949, brought with it a cottage hospital insurance plan (Health Canada, 2006).

While the National Health Grants Program allowed a number of provinces to provide more accessible health care services, these services were still almost solely within the jurisdiction of the provinces, and were still very limited in the types of services covered within their insurance plans. Moreover, these services varied greatly between provinces and regions (Renolds, 1982). In response, the federal government under Prime Minister John G. Diefenbaker passed the Hospital Insurance and Diagnostic Services Act in 1957, which established 50/50 cost sharing for provincial and territorial hospital insurance plans (Government of Canada, 2007). This act was intended to provide free acute care and laboratory and radiological diagnostic services to Canadians. The next four years saw each of the provinces either establish hospital insurance plans or bring their own plans within this federal cost-sharing programme, with Quebec the last province to join in 1961. The provinces of Saskatchewan (1962) and British Columbia (1965) expanded their public health services with the creation of medical insurance plans for physicians' services (Health Canada, 2006).

Although this federal cost sharing programme allowed the provinces to begin to establish broader health policies and develop the infrastructure needed to provide public health care, these programmes remained very limited in their scope and were largely

inconsistent between provinces and regions. In 1961, the federal government established a Royal Commission on Health Services to study the need for health insurance and health services and appointed Mister Justice Emmet M. Hall as Chair of this Commission (Government of Canada, 2007). The Commission was mandated to “inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative power in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians” (Order in Council on June 20, 1961, under Part I of the Inquiries Act, as cited by Health Canada, 2005). This Commission presented its report in 1964 with its chief recommendation being the development of a national health policy and a comprehensive universal health care programme for three main areas: health services, health personnel, facilities and research and financing priorities (Health Canada, 2005).

The development of national health policies and services, involving an almost complete revision of the details of Confederation, was implemented slowly over the next twenty years (Government of Canada, 2007). In 1966, the federal government, under Prime Minister Lester B. Pearson, passed the Medical Care Act - a 50/50 cost-sharing programme for physician services (Health Canada, 2006). In the same year, Pearson’s government also introduced the Canada Assistance Plan - a cost-sharing arrangement for social assistance programmes (Department of Finance, 2007). Unlike previous programmes, the Canada Assistance Plan programme attached specific conditions to the

money and required the provinces to meet certain standards in order to continue to receive federal funding under this arrangement. Combined with the 1957 Hospital Insurance and Diagnostic Act, these acts would establish a consistent formula for determining federal transfers to the provinces based upon the individual provinces' health expenditures (Department of Finance, 2007). As health care was an explicitly provincial jurisdiction, the federal government was forced to negotiate with each province individually, a process which took six years to complete (Health Canada, 2006). It is interesting to note that, during this period of negotiation, federal-provincial relations were increasingly strained with tensions between Quebec and the federal government being particularly acute. In 1970, Trudeau invoked the War Measures Act in response to the increasingly violent dissent present in Quebec in regard to Trudeau's process of expanding federal jurisdictions in Canadian politics. By 1972, however, each province had developed its own system of jointly funded public health care which included free access to physician services (Health Canada, 2006). Also noteworthy, at this time, was the establishment of the National Action Committee on the Status of Women (NAC) in 1971, which eventually grew to encompass over 700 women's organizations over the following two decades. Thus, while provinces, such as Quebec, were lobbying for increased autonomy, the women's movement was consolidating its national character and the national identification of women's issues. As will be shown through the document analysis, it is during this period that gender becomes incorporated into the national population health strategy.

During the following years, with the increased scope of the public health care system, operating costs began to rise dramatically. In particular, provincial health expenditures became increasingly unmanageable expenditures for the provinces to maintain. While the cost sharing arrangements ensured that both the federal and provincial governments carried an equal cost of the new health care services, the increased ability of the federal government to generate tax revenue translated into the provinces carrying a much higher relative cost in the provision of health services (Chenier, 2002). As a result, the federal transfer payments to the provinces became crucial to the provinces which, in turn, resulted in yearly negotiations regarding the federal-provincial funding relations (Department of Finance, 2007a).

In 1977, in response to this ongoing problem, the federal government established the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (Government of Canada, 2007; Health Canada, 2006). This Act replaced the formulas outlined in the 1957 Hospital Insurance and Diagnostic Services Act and the Medical Care Act of 1966, and, instead, set up the Established Programs Financing - block transfers of cash and tax points to the provinces intended to finance not only health care services but also post-secondary education. Under the Established Programs Financing provinces received 13.5 percentage points of personal income tax and one percentage point of corporate income tax and included some previous financing points carried over from the previous post-secondary education programme. The value of the transferred tax points was equalized and its value was to be escalated by the growth rate of the per capita

gross national product (Department of Finance, 2007). In 1982, the Established Programs Financing transfers would be decreased through the application of the gross national product per capita escalator to the total Established Programs Financing, rather than the Established Programs Financing cash (Department of Finance, 2007). In 1983, the Established Programs Financing transfers were further decreased with the limitation of the post-secondary education portion to six percent and five percent growth for 1983-84 and 1984-85 under the "6 & 5" anti-inflation programme (Department of Finance, 2007). Despite the decreases in Established Programs Financing transfers, however, this Act continued to ensure that the Federal government financed the bulk of health care costs.

While the Established Programs Financing transfers ensured that the costs of providing health care services were not prohibitive to the provinces, the bulk transfers removed the ability of the federal government to establish national standards for the provision of health services (Government of Canada, 2007). As a result, the provinces were once again able to institute extra-billing and user fees in their local services - practices that had been curtailed under the Canada Assistance Plan formula. In response, Justice Emmett Hall was asked to institute a review of the current health care system and to report on the future of health care in Canada (Government of Canada, 2007). In 1979, Hall drafted 'Canada's National-Provincial Health Program for the 1980s' in which he argued that accessibility to health care services was being compromised by the provinces' practice of instituting additional user-born costs for health services. Unless

these additional fees could be curtailed, Hall argued that the ideal of having a nationally accessible health care system would never be realized (Chenier, 2002).

In 1984, the Trudeau government introduced the *Canada Health Act* (Health Canada, 2006). This Act was in fact an amalgamation of the 1957 Hospital Insurance and Diagnostic Act and the Medical Care Act of 1966. The *Canada Health Act* defined five national principles for the provision of health care services (universality, accessibility, portability, comprehensiveness, and public administration) and attached conditions to the Established Programs Financing transfers (Chenier, 2002). In addition, this Act established provisions for withholding federal funding from provinces whose health care services continued to be inconsistent with nationally defined health policies and principles. In actuality, the 1984 Canada Health Act established a truly national health care system and represented a complete shift in federal-provincial jurisdictions in regard to the provision of health services (Chenier, 2002).

Having established a national health system, the federal government was no longer compelled to purchase provincial complicity. As a result, the late 1980s and early 1990s witnessed a steady decrease in national health transfers. In 1986, the Mulroney government reduced the Established Programs Financing growth rate from the gross national product formula to gross national product minus 2% indefinitely (Department of Finance, 2007). In the following years, the growth of both the Established Programs Financing and the Canada Assistance Plan transfers would be further decreased. The 1989 budget reduced the Established Programs Financing growth rate to gross

national product minus 3% and limited the Canada Assistance Plan growth rate to 5% for the non-equalization provinces of Ontario, Alberta and British Columbia (Department of Finance, 2007). In 1991, the Mulroney government extended the Established Programs Financing freeze and Canada Assistance Plan growth limit for an additional three years (Department of Finance, 2007). This freeze would eventually be reiterated by Chretien's government in 1993 and would extend until 1996 when the Established Programs Financing and Canada Assistance Plan transfers were replaced by a Canadian Health and Social Transfer block funding (Department of Finance, 2007). Although the transfer formula had changed, the policy of reducing federal health care transfers continued. In 1996-97, the Canadian Health and Social Transfer was set at \$26.9 billion and was reduced to \$25.1 billion for 1997-98 (Department of Finance, 2007).

This trend of reducing federal health care transfers came to an end in the mid-1990s when it became obvious that the current level of health care could not be maintained with the reduction of funding. In 1998-99 the federal government announced a five-year Canadian Health and Social Transfer funding arrangement that would provide a cash floor of \$11 billion per year and would allow for the gradual increase of Canadian Health and Social Transfer growth rates in years three through five of the arrangement (Health Canada, 2006; Department of Finance, 2007). In addition a new allocation formula was established that would allow the Canadian Health and Social Transfer transfers to better reflect the changes in provincial population growth and narrow existing funding disparities with the goal of moving halfway to equal per capita transfers by

2002-03 (Department of Finance, 2007).

In conjunction with the cutbacks to federal transfer payments, the 1990s were also characterized by a consolidation of federal control of health policies through the establishment of national health policies and infrastructure. On November 4, 1993, the Department of National Health and Welfare was collapsed and was replaced by Health Canada (Parliament of Canada, 2006). The new department was mandated to “improv[e] the lives of all of Canada 's people and to mak[e] this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system” (Health Canada, 2005a, p.1). As part of this mandate, Health Canada was to identify national health priorities and to coordinate national responses to the identified issues (Health Canada, 2005a). The implementation of this new mandate and national presence is evidenced by the massive numbers of far-reaching initiatives. By way of example, the following represents only a partial list of Health Canada's involvement.

- Information Highway Advisory Council (IHAC) 1994-97
- National Forum on Health (NFOH) 1994-97
- Centres of Excellence for Women's Health est. 1996
- Health Transition Fund (HTF) est. 1997
- Office of Health and the Information Highway (OHIH) est. 1997
- Advisory Council on Health Infostructure (1997-99)
- National Children's Agenda (NCA) est. 1999

- Social Union Framework est. 1999
- Canadian Population Health Initiative est. 1999
- Canadian Consortium for Health Promotion Research est. 1999
- Canada Health Infostructure Partnership Program est. 2000-02
- Canadian Institute for Health Research (CIHR) est. 2000
- The National Aboriginal Health Organization (NAHO) est. 2000
- Canada Health Infoway est. 2001
- Public Health Agency of Canada, est. 2004
- Early Learning and Child Care Initiative (ELCC) est. 2005
- Universal Child Care Benefit (UCCB) est. 2006

What this genealogy, overall, and the above list perhaps in particular, clearly indicate is that the establishment of a separate department to conduct national health projects represented a significant departure from the previous styles of federal involvement in health care. To elaborate, until Health Canada was established, federal involvement in health consisted primarily of the development of broad national legislation and the division of fiscal responsibilities. Health Canada, on the other hand, represented a new federal active and visible **presence** in the development of health care policies at the provincial and local levels. This departure had a two-fold effect: first, it represented the consolidation of federal financial control of health expenditures; and second, it marked a new era of federal control, namely over provincial and local agendas and initiatives. This left the provinces with little influence over local health issues,

implying that regional concerns, such as proximity to toxic environments, may be subsumed under a national agenda. By my interpretation, it may even be fair to say that Dr. Bryce's vision of a national health care system that he articulated in 1919 has been realized.

Population Health Strategy - Document Analysis

The current governmental focus on limiting high-risk behaviours falls within this broader historical context of health promotion and population health strategies. The documents reviewed in this section indicate that current approaches to health promotion and population health essentially continue the link between health and national prosperity that Dr. Bryce highlighted almost a century ago. Today, population health features prominently at provincial, national and even international levels of government and, in many cases, has become the standard for measuring the effectiveness of health care systems (World Health Organization, 2004). What has changed significantly is not the underlying principles, but rather the expropriation of feminist and social justice language and discourse. This expropriation has the effect of continuing the attachment between good health and citizenship, through a new focus on risk-behaviours and vulnerable populations. Utilizing this language, health promotion strategies have been extremely successful in curtailing individual choice, particularly among young women and other identified target groups and limiting a broader debate with regard to the underlying mandate of Health Canada. All of this becomes evident on close scrutiny of Health

Canada documents.

Because I was interested in understanding power relations against the backdrop of Health Canada's discussion of vulnerability and risk, I began with a content analysis of the key public documents produced by Health Canada. My decision to use these documents was based on my assumption that, by and large, they represent a key strategy for insuring public attention to officially identified public health issues and vulnerable populations, and encouraging public compliance with health policy. In particular, they provide a public display of Health Canada's population health approach, in turn giving shape to public opinion and facilitating the development of arms-length community-based interventions and coalitions. The method of document analysis, which I outline below, was informed by LeCompte and Preissle (1993), Cohen, Manion and Morrison (2000) and Flick (1998), all of whom emphasize the importance of selecting and organizing appropriate documents before conducting the analysis.

(i) Identifying pertinent documents. The concept of population health was first attended to by Health Canada in 1974 with the release of *A New Perspective of the Health of Canadians* (Lalonde, 1974). Thus, in order to get a sense of the evolution of population health definitions, concepts, strategies, and so forth, I begin my analysis there. Specifically, I analysed the text for definitions of health, vulnerability and risk, vulnerable populations and valuations of lifestyles and behaviours. This analysis then provided a baseline for mapping the development of the population health approach.

Following this step, I identified other pertinent documents (from the some 30

years of publications by Health Canada since that time) by a two-phase screening process. For the initial screening, I selected documents that met the following criteria:

- published and owned by the federal department of health (documents funded by the federal department of health, but which contain a disclaimer will be eliminated)¹⁰
- accessible to the public
- deal with population health, as conceptualized by Health Canada¹¹
- outline specific population health strategies or directions

I selected the above criteria for a number of reasons. First, by excluding documents that contained a disclaimer, I was able to focus on documents that reflected only the views of Health Canada. Second, considering that the tasks I have laid out concern issues surrounding public acceptance of the population health approach, it was clear that only documents available to, accessible by, and marketed toward the public would be relevant. That is to say that documents internal to the department or within subsidiary agencies would be outside the purview of this thesis. Third, because the focus of my analysis is on the population health approach, as conceptualized by Health Canada, I selected only those documents that dealt with the population health approach and specific strategies or directions.

Following this initial screening, I refined my search by identifying documents

¹⁰ Such a disclaimer normally reads “The views expressed are not necessarily the views of Health Canada or the Government of Canada.”

¹¹ These conceptions changed over time, as the analysis of the documents shows.

which illustrate a clear conceptual change in the focus or direction of health policy in Canada. I undertook this screening because, as I outlined in Chapter 1, the concern of this thesis is the overall process by which the population health approach was developed, institutionalized and operationalized over time. My concern for process, rather than product, that is, individual programmes, projects or policies, meant excluding documents which described or advocated for these particular products. Using this framework, I identified five key documents that would provide the focus for an analysis of the development of the population health approach. These documents are as follows:

- *A New Perspective on the Health of Canadians (1974)* This document was intended to foster understanding of the social causes of poor health effects.
- *Achieving Health For All: A Framework for Health Promotion (1986)* This document was intended to identify key challenges to improving the health of Canadians.
- *Strategies for Health Promotion: Investing in the Health of Canadians (1994)*
The intention of this document was to summarize the past understandings on the determinants of health, to present a framework that could guide future policy, and to propose strategies for intersectoral collaboration.
- *Toward a Common Understanding of Health Promotion: Clarifying the Core Concepts of Population Health (1996)* This paper focussed primarily on addressing the challenges associated with developing cost-effective national programmes that would provide measurable improvements in the health status of

Canadians.

- *Taking Action on Population Health (1998)* This document was intended to provide a technical framework for incorporating the population health approach into all aspects of Health Canada's involvement in health care.

Following the identification of the above documents, I moved next to the preliminary analysis, the second step I describe below.

(ii) Undertake a preliminary analysis. The initial stage of the analysis involved the categorization of each document according to date of publication, intended audience, the circumstances under which it was produced, and its purpose and broad message. For example, the Lalonde document, cited above, was tagged by date (1974), intended audience (health policy-makers), the circumstances under which it was produced (soaring health care costs), purpose (to decrease rates of preventable illnesses and morbidity) and broad message (an expansion of medical model is required). Once the documents were tagged in this way, I began the evaluation and interpretation.

(iii) Evaluate, interpret and discuss each document in detail. This step involved integrating the preliminary analysis of the documents with the genealogy in order to contextualize more completely the discursive aspects of the material. For example, I considered to what extent the documents reflected 'lived experience' or operated to mediate and shape experience. In practical terms, this meant focussing on understanding the evolution of concepts, definitions and categories as they relate to valuations of lifestyles and behaviours. As an example, in considering Health Canada's

variable and changing conceptions of vulnerability, I focussed particular attention to how certain concepts of vulnerability or risk-taking are gendered and were linked with certain groups, for example, women, Aboriginal peoples, immigrants, and so forth. My analysis begins with the first document noted, namely *A New Perspective on the Health of Canadians* (1974).

A New Perspective on the Health of Canadians, 1974

As shown, health promotion and population health strategies began to take prominence in the 1970s in conjunction with the establishment of a strong federal presence in health care delivery. These strategies denote a focus on the range of, and interactions between factors that influence health status within the population. Prior to the mid-1970's, health status was seen as a function of access to advanced medical treatments. Subsequently, the majority of health care spending in Canada was directed toward physicians, hospital care, laboratory tests and prescription drugs. In 1974, this spending averaged almost \$7 billion ¹² on a system which was designed almost exclusively to treat existing illness (Lalonde, 1974, pp.8-12).

In the mid-1970's, however, health care policy began to shift with the development of a more inclusive understanding of the factors that influence health. In 1974 the Federal Department of Health and Welfare released a working document

¹² This figure includes money spent on direct 'physician-centred' expenditures, dental care, and the services of health care professionals such as optometrists and chiropractors.

authored by Lalonde, entitled *A New Perspective on the Health of Canadians*. The intention of the department was to promote an understanding of the links between different behaviours and/or situations and their underlying causes so as to be able to make informed judgements regarding potential health risks. Central to the development of this paper was the belief in the need for a framework to guide decisions regarding the future of health policy in Canada. To quote Lalonde, "These judgements must be made by individuals in respect of their own living habits, by society in respect of the values it holds, and by governments in respect of both the funds they allocate to the preservation of health and the restrictions they impose on the population for whose well-being they are responsible" (p. 9).

Using a 'health field' approach, this document identified four broad elements that influence the health of a population: human biology; environment; lifestyle; and health care organization (pp. 11-18, 31-34). Using this approach, an individual's and, indeed, a population's health status can be seen as a product of the intersection of these four elements. The 'health field' concept was not unique to this document, however, the idea of the centrality of individual responsibility for limiting negative behaviours represents a clear break from previous approaches to health policy in Canada (p. 18). Indeed, this document goes so far as to link a number of 'self-imposed' risks to certain causes of morbidity. Included in this list are:

- "drugs (alcohol addiction, social excess of alcohol, cigarette smoking, abuse of pharmaceuticals, addiction to psychotropic drugs and social use of psychotropic

drugs);

- diet and exercise (over-eating, high-fat intake, high carbohydrate intake, fad diets, lack of exercise, malnutrition and lack of social or recreational relief from work and other pressures); and
- other (careless driving, lack of seatbelt use and sexual promiscuity and carelessness)” (pp.16-17).

In addition to identifying self-imposed risks, this document also highlights the role of social and physical environmental factors in determining health status. Factors such as income, rurality, air quality, housing, social change and working conditions are all identified as contributing factors in determining population health (pp. 17-18). These factors are then used to help identify specific ‘at-risk’ or vulnerable populations to be targeted by social policy and legislation.

The relationship(s) between environment, biology, lifestyle, health care organization and health status is now almost accepted as ‘common sense’. It is important to recognize, however, that this inclusive approach to health care had the effect of expanding the jurisdiction of the Department of National Health and Welfare (now known as Health Canada). It also provided the federal government with added legitimacy in creating legislation directed at what were previously considered ‘personal’ choices, for example, seat belt use.

A New Perspective on the Health of Canadians frames health as a political ‘good.’ By underlining the need for Canadians collectively to decide what kind of health

services they require, how much they are willing to spend and what balances should be struck, the Department of Health and Welfare appears to be initiating a national debate on the shape of health care. At the same time, the intention of the department to ensure its right to regulate individuals' behaviours is clear:

The ultimate philosophical issue raised by [the health field] concept is whether, and to what extent government can get into the business of modifying human behaviour, even if it does so to improve health (p. 36).

What is also evident is the intention to market its influence over individual behaviours.

If the siren song of coloured television, for example, is creating an indolent and passive use of leisure time, has the government not the duty to counteract its effect by marketing programs aimed at promoting physical recreation? . . . One must evidently conclude that society, through government, owes it to itself to develop protective marketing techniques to counteract those abuses (pp. 36-37).

Finally, the department ensures that any debate regarding its involvement in the shaping of health care policies is silenced. Instead of reiterating the department's expressed commitment to facilitating national debate, the document concludes with the identification of two broad objectives for the federal government in relation to establishing a national agenda for health care and health promotion. These objectives of reducing mental and physical health hazards for those parts of the Canadian population whose risks are high and improving the accessibility of good mental and physical health care for those whose present access is unsatisfactory, are further subdivided into five strategies for federal action. The strategies aimed at health promotion, regulation, research, health care efficiency, and goal-setting are clear, concrete and non-negotiable projects (p. 66). Thus, while maintaining the guise of fostering national debate, the

federal government is, in actuality, stating its intention to take an active and aggressive role in regulating health, health promotion and behavioural choices at all levels of Canadian society.

Also interesting is the tone of this document - a tone which is characteristic of population health documents in general. The tone is one of impending crisis. The document begins with the statement that the then current health care system has succeeded in eradicating infectious diseases from being the leading cause of mortality of Canadians. However, instead of applauding this achievement, it adopts a crisis tone in relation to the emergence of chronic illness and accidents as the new leading causes of morbidity and mortality, citing the increased costs (both human and financial) of treating long-term illness. What the document fails to mention is the relationship between the reduction in mortality rates due to the eradication of infectious diseases and the increase in mortality rates due to chronic illness, that is, having failed to die of an infectious disease, individuals are now living long enough to develop a chronic illness that will result in their death. Likewise, rates of mortality due to accidents experienced no significant change, with relative movement up the scale of causes of morbidity and mortality being a result of the downward movement of infectious diseases. This tone of impending crisis operates as a deflecting agent, masking past achievements of the health care system and providing a vehicle for the promotion of increasingly invasive policies and legislation. Perhaps the crisis tone also manifests a cultural preoccupation with death and dying. Such preoccupations are part of a cultural ethos in which technology and

science are seen to be able to eventually control everything.

Achieving Health for All: A Framework for Health Promotion, 1986

Having expanded the national approach to conceptualizing the factors that influence health, the federal government began to recognize the need to develop a correspondingly broad analysis regarding possible solutions to address current health concerns. In 1986 Health Canada released a position paper entitled *Achieving Health for All: A Framework for Health Promotion*. This paper identified three key challenges to improving the health of Canadians: reducing health disparities between low and high income groups; increasing the prevention effort; and enhancing an individual's capacity to cope with illness (Health Canada, 1986, pp. 2-4).

Unlike previous analyses that focussed on the availability and accessibility of advanced treatments, these challenges reflected social, behavioural and economic concerns. In response to these challenges, Health Canada argued that in order to ensure continued improvements in the health of Canadians, health promotion strategies would have to feature prominently in all future health planning (pp. 5-6). While health promotion strategies had been present prior to the release of this document, these programmes had been developed on an ad hoc basis. What is new in this document is the call to develop health promotion strategies in a more systematic fashion and to draw in all levels of government and all related departments and organizations under the management of the Department of Health and Welfare (p. 7).

To this end, *Achieving Health for All* proposed three strategies that would guide the development of future health policy. The first strategy was to foster public participation. As such, Health Canada would need to take a primary role in helping to equip individuals with the necessary information and skills to assert control over the factors that influence their health. In addition, the policy process would have to be expanded to encourage public participation in the development and implementation of health promotion strategies (pp. 7-8). The second strategy that was proposed was to strengthen community health services. According to this strategy, the health care system should be adjusted so that the role of community health services is expanded and the resources made available to promote health at the community level (pp. 8-9). The final strategy was to coordinate healthy public policy. As argued by Health Canada, many of the challenges facing Canadian health care are outside of the traditional health field. In order to meet these challenges, various departments and levels of government would need to collaborate in developing public policy (pp. 9-11).

The approach to understanding health problems (and solutions) advocated is much more far-reaching than the medical treatment models that had previously underpinned the Canadian health care system. As a result, according to these 'new' understandings, it was clear that any improvements in the health status of Canadians would require the concerted and coordinated efforts of federal, provincial and territorial governments. At the same time, it is clear that this document is at once a continuation of the political project outlined in *A New Perspective on the Health of Canadians*, and

consistent with the department's agenda of establishing a strong federal presence in the provision of health services. Moreover, it solidifies federal control of individuals' health and lifestyle modification by deflecting attention from the political nature of health care delivery and redefining health issues as technical, managerial achievable concerns, again silencing any potential debate. This document thus marks the end of even a rhetorical exercise in national debate. As evidence, the document contains a wide selection of truisms, such as the following:

Health promotion means ensuring that Canadians are able to act in ways that improve their own health. In the national quest for health, people constitute a major resource, both individually and in groups. Our experience confirms that people understand and are interested in the circumstances and events that influence their health. *We know that [Canadians] are seeking opportunities to take responsibility* [italics added] (p. 8).

Also notable within this quote, is the focus on individual responsibility for health. It is clear, that the intention here is to lay the foundation for linking health and duty through establishing the responsibility of 'good' citizens to maintain 'good' health through making 'healthy choices.' As well, the expansion of federal jurisdiction is once again legitimized by the tone of the document. Like the previous document, a crisis tone is adopted to advocate for a blurring of legal and constitutional boundaries, and to include processes and interventions which would not be countenanced by the population if they were not couched within the 'health crisis' discourse. For example, within the document is a clear statement about the need to blur legal and constitutional boundaries, namely "The concept of boundaries is inappropriate when we speak of the promotion of health" (p.7). Also clear is the stated intention of establishing an active federal presence in

health policy, as evidenced by the following statement:

Yet, to the extent that there are in place policies and practices which support the concept of health promotion, these tend to be implicit rather than explicit. In most instances, they are not the result of deliberate strategic planning. In our view, it is time to clearly articulate a direction which is designed to promote the health of Canadians (p. 7).

Related to the tone of the document is the repeated use of the term 'choice' which is employed in very specific ways. Rather than using 'choice' to imply free will, the document moves the term out of its usual 'liberating' context and uses it to assume a consensus about 'healthy choices,' and to presume that individuals 'must' make healthy choices and avoid engaging in risk behaviours, all the while assuming that healthy, responsible choices are consistent with those outlined by the health promotion strategy. Within this discourse, one cannot rationally choose to smoke, have promiscuous sexual encounters, or use recreational drugs, for instance, regardless of the contexts and rationale underlying those behavioural and lifestyle choices. This particular use of the word 'choice' is peppered throughout the document, as the following two statements illustrate:

This view of health recognizes freedom of choice and emphasizes the role of individuals and communities in defining what health means to them (p. 2).

When we speak of self-care, we refer to the decisions taken and the practices adopted by an individual specifically for the preservation of his or her health....Simply put, encouraging self-care means encouraging healthy choices (p. 6).

Another key issue is the stated intention of the department to encourage the population to demonize risk-taking behaviours. What is of interest is not the potentially

negative outcomes of these behaviours, but rather the fact that the department's self-identified "responsibility to make [risk-taking behaviours] socially unacceptable" (p. 10) prior to developing and passing legislation to officially, formally criminalize the behaviours. In this case, the document is referring to impaired driving, which from our current perspective, is neither socially nor legally acceptable. Yet, the current process of demonizing smoking, a legal activity, stands as a contemporary example of this process, which is another clear example of Health Canada shaping individuals' ability to make their own 'choices.' While the two may appear incomparable from our current perspective, it is possible to see the demonization of smoking as a potential precursor to the criminalization of the activity.

Linked to the issue of 'choice' and the demonizing of risk-taking behaviours is the new attention to vulnerability to negative health effects experienced by disadvantaged populations¹³, and the increased role of Health and Community Services in targeting these groups. While this is consistent with the technical framing of health concerns and health promotion, it also signifies how health promotion will operate in the future, particularly with regard to at-risk groups. The process which becomes evident is how valuations and stereotypes are directing health initiatives. These valuations and stereotypes are cleverly masked in the document by the use of technical and managerial language, and especially by the document's attention to management issues, such as those associated with the establishment of locally targeted addiction centres, to provide

¹³ This is the first usage of the term 'vulnerability' in the Health Canada population health documents (p. 4).

just one example. The process of valuation is particularly obvious in the document's treatment of women and the poor. As an example, it is clear that the document attributes health problems in the community and women's health problems, more specifically, to the gains made by the women's movement and to changes in gender relations within families. At the same time as women are seen as a specific target group, or an 'at-risk' population, they are also viewed as the providers of health care within families and communities, marking them as both the cause and consequence of poor self-care and health management. The discourse with regard to women within the document thus strikes a delicate balance between feminist ideas of social justice and stereotypical ideas about women. Indeed, the document goes so far as to blame women's mental and other health issues on their increased freedoms.

The times in which we live are characterized by rapid and irreversible social change. Shifting family structures, an aging population and wider participation by women in the paid labour force are all exacerbating certain health problems and creating pressure for new kinds of social support (p. 1).

Surveys indicate that many Canadians find their lives stressful. Women are more vulnerable in this regard. The fact that women are prescribed tranquillizers and anti-depressants more than twice as often as men is a telling sign of the emotional strain women are experiencing. For some, it may be the changing and uncertain nature of their role that is unduly stressful (p. 4).

What the above statements clearly demonstrate is the intention to maintain the facade of improving the health of women while reiterating that many of their health concerns are related to their lack of acceptance of traditional roles.

As an example related to the poor, what is most interesting is the vanishing act the document does in terms of poverty. Having identified the reduction of health

disparities between low and high income groups early in the document, it refocuses this discussion by providing little more than a description of some of the health effects experienced by those living in poverty, namely:

Among low-income groups, people are more likely to die as a result of accidental falls, chronic respiratory disease, pneumonia, tuberculosis and cirrhosis of the liver. Also, certain conditions are more prevalent among Canadians in low-income groups; they include mental health disorders, high blood pressure and disorders of the joints and limbs (p. 3).

These impacts are then linked to specific groups, within the category of poverty: "older people, the unemployed, welfare recipients, single women supporting children, and minorities such as natives and immigrants..." (p. 3). In a later section, the document then addresses a number of "risk behaviours" that contribute "variously to lung cancer, cirrhosis of the liver, cardiovascular disease and motor vehicle accidents" (p. 3) namely: "smoking, alcohol consumption and high-fat diets" (p. 3). It is interesting to note that many of these behaviourally caused health effects are those that the document highlights in relation to poverty.

What is missing from the document is any discussion of why people are poor or what National Health and Welfare intends to do about the relationship between poverty and poor health, beyond a vague reference to 'unhealthy conditions and surroundings.'

We believe that the three mechanisms to health promotion are: self-care, or the decisions and actions individuals take in the interest of their own health; mutual aid, or the actions people take to help each other cope; and healthy environments, or the creation of conditions and surroundings conducive to health (p. 6).

While this discussion of poverty is tangential and vague at best, the document returns to the issue in its conclusion in a way that presumes that the challenge of removing the

relationship between poverty and poor health has in fact been addressed through the proposed framework and strategies.

In summary, health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems (p. 10).

This document represents a continuation of the political project outlined in 1974 of establishing a strong federal presence in the field of health care. Surpassing the previous document, *Achieving Health for All* advocates for a systematic and coordinated approach to the development of health promotion strategies. Beyond this call for an integrated approach to health promotion, the document introduces the concept of “healthy choices,” emphasizes individual’s responsibility for making healthy choices, and defines the parameters of what those choices ought to include. Moreover, the document focuses on social health aspects of health related to women and the issue of poverty.

Strategies for Health: Investing in the Health of Canadians, 1994

In 1994, the Federal, Provincial and Territorial Advisory Committee on Population Health developed a background paper on strategies to collaborate on the promotion of population health. This paper, entitled *Strategies for Health: Investing in the Health of Canadians*, was presented to, and endorsed at, a meeting of the Ministers of

Health in September 1994. The intention of this paper was to provide a concise summary of the then current understandings of the determinants of health, to present a framework that could guide future policy, and to propose strategic directions for collaboration between stakeholders.

Like *A New Perspective on the Health of Canadians* and *Achieving Health for All, Strategies for Health* advocated for an inclusive approach to the analysis of health problems. Unlike the previous documents, which defined health factors in the broad terms of biology, lifestyle, environment and health care, this paper identified nine determinants of health and concentrated on providing concise definitions for each (Health Canada, 1994, pp.1-25).¹⁴ These factors were then divided into two categories, collective factors and individual factors, and integrated into a framework for health promotion (p. 30). Within this framework, integrated tools and supports (research, information and public policy) would provide the foundations for taking action to improve the collective factors that influence population health. These ‘improved’ collective conditions would then provide individuals with the social, economic and environmental capacity to make ‘positive’ modifications in their own health practices (p. 28-33).

In addition to providing a framework for health promotion, this paper also addressed the need for strategies to improve the quality of intersectoral collaboration. In response to this need the national advisory committee advocated three approaches. The first two strategies were aimed at strengthening both the general public and the

¹⁴ See Chapter 2 - Literature Review for a list and description of the determinants of health.

government partners' understandings of the determinants of health, and their commitment to removing the social inequalities that have an adverse effect on health status (pp. 35-36). The third strategy represents, perhaps, the clearest break from past approaches to health promotion and intersectoral collaboration. This strategy advocated the development of comprehensive intersectoral initiatives for a limited number of priority areas of health promotion. These priority areas would be of national scope and would be identified through collaboration between departments, levels of government and other stakeholders. For an area to be considered a priority it would have to have a national significance, a broad impact and a measurable return. In addition, it would need to be consistent with the identified goals of provincial and territorial governments, to be cost effective, and to allow for flexibility in the implementation of programmes (pp. 37-39).

This document is very much in keeping with the trajectory of health promotion outlined in its predecessors. Like the previous documents, it shapes health concerns in terms of technical goals, namely "provid[ing] a consistent and rational basis for setting priorities, establishing strategies, making investments in actions to improve population health and measuring progress" (p. 32). However, it takes the technical direction a step further by outlining a more clearly defined, step-by-step process, by further refining the categorization of determinants and strategies, by the consistent use of the terms 'evidence,' 'consistency,' and 'rationality,' and by the introduction of the notion of 'measurable' returns. Once again, what stands out is Health Canada's presumption of a

national consensus regarding what is 'healthy', what shape our health care system should take, and what type of services the public is willing to collectively finance.

More importantly, perhaps, this document makes an explicit link between health and civic duty, reflecting the continuing federal links between good health and the need for national stability and international economic competitiveness.

Investing in a population health approach offers benefits in three main areas: increased prosperity, because a healthy population is a major contributor to a vibrant economy; reduced expenditures on health and social programs; and overall social stability and well-being for Canadians (p. 1).

In taking up the issue of poverty, this document further masks the valuations and stereotypes directing health promotion, as evidenced by the 'new' way of thinking about risk behaviours. As shown, in the previous document, poverty was explicitly linked to poor health effects such as chronic respiratory disease and cirrhosis of the liver, which were, in turn, linked to specific risk behaviours (Health Canada, 1986). In *Strategies for Improving Health* these links have disappeared. Instead, poverty is addressed under the category "income and social status" (p. 12), while risk behaviours are addressed under the category of "personal health practices and coping skills" (p. 21). At the same time, these risk behaviours, newly categorized, are the same as those identified in the prior document, that is, risk behaviours associated with poor people (Health Canada, 1986). This maintenance of categories of risk behaviours indicate that the attention to the behaviours of the poor has not disappeared; instead, the naming of poor people as those engaged in risk behaviours has vanished. Effectively, this implies a reiteration of the connection between poverty, poor health and risk behaviours, without an accompanying

justification for the maintenance of the link, beyond noting, “lower socio-economic status seems to underlie the prevalence of ‘something wrong’ in a very general way, no matter what the specific health problem is” (p.15). At the same time, the document uses social justice language without any implication of an accompanying strategy for reducing systemic socio-economic inequities. As an example, the document states, “Many studies demonstrate that the more equitable the distribution of wealth, the healthier the population” (p. 13).

As with the issue of poverty, women are integrated into the document in ways that are driven by underlying stereotypes regarding women and women’s roles, and the social character of women’s health issues. This is apparent in a conceptual shift, from the previous document, from women themselves to women as implied targets under each of the categories of the social determinants of health. Within *Strategies for Improving Health*, women are only explicitly referenced under the category of “biology and genetic endowment” (p. 20) in which women’s experiences of poor health are described as being primarily caused by “differences in the traits, attitudes, values, behaviours and roles society ascribes to males and females” (p.20). Apart from this reference to women under the category of biology and genetic endowment, women show up in the document in one of two other ways: first, as being particularly susceptible to poor health effects under each of the social determinants of health, and second, as the implied care-givers who are responsible for the health of others. An example of the former is the statement that “Because women on average have lower incomes than men and are concentrated in lower

status occupations, particular attention should be given to improving women's health through action targeted at the social and economic environment" (p. 15), a statement which comes under the category of "income and social status" (p. 12). An example of the latter may be found under the category of "healthy child development" (p. 23), with the statement, "The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful" (p. 3). Other examples of how women are seen as tied to the health status of others abound, such as "There is a strong relationship between income level of the mother and the baby's birthweight...This tells us the problems are not just those of poor maternal nutrition and poor health practices, most likely to be associated with disadvantage, although the most serious problems occur in the lowest income group" (p. 23). Taken individually, each one of these statements which are prevalent throughout the document, seem compatible with feminist goals, couched as they are in social justice language. On the other hand, my analysis suggests that the conceptual shift from the presentation of women as a vulnerable group in and of themselves (as in the previous document, Health Canada, 1986) to seeing women as vulnerable to poor health effects related to each of the social determinants of health, effectively accomplishes the same rhetorical goal as with the case of poverty. That is to say, while the poor were distanced from risk behaviours and specific health effects, the connection between the poverty, behaviour and health was still maintained. The treatment of women within this document illustrates the same rhetorical distancing, while maintaining women in the status of vulnerable or at-risk. This allows

for the category of women to be established as a client population without requiring the statement that women are a vulnerable population in and of themselves, and thus sets the groundwork for interventions into almost every aspect of women's lives.

To summarize, this document presents an expanded version of the social determinants of health and reiterates the call for increased information, research, public policy and intersectoral collaboration. More importantly, perhaps, is the advocacy for the establishment of national priority areas, signifying the Department's intention to solidify federal control over health. Additionally, while giving great attention to technical goals and measurable outcomes, the document links health and civic duty and redefines the connections between risk behaviours and group attachment, particularly with regard to women and the poor.

Towards a Common Understanding: Clarifying the Core Concepts of Population Health, 1996

The strategy of identifying key areas for intersectoral collaboration was revisited in the 1996 Health Canada paper entitled, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health*. This paper focussed primarily on addressing the challenges associated with developing cost effective, national programmes that would provide measurable improvements in the health status of Canadians. It is important at this point to recall that this document was embedded within the context of a national discourse of fiscal restraint, rising health care costs, and provincial pressure to increase

federal health transfers, as indicated by the genealogy.

The primary focus of *Towards a Common Understanding* was on the management of national programmes involving diverse groups of stakeholders. In particular, this document sought to address the following questions: How to correlate a specific risk factor with a specific determinant of health? Which subgroups should be targeted and with what programmes? And how to accurately measure the success rates of ongoing programmes? In response, *Towards a Common Understanding* argues the need to adopt what it defined as “evidence-based decision-making processes”. According to the document, these processes would demand a strengthened role for research (both in terms of issue identification and programme evaluation) at the community, provincial and national levels and would ensure that future health policy was directly reflective of the needs of targeted groups (Health Canada, 1996, pp. 1-8).

Of particular interest within the document is the treatment of the terms ‘gender’ and ‘women.’ The term gender implies a concern for the health issues of both women and men, yet, men’s health’s concerns are not presented within the document as a product of gender, while women’s health concerns are inexorably tied to their gender and the accompanying social roles. This bifurcation is accomplished in a number of ways. First, the document adds gender to the determinants of health as a specific category for funding, programmes, research and national initiatives and interventions. Second, it provides an appendix on gender, which highlights women’s vulnerability to certain poor health effects, for example, “vulnerability to sexual or other forms of violence; female

genital mutilation in certain communities; poverty arising from low-paid employment or unemployment; higher probability of lone parenthood and its economic consequences, etc.” (p. 2). Third, within the appendix, the document critiques the “medicalization of women’s natural life occurrences, events such as onset of menses, childbirth, reproduction, menopause, etc.” (Health Canada, 1996, appendix D), and addresses gender using feminist language to describe women’s subordinate position:

The embodiment of gendered norms in social institutions and practices has subordinated women, inhibited their achievement of political, cultural, social and economic equality, and, as a consequence, impeded their attainment of optimal health status (Health Canada, 1996, appendix D).

However, the ‘victim’ language is prominent throughout, with women being portrayed as a passive, vulnerable group.

As well, certain women’s health issues which are a function of the status or role of women in society and culture (i.e., vulnerability to sexual or other forms of violence; female genital mutilation in certain communities; poverty arising from low-paid employment or unemployment; higher probability of lone parenthood and its economic consequences, etc.) receive relatively limited attention (Health Canada, 1996, appendix D).

While it may appear on first reading that Health Canada has taken a first step toward addressing the health affects of the subordinate position of women, the treatment of gender in this way and in this context may actually be seen as part of a much different project, especially when considered within the context of federal-provincial tensions and the national character, at the time, of the Canadian Women’s Movement (as indicated by the genealogy, p. 50). At best, using the terms ‘gender’ and ‘women’ in this way demonstrates that the writers of the document have no clear idea about the relationship

between gender and health. On the other hand, it may be seen as a subtle attempt to justify the expansion of federal jurisdiction while simultaneously quashing feminist dissent.

What seems to be happening here is an attempt by Health Canada to use the women's movement's national attachment and identification to support a national health agenda, in opposition to the rights of the provinces. Evidence of this may be seen in the juxtaposition of feminist and victim discourse with the continuing link between women's involvement in the workplace and children's poor health status. While the document does reference economic and social factors that influence health, overall, this discussion may be seen as providing justification for targeting certain populations. Gender, and women more specifically, thus represent a discursive vehicle for ensuring support for a continuing federal control of health and for its population health approach.

Against this background, the population health approach and its accompanying truisms, are expounded upon at length with regard to its potential benefits, expressed in terms of an incontestable good. For instance, *Towards a Common Understanding* emphasizes the potential of the population health approach to result in financial savings (p. 1), in the improvement of the status of women (Appendix D), in ensuring healthy childhood development (Appendix C), in reducing economic inequalities (p. 6), in helping aboriginal people and immigrant populations (p. 5), in reducing the rate of sexually transmitted diseases, and of smoking and other addictions (p. 2), and on and on. On closer examination, however, these claims are unsupportable. As an example, in

relation to the potential for financial savings, it overlooks the increased costs associated with a population that lives longer. From a fiscal point of view, if the population health approach were to be successful in reducing risk behaviours, it has the potential to significantly increase the costs of health care in that the greater number of years that an individual lives as a senior, the greater amount of money will be needed to deal with the chronic ill effects of aging. Similarly, in relation to the status of women, it is hard to imagine how a population health approach, as described in the document, would reduce gender-based income disparities, increase opportunities for career advancement, provide for accessible, quality day-care, and eliminate men's abuse of women, to name just a few of the demands of the women's movement that bear direct relation to women's health status. Related to these unsupportable claims is the tone of the document, which deflects concerns regarding the use of federal power to modify behaviour or to target already marginalized groups.

To summarize, while the crisis tone is present within all of the population health documents, *Towards a Common Understanding: Clarifying the Core Concepts of Population Health* presents the population health approach as being a 'natural' evolution of the health care system, which is wholly beneficial and realizable through improved technical management.

Taking Action on Population Health, 1998

By the end of the twentieth century, the right of the federal government to play an

active role in defining the parameters, goals and objectives of the health care system had been well established. Key to this consolidation of federal control was the population health approach, an approach which would come to dictate the parameters of health discourse across the country. What remained unfinished was the project of incorporating the population health approach throughout Health Canada's daily operations, including those of its subsidiary organizations, locally based branches and related groups and organizations.

Written in 1998, *Taking Action on Population Health* was intended to provide the department's staff with a guide to incorporating the population health approach into all aspects of their work. Like its recent predecessors, this document was largely technical in style and focussed primarily on pragmatic concerns and modifications that could be readily incorporated into daily management procedures (Health Canada, 1998, p. 1). What is unique to this document, however, is the dearth of attention allocated to marketing the perceived benefits of the population health approach. While the benefits of the approach are, indeed, referenced in this document, they are not given the same centrality of focus here as they have been in the previous publications. Instead, the benefits of applying a population health approach to all aspects of Health Canada's involvement are treated as understood, with the only remaining concern being its adoption as the driving force behind the department's internal efforts and its relationships with other departments, organizations and the general public. To this end, the document simply references the application of the population health approach to result in tangible

dividends regarding the improved health status of the population and the increased manageability of the health care system (p.6). These benefits are prefaced on five key tasks: integrating and breaking down barriers in the health system; engaging partners from other sectors; informing decision-making on health; promoting increased growth and productivity of the nation; and strengthening social cohesion and citizen engagement (p. 6).

Adopting a managerial style, *Taking Action on Population Health* provides concise guidelines for the appropriate forms of integration of the population health approach. The document begins with a clear definition, stating, “in a population health approach, the entire range of known (i.e., evidence-based) individual and collective factors and conditions that determine population health status - and the interactions among them - are taken into account in planning action to improve health” (p. 1). According to Health Canada, the adoption of this approach entails integrating it as a “conceptual framework for thinking about health,” (p. 2) a “framework for taking action” (p. 2) and “involves actions primarily targeted at the societal, community, structural or system level” (p. 2). In addition, it entails incorporating “decisions that are guided by a consideration of the evidence,” (p. 2) and necessitating “collaboration between multiple sectors” (p. 2). In support of this definition, the document outlines eight core principles of a population health approach. These principles include:

- health is a capacity, a resource for everyday living
- the determinants of health are addressed recognizing that they are complex and

inter-related

- the focus is 'upstream,'
- health is everyone's business
- decisions are based on evidence
- accountability for health outcomes is increased
- management of health issues is horizontal
- multiple strategies in multiple settings in multiple systems are used (pp. 7-14).

Towards a Common Understanding concludes by identifying eleven strategies for ensuring that the population health approach is positioned as the "new vision of health in the next century" (p. 1). Fundamental to this positioning is a clear focus on action strategies, premised on intervention, accountability, measurement, evidence-based decision-making, sustained investment, collaboration, and community participation.

The change in style from marketing to application is a clear break from previous documents and is of particular relevance when viewed within the context of the consolidation of federal influence over health care that was orchestrated in the 1990s. The lack of aggressive marketing strategies, characteristic of the previous documents, appears indicative of the public's acceptance, or at least a belief in the public's acceptance of the principles of the population health approach and of the federal government's right to engage in such activities. Moreover, this stylistic shift is suggestive of a formal silencing of any remaining discussion or conflict regarding either the need for, or the desirability of, an active federal presence, in the guise of population

health strategies, at the local level.

The Population Health Approach in the Twenty-first Century

Health care discourse, during the period between 1974 and the close of the century can be characterized by the conflict surrounding both the role of the federal government and of preventative health strategies and population health approaches. It is clear, however, that by the end of the twentieth century the federal government had succeeded in firmly establishing its right to define a national agenda for health care and health promotion and, in doing so, ensured its continued right to engage in activities intended to modify behaviours that were seen as undesirable and inconsistent with the goals of national stability and economic prosperity.

The documents to emerge in the twenty-first century all appear to suggest the cessation of conflict, yet not the end of hegemonic processes. Whereas previous documents found it necessary to encourage public acceptance of the principles of the population health approach and the role of the federal government in promoting and later managing the associated activities, the documents to emerge more recently are focussed on either streamlining the management of population health strategies, or on promoting national strategies with regard to the identified target groups and/or behaviours. The following provides only a partial list of Health Canada's documents related to these two goals:

- The Population Health Template, 2001

- Dare to Age Well: Workshops on Healthy Aging, 2001
- Canada's Aging Population, 2002
- Exploring Concepts of Gender and Health, 2003
- Taking Action on Healthy Living: The Pan-Canadian Healthy Living Strategy, 2005
- Reducing Health Disparities - Roles of the Health Sector, 2005
- The National Strategy: Moving Forward, the 2006 Progress Report on Tobacco Control, 2006

As the list indicates, the time for even a limited discussion of principles is past, and the "vision of health for this next century" (Health Canada, 1998, p.1) appears secure. While each of the above documents could warrant further study, of more interest here are the processes by which the population health approach took hold and served to establish federal control.

Chapter 5

Discussion

The processes illustrated by the production of documents, and the engagement with the documents' related activities over time are marked mainly by the active silencing of a wide-ranging national debate. While ostensibly operating under the guise of improving national health status, the population health approach has been used essentially as a vehicle to redefine federal/provincial jurisdictions, to create ideological shifts regarding the freedom of choice, to expand what legitimately falls within a public domain (e.g., smoking, nutrition, sexual activity, etc.), and to change the balance between individual and collective needs, wants and desires. What is particularly noteworthy is the employment of gender broadly and the women's movement more particularly, to consolidate these ideological, economic and political shifts. In other words, these processes are in essence a re-writing of the social contract. As noted, the nature of a social contract is that its legitimacy is based on an active negotiation of the boundaries and principles underlying the contract. While the contract is open for debate or renovation, in this case, health, as a collective good and the civic responsibility of all citizens, has been used for establishing the shift without renegotiation, and without even the acknowledgment that negotiation is necessary. Because it is hard to imagine how to argue effectively for 'poor health' as an alternative to the federal agenda, this shift is nowhere near as benign as it appears to be.

In this chapter, I discuss the implications of seeing health as both a collective

good and a socially derived product by considering the extent to which we may see a relationship between the social construction of vulnerability, risk, and good health and the non-codified boundaries of citizenship. More specifically, I focus on the more theoretical question of whether health promotion may be seen as a political act which disenfranchises women, promotes valuations of lifestyles and behaviours, and links gender to definitions of vulnerability and risk. The attempt here is to make visible the power relations that operate through the valuations of gender, lifestyle, and behaviours to define the boundaries between citizens, and between citizens and the state and particularly between women and the state.

Heath Promotion as a Political Act

As the historical description and the document analysis indicate, the processes associated with the population health strategy have moved health away from being solely within a medical model to being a collective 'good.' While the medical community continues to exert a great deal of influence over definitions surrounding health, and health care, and to a large extent continue to control the technical/medical aspects of diagnosis and treatment, health is no longer simply within the purview of the medical community. Instead, with the adoption of a publicly funded, state managed, universal health care system, health care and its related projects have become both collective rights and responsibilities, or, in other words a collective 'good.'

While, as Second Wave feminist critics have repeatedly contended, the division

between medical spheres and political ones are by and large arbitrary, and, in fact, no sphere is apolitical, the rules, understandings and traditions within each sphere are sufficiently different to call for an exploration of the implications of this movement between spheres. As shown in the genealogy, previously health was considered to be mainly a matter of access to advanced medical treatment. It is now positioned as a collective 'good,' meaning the sustaining, and even enforcing, of good health is now a collective responsibility. Thus, while good health is an unequivocally good thing to have, viewing health as a collective 'good' compels us to consider the degree to which the construction of an inclusive system of health care and promotion are (re)shaping the boundaries of the political community, for example, by changing the balance between collective responsibilities and individual freedoms. This is not to say that change is detrimental, nor is it to advocate for a static system. In fact, it is important to recognize that one of the benefits of the Canadian parliamentary system is that there is the potential for change when necessary, through negotiation and compromise (Kellas, 1998). Yet, the process of change needs to be active, open and transparent so that we may evaluate the new parameters associated with our engagement in the social contract. Thus, any discussion of health promotion needs to focus on a holistic evaluation of the agenda itself, recognizing that it is an active, constructive, political process which, by definition, has implications for our own expectations of freedom and autonomy and our responsibilities to the society as a whole.

Viewing the population health strategy as a political act, as opposed to a natural

evolutionary process, means making an attempt to understand how the act itself changes the rules of engagement for all. In particular, however, it compels us to explore how the population health strategy itself (re)positions women in specific ways in relation to the state, to each other, and to men. Since gender and the challenges posed by the women's movement were clearly used within the documents as one of the primary vehicles for establishing the new federal agenda, it is more important to take a broad look at the implications of the conceptual shift rather than to evaluate its individual projects, for example, new provisions for pre-natal care, breast cancer screening, the HPV vaccine and so forth.

To begin with the broad implications of changes in the social contract, the definition of health as a collective 'good' explicitly charges the federal government with the responsibility of maintaining the health of Canadians and the reduction of health disparities between groups. This responsibility in turn reduces the autonomy of individuals to make health/lifestyle choices which may be seen to have an impact on the collective good. At the same time, the shift links good health with the duties of citizenship. Citizens' responsibilities for national prosperity and international economic competitiveness compel individuals to make 'healthy choices,' meaning choices that are consistent with the government defined agenda regarding what is healthy.

(i) Healthy choices. The framing of individual choices as being 'healthy' or 'unhealthy' is a primary characteristic of the changing relationship between citizens and

the state and has far-reaching implications for the shape of Canada's political community and the boundaries of legitimate uses of coercive, collective power. At the same time, for the purpose of this discussion, it is necessary to highlight that citizens and the state are one and the same. It is not just our collective operations which embody the state, but also our individuality which is both acting and acted on by our membership in the collective operations. In other words, in this discussion, I go beyond the formal coercive powers of the state, to focus on both our individual desires to regulate others and ourselves in ways that are in keeping with the collective operations, and the tensions that occur between our desires and obligations. This is a key point, since the enforcement of 'healthy choices' now resides within individuals, both in terms of regulating others and themselves. These self-regulated and collectively regulated choices are then allowed to operate invisibly to relocate accountability for good health to individuals and away from the formal apparatuses of the state. In turn, this regulative activity shapes who can engage in discussions and debates regarding concepts of choice, risk, vulnerability and so forth, and limits how those discussions might take place. For instance, smokers can enter a discussion about the health effects of tobacco in relation to their addiction, yet, in theoretical terms at least, the regulative activities associated with the population health approach may prevent them from arguing in favour of their personal choice or engaging the government in the reduction of toxins and additives in tobacco. Likewise, again, in hypothetical terms, a single mother can enter debates on motherhood in ways that reflect her single motherhood and its poor effects on her, and her children's health, thus

potentially silencing any thoughts she may have about the health benefits she may obtain by not having a male partner.

(ii) Social justice. The legitimacy of the link between health and duty and its subsequent regulative activities in the valuations of choice is derived from the use of social justice language. As seen from the documents, social justice language, the category of gender, and the attention to the challenges posed by the women's movement all featured prominently in the process of framing the population health strategy and the national health care system more broadly. At the same time, what my analysis of the documents indicate is that the politics of liberation were not predominant interests in the framing of the strategy, nor were they seen to be desirable on the part of Health Canada. Instead, as shown, the attention to women's issues was used primarily to garner support for the federal agenda and to capitalize on the national identification of the women's movement. This is evident in the juxtaposition of social justice language with continuing stereotypical ideas about women's experiences and roles as mothers, wives and providers of health, as shown by the document analysis. However, the use of social justice language requires a corresponding visible presence of social justice work or projects responsive to issues surrounding gender and equality. Yet, the process of centralization, by definition, requires the concentration of power within a small group, in this case, the federal department of health. The resulting tension between federal and provincial jurisdictions may be seen to have been resolved through the categorization of vulnerable

populations or targeted groups, permitting an ostensible illustration of the government's commitment to removing inequalities from the health care system, while simultaneously ensuring that any dissent is channelled in ways that are compatible with the federal agenda. Thus, by centralizing national control, while maintaining the illusion of being open, egalitarian and responsive, and by embedding the discourse of 'choice' within valuations of behaviours and regulative activities, the federal agenda may be seen as creating an even greater distance between women's daily experiences of health and the power relations that govern the formulation of a national health agenda. This is accomplished through the categorization of women as a vulnerable, client/dependent population, while seeing them as simultaneously being both the providers of good health and the cause of poor health, for example, of their children, as shown in the document analysis.

(iii) Gender, vulnerability and risk. As the historical description and document analysis illustrate, the categories of vulnerability and risk have been constructed in very specific ways for very specific purposes. As the document analysis of the treatment of gender and poverty indicate, essential to this construction has been the rhetorical deployment of gender and socio-economic status in the development of categories. Women are always considered to be at risk or vulnerable, whether or not they are also aboriginal, living in poverty or in unsafe living conditions, or working in unhealthy environments. In fact, it is not hard to imagine from the reading of the documents that the only group who is not considered to be at risk of negative health outcomes as a result

of their position, environment, and personal lifestyle choices is the 'silent dominant' - white middle class men between the ages of 18 and 65. What is perhaps most interesting about this construction of vulnerability is the absence of any analysis of the systemic factors that influence women's health. For instance, one of the most prevalent causes of poor health among women concerns their involvement with men, as noted by the World Health Organization (2005) in their study of the relationship between men's violence against women and women's poor health. However, only one document, *Achieving Health for All: A Framework for Health Promotion* (Health Canada, 1986), refers to the abuse of women by men and that is in a quick sentence referring to "family violence" (p. 4) as if family violence was a given, like poor weather, and not the active abuse of women and children by men. This neglect of the health effects of women's involvement with men is symptomatic of a broader heteronormative process, since what is continually implied throughout the documents is that women's health would improve if they were living in two-parent, male-headed, middle class households.

Another feature of the construction of vulnerability and risk is the promotion of gendered valuations of lifestyles and behaviours, a principal component of regulative activities. In this respect, what is left out of the documents is perhaps as important as what is included. Ignored are such activities as jogging, mountaineering, skiing, any of the 'extreme' adventure sports, ATV riding, snowmobiling, and so on, all of which may be seen as risks to good health, as well as carrying large collective costs, not only in regard to treatment of injuries, but also environmental damage, noise pollution, rescue

activities, and so on. It may be interesting also to note that one adventure sport that does get attention is skate-boarding, revealing the class and age biases of these classifications. This selective definition of categories of risk and vulnerability allows for attention to be deflected away from the structural features of society that create barriers to 'good health' and success and allows for failures to be defined as personal failures. Also excluded from the documents is a discussion of the social meaning(s) associated with engaging in risk-behaviours. Examinations of the role of various risk-behaviours in the creation of peer groups or sub-cultures, as a means of negotiating or bearing untenable positions or formulating acts of resistance, are all ignored in favour of fixed classifications of activities as being good or bad, healthy or unhealthy. Likewise, social barriers to good health that are experienced by those who are not identified as being 'at-risk,' namely white, middle-class men between the ages of 18 and 65, are ignored, in keeping with a canonical version of masculinity which prohibits investigations of emotional health, and so forth. For example, a discussion of the stress, which men may experience as a result of the tensions between workplace demands and family life, is absent. Moreover, this gendered framing of vulnerability and risk, by selective definition, reinforces a traditional model of health which favours men for physical treatment, research, and so on, while simultaneously relegating women's health complaints to problems which are by and large seen as psycho-social dysfunctions, such as anxiety and depression (Health Canada, 1986), or as purely socially driven (Health Canada, 1994; Health Canada, 1998).

(iv) *Resistance, agency and autonomy.* Apart from the gendered nature of the construction of vulnerability, there is the issue of loss of agency and autonomy, an issue which goes beyond freedom of choice. Once defined as 'vulnerable,' meaning in a client or dependent relation to the federal strategy, individual successes may be attributed to the programme itself, and not to the individual. Thus, for instance, a person who succeeds in quitting smoking may be seen as successful because of the efficacy of a particular programme or policy, such as mandatory warning labels on tobacco products, and not as a result of their own resolve. Likewise, the vulnerable individual's failure to improve her or his health status may be seen as the failure of the programme's inability to target or reach appropriate groups with the appropriate programme, that is 'falling through the cracks.' Indeed, the only ownership that the individual has is over those failures that occur as a result of non-compliance with the federal strategy. In this way, loss of ownerships signals a loss of autonomy, and allows for 'success stories' to be paraded as governmental success. Non-compliance to the approach and the related programmes and policies, which could be seen as acts of resistance (acts normally applauded by the women's movement), is thus easily incorporated into the hegemonic processes and in many instances used to support the treatment of vulnerable persons as being incapable of making 'healthy choices' or acting in their own best interests.

The Social Construction of Acceptance

As noted, the right of universal access to timely, first-class medical service has

become embedded within the national character of Canada to the extent that it appears to have become both a source of national pride and a cherished cultural value. The successes claimed by Health Canada tend to be seen, then, as a collective success, and an indicator of our global standing in providing quality health care. At the same time, Canadian's acceptance of these successes and, indeed, faith in the system that has accomplished them, serve to mask the choices that were taken at varying levels of power and relocate them as a 'natural evolution' of what is considered overall to be a fine system, at least in the sense of its universality. What this analysis makes visible, however, is the political nature of those choices and the various ideologies that are represented by them. Increasingly obvious, in fact, is the socially constructed nature of the federal strategy and alternative directions that may have been taken, given a different set of priorities. As seen, the initial motive in 1919 for establishing a separate national department of health was the need to be able to field a healthy, disciplined, modern, industrial army. This initial motive was expanded in 1984 to include the demands of international economic competitiveness and economic prosperity. This expanded motive has been carried through the development of Health Canada and has been used to inform the decisions taken to formulate a national health care system. This point is key to understanding how alternative priorities and projects have been overlooked and/or rejected. If the priority from the beginning had been to improve the health status of marginalized populations, for instance, changes in the system could have been more reflective of regional disparities and cultural diversity, to name just two aspects of the

Canadian cultural character. Regional disparities may, in fact, be better served by strengthening provincial jurisdiction and funding, rather than through the development of a centralized federal system.

Even given Canadians' insistence on universal, accessible, and publicly funded health care, an insistence that is also socially constructed, it is possible to envision a different role for the federal department of health. Hypothetically, the federal government could have acted solely as an intermediary between the provinces and the international arena. If this had been the case, we could envision federal projects related to nutrition, such as the development of cheaper food production and distribution, and stronger regulation of food quality, both local and imported. We could also see a positive federal role in decreasing the cost of medical services themselves, and not through the regulation of the population, but through such initiatives as limiting the political power of lobby groups and the medical professions, through nationalizing the research, development and production of pharmaceuticals, and reducing the length of drug patents, to name just a few. Furthermore, and this is a point that requires greater consideration, the federal government could take a firm and proactive position on addressing the systemic issues surrounding poor health - environmental issues, gender, race, class, ethnicity, and so forth - rather than their current project of simply attempting to manage what is viewed as the more 'disruptive' elements. Thus, by presuming the need for a centralized system of health care, the federal strategy has been developed in such a way as to focus less on these national and international issues and more on the micro-level

events or decisions that are part of daily life.

A focus at the national and international level could have fostered national debate. Rather, what this analysis indicates is that debates have occurred in a limited and fragmented way, and have been focussed primarily on the technical and managerial aspects of the current system, again taking for granted Canadian's faith in that system overall. This focus has clearly resulted in a neglect of systemic factors that influence health and the international issues that affect the cost of health services and the general health of Canadians. Missing are wide-ranging debates on the factors that result in health disparities between targeted groups, the political nature and socio-political ramifications of promoting behaviour modifications and the targeting of historically disadvantaged groups for 'special treatment,' and the variable and plural nature of definitions of 'health,' and 'being healthy.' Finally, this focus has precluded a recognition of how healthy we are as a population, and has prevented a collective discussion of whether or not we need to be 'healthier,' and if we do, whether or not the end, being 'healthier,' justifies the means, that is political incursions into personal behaviours.

Beyond Exclusion

Having established the political nature of the development of the federal strategy, and the specific ways in which the strategy has taken shape, I turn now to the key questions: what sort of power relations do valuations of lifestyles and behaviours create between citizens, and between citizens and the State, and particularly between women

and the State?

To begin with the valuations of lifestyles and behaviours, it is useful to recall how good health, through its acceptance as a collective 'good,' became linked with the duties of citizenship. As argued, good health in turn became connected to the concept of 'healthy choices,' with its inherent valuations and regulative activities, and was legitimized and marketed through the use of social justice language. In this context, the categories of risk and vulnerability may be seen as performing a dual role: first, of providing ostensible evidence of the presence of a social justice agenda; and second, of ensuring the centralization of the health care system. As shown, in and of themselves these categories are gendered and carry negative consequences for women. While these consequences are clearly significant issues which need to be confronted, what might be overlooked in an attempt to address each in turn is a broader exclusionary process. It is this broader exclusionary process which should be of central concern in an analysis of women and health. This is because, while individual projects coming out of the population health strategy might be highly effective and reflective of women's needs, the fact that they are predicated on gendered categories of vulnerability and risk calls for an interrogation of the broader consequences for women in terms of their expectations of membership in the polity. In other words, what I am arguing here is that the evaluation of individual projects is less important than exploring how women have been resituated politically by the federal strategy as a whole and what that shift suggests for women's position as citizens in Canada.

It is useful to take Rawls' *Theory of Justice* (1999) and his conceptual framework of 'redistributive justice,' as a point of entry into an interrogation of the exclusionary processes which operate through the imposed categorizations of vulnerability and risk. In his treatise on justice, Rawls (1999) argues that "in a just society the liberties of equal citizenship are taken as settled; the rights secured by justice are not subject to political bargaining or to the calculus of social interests. . . an injustice is tolerable only when it is necessary to avoid an even greater injustice" (pp. 3-4). In support of this argument, Rawls envisions a hypothetical and ahistorical process wherein each person engages in the development of a future society without any knowledge of their particular characteristics as an individual or of their future position within the potential society. Referred to as the 'veil of ignorance,' this original position requires a complete divestment of categories of group identification. Rawls then argues that, having come together under this 'veil of ignorance,' those involved, being self-interested, could not help but come to the conclusion that their future interests would be best served through an egalitarian political system based upon two originally agreed upon principles of justice, namely: "each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberty for others" (p. 53) and "social and economic inequalities are to be arranged so that a) offices and positions must be open to everyone under conditions of fair equality of opportunity and b) they are to be of the greatest benefit to the least-advantaged members of society" (p.53). In other words, rights would be equally distributed amongst all members of the polity except in

cases where the uneven distribution would operate to allocate additional rights or opportunities to those least advantaged. In his later work, *Politics of Liberalism* (1993), Rawls revises his procedural description of the 'original position' and situates the debate in the context of being an ongoing process that is embedded within the political culture of a democratic society. Instead of looking toward an original agreement, Rawls hoped to elucidate the shared principles that, when translated into a political conception, underwrite a just regime (Rawls, 1985, pp. 246-247). Again, this vision of democratic liberalism argues for pluralism by demanding that individuals collectively agree upon the principles of justice independent of their own moral, religious or conceptual predispositions (Rawls, 1993).

Rawls' theory of justice, and the process that he identifies as underlying its formulation, have been the subject of much criticism by feminist and other critical theorists. Many feminist political theorists have criticized Rawls for both his reliance upon a public/private split (Okin, 2004) and for his focus on the content of political decisions rather than on the process (Phillips, 1991). While these critiques are necessary, what is of more interest to the discussion on the political implications for women of categories of vulnerability and risk, are those critiques lodged by the proponents of radical democracy, who, while agreeing with the principles he identifies, disagree with the arguments Rawls makes in their support. In summary,

What Rawls requires, they argue, is a conception of community and identity that does not reinscribe the reductionism and essentialism of classical liberalism. Rawl's error, they argue is that in the construction of his pluralism he fails to acknowledge the *contingency* and *ambiguity* of every identity as well as the

constitutive character of social division and antagonism. Against Rawls's essentialism that supposes some original unfissured identity, it is suggested that the social agent has to be thought as the articulation of an always unstable ensemble of subject-positions constructed through and within specific discursive formations. Identity, in short can only be constituted through acts of *identification* (Scott, 1999, pp. 153-154).

Upon an initial examination it may appear that the federal population health strategy, through its use of the constructed categories of risk and vulnerability are promoting a political agenda that is consistent with the tenets of redistributive justice while simultaneously recognizing an individual's identification with a particular group or groups. To elaborate, on the surface, it would appear that the operation of a centralized universal health care system, would be in keeping with Rawls' first principle of justice (strict egalitarianism) while the use of categories of vulnerability to address historic inequalities would appear to reflect the application of his second principle, namely weighting any differences in the distribution of rights in favour of those least-advantaged. Similarly, it would appear that the targeting of specific groups is indeed a recognition of the variable and constructed nature of identity and the subsequent inability of an individual to speak from a position that is divorced from their identity. Indeed, it is this superficial reading of the categories of vulnerability and risk - as indicated by the document analysis as a whole - as compatible with the tenets of redistributive justice that are used to justify their presence in the federal population health strategy.

Yet, upon a closer examination of the development and operationalization of the categories of risk and vulnerability and the subsequent links to specific target groups, it is possible to discern a different, and perhaps more sinister, process of exclusion that is

operating through these categories. This process of exclusion is both subtle and well-masked with implications that, while far-reaching, may not be readily discernable even to those directly affected. In an attempt to render this process of exclusion more visible, it might be useful to look at these categories through a variety of lenses, thereby allowing for a deconstruction of the various layers of operations that situate women, and other 'vulnerable' groups in very specific ways in relation to others and to the state.

To begin, the categorical labels of 'vulnerability' and 'risk' are, themselves, indicative of negative valuations, particularly evident when viewed in relationship to their antonyms, namely 'strength' and 'security.' Indeed, the definitions of 'vulnerable' and 'risk' are referenced in the Webster's Dictionary (1996) as:

***vulnerable** - that can be wounded or physically injured; open to criticism or attack, easily hurt, sensitive, affected by a specified influence, temptation.*

***risk** - the chance on injury, damage, or loss, dangerous chance or hazard.*

What these negative valuations denote is the presumption of irrationality, that is, an inability to make appropriate (healthy) decisions and the subsequent need for protection - from the social aspects of poor health, and from themselves. This is one method of establishing women and other 'vulnerable' populations in a dependent, almost child-like relation to the state, requiring a paternalistic (male) state presence (a legacy of being non-persons).

Beyond definitional issues, there is a need to unpack the process of categorization. There are at least two aspects to this: one is the development of categories of risk and vulnerability, in and of themselves; another is the definition of identity groups

and the linking of the two. This process of linkage is key to understanding how exclusion takes place. First, noting how the connection is made between risk, vulnerability and targeted groups, we are able to see that the categories of identity, for example, as outlined in the federal strategy, are pre-determined, static and finite. What this means is that the categories themselves were defined by the federal government, without the benefit of debate and in advance of individual's identification or self-identification. Moreover, the boundaries of the categories of identity were clearly marked by the federal government and appear fixed, unconflicted and not open for renegotiation. Finally, membership within the targeted groups was determined by the federal government, and not predicated on any active identification by individuals. Thus, whether or not one self-identifies as poor, she or he would still be cast as belonging to this vulnerable group and subject to its accompanying governmental projects.

Butler (1993) speaks to the issue of categorization, noting that categories are only useful to the degree that there is a recognition that they are arbitrary, and that they are actively adopted to accomplish a certain goal, and not indicative of the whole of a person. She notes as well that even in a limited, temporary context, categories of identification are still being contested. To take up Butler's argument, with regard to the connection between risk, vulnerability and group identity, it becomes apparent how this linkage determines how those identified by external sources as belonging to a certain group can enter into an engagement with the political sphere in general, and with health care in particular. Moreover, the linkage between risk, vulnerability and group membership

limits who can engage in debates related to health care. This linkage means that, as women, we cannot use the categories to accomplish our own goals, and that while we can have membership in different categories, we cannot speak from multiple subjectivities, for example, as an aboriginal person and single mother. Neither can we speak to conflicts among ourselves as women, or even within ourselves as individuals, or to the health projects that these conflicts might inform.

Finally, more broadly, the connection between risk, vulnerability and group identity ensures that gender issues cannot be discussed by women without the layer of vulnerability and risk, and thus without the language of victimization. In essence, this process ensures that white middle-class males, those normally not classified as vulnerable, can be informed, speak and act as active agents within the totality of the political, social, cultural and economic system, while the whole notion of vulnerable group membership, a position to which women are relegated, means that women can only speak constructively and rationally to issues that are not related to their group membership. This results in a self fragmented by external agents, in terms of actions associated with citizenship. Thus, it is apparent that the process outlined is one that runs contrary to the principles of redistributive justice and indeed is in direct conflict with Rawls' difference principle.

To summarize, in this discussion I have highlighted the aspects of the documents, taken in their historical contexts, which speak to the political nature of health promotion, and its attendant focus on healthy choices, social justice language, and gender,

vulnerability and risk. I have shown how women's acceptance has been socially constructed and how women's potential resistance has been accommodated. Throughout this discussion, I have underlined the active silencing of a broad, national debate on the principles driving the federal strategy and highlighted how the strategy was employed to reconfigure federal and provincial jurisdictions, to create ideological shifts, to expand what legitimately falls within a public domain, and to change the balance between individual and collective needs, wants and desires. Also key to this discussion has been my focus on the employment of gender broadly, and the women's movement more particularly to consolidate these ideological, economic and political shifts. By highlighting, as well, the relationship between the social construction of vulnerability, risk and good health and the non-codified boundaries of citizenship, I have made visible the power relations that operate to (re)define the boundaries between citizens, between citizens and the state and particularly between women and the state. Finally, I have argued that any discussion of health promotion needs to focus on a holistic evaluation of the agenda itself, recognizing that it is an active, constructive, political process which has implications for our own expectations of freedom and autonomy, and our responsibilities to the nation as a whole.

Chapter 6

Conclusion

This thesis represents an exploratory, grounded theory study of the development of Health Canada and the operationalization of the population health approach and its political implications for the status of women. Essential to my approach was the combination of a genealogy and document analysis, an integration which allowed for the public documents to be seen within the broader context of the Canadian political, social and economic environment. This integrated analysis revealed the relations of power that went into the development of the strategy more broadly and into each one of the documents more specifically. Of particular interest to this project was the connection between the federal strategy and the Canadian women's movement, a connection which underlines how women have been caught up in the hegemonic "web of power structures that they purport to reject and challenge" (Ryan, 2005, p. 2).

This integrated analysis was strengthened, despite my attendant theoretical dilemma with regard to the public/private split which I described earlier, by complementing feminist poststructuralist theory with some key concepts drawn from social contract theory. This particular combination of conceptual frameworks became a powerful tool in not only deconstructing the federal strategy, but also providing a framework for interrogating its political implications for women in relation to their expectations for full membership in the polity.

By taking this analytic approach, I have decentred the accepted history of Health

Canada and its component parts, particularly its population health strategy, and challenged the assumed correlation between the federal population health strategy and the adoption of feminist agendas at the federal level of government. In addition, by making a conceptual shift away from the issue-group approach that has characterized much of feminist research and activism in the field of health, I have demonstrated that the federal population health strategy is not only inconsistent with feminist agendas in the field of health, but also has serious political implications for women's expectations of citizenship. Integral to my analysis is the finding that the use of predefined categories of vulnerability and risk, the negative valuations of behaviours and lifestyles that are embedded within these categories, and the persistent link between vulnerability, risk and targeted populations operate as a subtle exclusionary process wherein women, and other identified vulnerable populations are disenfranchised.

While my research is limited to an examination of the public population health documents produced by Health Canada between 1974 and 1998, this analysis indicates the necessity of furthering our understandings of the role of feminist discourse in the promotion of particular governmental agendas and projects. It is clear from this study that what the women's movement has commonly identified as 'successes' (in this case, the federal adoption of gender as a social determinant of health) may not in actuality be of benefit to women. In fact, the federal agenda may be seen as creating an even greater **distance** between women's daily experiences of health and the power relations that govern the formulation of a national health agenda.

The findings of this study have implications for a wide range of feminist analyses, activism and research. As a first step, we may want to reexamine what many feminists have identified as successful outcomes of activist projects. Perhaps we could begin by rethinking how we are taking up the task of evaluating current health projects aimed at women, and consider how we could continue these evaluations through a different lens, for instance, by giving attention to women's acceptance and/or resistance to, not only the federal health strategies, but also our own feminist projects. In more theoretical terms, the analysis that I have conducted here argues for the necessity of revisiting feminist theorizing on the public/private split. The removal of this division between public and private has been foundational to feminist theorizing and activism, yet my analysis indicates that this foundational conceptualization may be limiting our visions for future projects.

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Appendix A

Chronology of the Development of Health Canada and Health Policy in Canada: 1919 - Present

This chronology which follows in chart form provides an outline of the major events that occurred throughout the development of a national health care system in Canada. The following sources were used.

Department of Finance (2007) *Federal Transfers to the Provinces and Territories: A brief history of the Health and Social transfers*. Retrieved May 2, 2007 from www.fin.gc.ca/FEDPROV/hise.html.

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Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
1919	The Scope of a Federal Department of Health	<i>Borden, Sir Robert Laird</i> (1917.10.12-1920.07.09) Unionist (Conservative and Liberal) *1917 G(153), O(82) Majority 71	Federal Department of Agriculture responsible for marine hospitals and quarantine; Department of Health established Sept. 1, 1919 Newton Wesley Rowell - Minister		One year after the end of the First World War
1921		<i>Meighen, Arthur</i> (1920.07.10 - 1921.12.28) Unionist (Conservative and Liberal) *1917 G(153), O(82) Majority 71 <i>King, William Lyon Mackenzie</i> (1921.12.29 - 1926.06.28)	Department of Health John Wesley Edwards - Minister		Royal Commission on Health Insurance, British Columbia Municipal hospital plans established in Manitoba, Saskatchewan and Alberta

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		Liberal Party of Canada *1921 G(99), O(119) Minority 3			
1936		<i>King, William Lyon Mackenzie (1935.10.23 - 1948.11.14)</i> Liberal Party of Canada *1935 G(173), O(72) Majority 101	Department of Pensions and National Health Charles Gavan Power - Minister		British Columbia and Alberta pass health insurance legislation but without and operating programme.
1939		<i>King, William Lyon Mackenzie (1935.10.23 - 1948.11.14)</i> Liberal Party of Canada *1935 G(173), O(72) Majority 101	Department of Pensions and National Health Charles Gavan Power - Minister		Outbreak of Second World War
1940		<i>King, William Lyon Mackenzie</i>	Department of Pensions and		Federal Dominion Council of Health

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		(1935.10.23 - 1948.11.14) Liberal Party of Canada *1940 G(181), O(64) Majority 117	National Health Ian Alistair Mackenzie - Minister		established
1942		<i>King, William Lyon Mackenzie</i> (1935.10.23 - 1948.11.14) Liberal Party of Canada *1940 G(181), O(64) Majority 117	Department of Pensions and National Health Ian Alistair Mackenzie - Minister		Federal Interdepartmental Advisory Committee on Health Insurance created
1945		<i>King, William Lyon Mackenzie</i> (1935.10.23 - 1948.11.14) Liberal Party of Canada *1940 G(181), O(64) Majority 117	Department of National Health and Welfare Brooke Claxton - Minister		End of Second World War

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		*1945 G(125) O(120) Majority 5			
1947		<i>King, William Lyon Mackenzie (1935.10.23 - 1948.11.14)</i> Liberal Party of Canada *1945 G(125) O(120) Majority 5	Department of National Health and Welfare Paul Joseph James Martin - Minister		Saskatchewan initiates provincial universal public hospital insurance plan
1948		<i>King, William Lyon Mackenzie (1935.10.23 - 1948.11.14)</i> Liberal Party of Canada *1945 G(125) O(120) Majority 5 <i>St. Laurent, Louis Stephen (1948.11.15 -</i>	Department of National Health and Welfare Paul Joseph James Martin - Minister	National Health Grants Program (federal) - provides grants to provinces and territories to support health-related initiatives, including hospital construction, public health,	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		1957.06.20) Liberal Party of Canada *1948 G(171) O(94) Majority 77		professional training, provincial surveys and public health research	
1949		<i>St. Laurent, Louis Stephen</i> (1948.11.15 - 1957.06.20) Liberal Party of Canada *1948 G(171) O(94) Majority 77	Department of National Health and Welfare Paul Joseph James Martin - Minister		British Columbia creates limited provincial hospital insurance plan Newfoundland joins Canada, and brings with it an established cottage hospital plan
1950		<i>St. Laurent, Louis Stephen</i> (1948.11.15 - 1957.06.20) Liberal Party of Canada *1948 G(171) O(94) Majority 77	Department of National Health and Welfare Paul Joseph James Martin - Minister		Alberta creates limited provincial hospital insurance plan (July 1)
1957		<i>Diefenbaker,</i>	Department of		Hospital Insurance and

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		<i>John George</i> (1957.06.21 - 1963.04.21) Progressive Conservative Party *1957 G(112) O(153) Minority 41	National Health and Welfare Paul Joseph James Martin - Minister (until 1957.06.20) Alfred Johnson Brooks - Acting Minister Jay Waldo Monteith - Minister		Diagnostic Services Act passed (federal) - proclaimed by Royal Assent May 1 - provides 50/50 cost sharing for provincial and territorial hospital insurance plans. - comes into effect July 1, 1958
1958		<i>Diefenbaker, John George</i> (1957.06.21 - 1963.04.21) Progressive Conservative Party *1958 G(208) O(56) Majority 152	Department of National Health and Welfare Jay Waldo Monteith - Minister		Manitoba, Newfoundland, Alberta and British Columbia create hospital insurance plans with federal cost sharing
1959		<i>Diefenbaker, John George</i>	Department of National Health and		Ontario, New Brunswick, Nova Scotia, and PEI

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		(1957.06.21 - 1963.04.21) Progressive Conservative Party *1958 G(208) O(56) Majority 152	Welfare Jay Waldo Monteith - Minister		create hospital insurance plan with federal cost sharing
1960		<i>Diefenbaker, John George</i> (1957.06.21 - 1963.04.21) Progressive Conservative Party *1958 G(208) O(56) Majority 152	Department of National Health and Welfare Jay Waldo Monteith - Minister		Northwest Territories and Yukon creates hospital insurance plan with federal cost sharing
1961		<i>Diefenbaker, John George</i> (1957.06.21 - 1963.04.21) Progressive Conservative Party	Department of National Health and Welfare Jay Waldo Monteith - Minister		Quebec creates hospital insurance plan with federal cost sharing Federal government creates Royal Commission on Health

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		*1958 G(208) O(56) Majority 152			Services to study need for health insurance and health services - Emmet M. Hall appointed Chair.
1962		<i>Diefenbaker, John George</i> (1957.06.21 - 1963.04.21) Progressive Conservative Party *1962 G(116) O(149) Minority 33	Department of National Health and Welfare Jay Waldo Monteith - Minister		Saskatchewan creates medical insurance plan for physicians' services - doctors in province strike for 23 days
1964		<i>Pearson, Lester Bowles</i> (1963.04.22 - 1968.04.19) Liberal Party of Canada *1963 G(129) O(136) Minority 7	Department of National Health and Welfare Julia Verlyn LaMarsh - Minister		Royal Commission on Health Services reports - recommends national health care programme
1965		<i>Pearson, Lester</i>	Department of		British Columbia creates

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		<i>Bowles</i> <i>(1963.04.22 - 1968.04.19)</i> Liberal Party of Canada *1963 G(129) O(136) Minority 7 1965 G(131) O(134) Minority 3	National Health and Welfare Julia Verlyn LaMarsh - Minister (until 1965.12.17) Allan Joseph MacEachen - Minister		provincial medical plan
1966		<i>Pearson, Lester</i> <i>Bowles</i> <i>(1963.04.22 - 1968.04.19)</i> Liberal Party of Canada *1965 G(131), O(134) Minority 3	National Health and Welfare Allan Joseph MacEachen - Minister 18.12.1965 - 05.07.1968	Canada Assistance Plan (CAP) introduced, creating a cost-sharing arrangement for social assistance programmes. Conditions attached to federal funding.	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				Medical Care Act (federal) proclaimed December 19 - provides 50/50 cost sharing for provincial/territorial medical insurance plans -comes into effect on July 1, 1968	
1968		<i>Pearson, Lester Bowles</i> <i>(1963.04.22 - 1968.04.19)</i> Liberal Party of Canada *1965 G(131), O(134) Minority 3 <i>Trudeau, Pierre Elliot</i>			Saskatchewan and British Columbia create medical insurance plans with federal cost sharing

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		<i>(1968.04.20-1979.06.03)</i> Liberal Party of Canada *1965 G(131), O(134) Minority 3 *1968 G(155), O(109) Majority 46			
1969		<i>Trudeau, Pierre Elliot</i> <i>(1968.04.20-1979.06.03)</i> Liberal Party of Canada *1968 G(155), O(109) Majority 46			Newfoundland, Nova Scotia, Manitoba, Alberta and Ontario create medical insurance plans
1970		<i>Trudeau, Pierre Elliot</i> <i>(1968.04.20-1979.06.03)</i> Liberal Party of			Quebec and PEI create medical insurance plan with federal cost sharing War Measures Act

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		Canada *1968 G(155), O(109) Majority 46			invoked due to conflict in Quebec
1971		<i>Trudeau, Pierre Elliot</i> (1968.04.20- 1979.06.03) Liberal Party of Canada *1968 G(155), O(109) Majority 46			New Brunswick and Northwest Territories create medical insurance plan with federal cost sharing National Action Committee on the Status of Women (NAC) established
1972		<i>Trudeau, Pierre Elliot</i> (1968.04.20- 1979.06.03) Liberal Party of Canada *1968 G(155), O(109) Majority 46 *1972 G(109), O(155) Minority			Yukon creates medical insurance plan with federal cost sharing

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		46			
1974	A New Perspective on the Health of Canadians	<i>Trudeau, Pierre Elliot</i> <i>(1968.04.20-1979.06.03)</i> Liberal Party of Canada *1972 G(109), O(155) Minority 46 * 1974 G(141), O(123) Majority 18	National Health and Welfare Marc Lalonde - Minister 27.11.1972-15.09.1977		
1977		<i>Trudeau, Pierre Elliot</i> <i>(1968.04.20-1979.06.03)</i> Liberal Party of Canada *2 completed terms in office with 2 remaining * 1974 G(141), O(123) Majority 18	National Health and Welfare Monique Begin - Minister 16.09.1977 - 03.06.1979	Established Programs Financing (EPF) was introduced with federal funding to be provided in equal parts through a tax transfer and a cash transfer. EPF replaced	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				cost-sharing programmes for health and post-secondary education. Provinces received 13.5 percentage points of personal income tax (PIT) and 1 percentage point of corporate income tax (OIT), including some points carried over from the previous post-secondary education programme. The value of	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				the transferred tax points was equalized. The value of the tax points was escalated by the growth rate of per capita GNP. EPF was to be distributed equal per capita over time.	
1979		<i>Clark, Charles Joseph</i> (1979.06.04 - 1980.03.02) Progressive Conservative Party *1979 G(136) O(146) Minority 10		Federal government creates health services review - Emmet M. Hall appointed Special Commissioner to re-evaluate publicly funded health care system	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
1980		<i>Trudeau, Pierre Elliot</i> (1980.03.03 - 1984.09.16) Liberal Party of Canada *1980 G(147) O(135) Majority 12		Health Services Review report released August 29 - recommends setting national standards and ending user fees and extra billing	
1981		<i>Trudeau, Pierre Elliot</i> (1980.03.03 - 1984.09.16) Liberal Party of Canada *1980 G(147) O(135) Majority 12		Provincial/Territorial reciprocal billing agreement for in-patient hospital services provided out-of-province/territory	
1982		<i>Trudeau, Pierre Elliot</i> (1980.03.03 - 1984.09.16)	National Health and Welfare Monique Begin -	GNP per capita escalator would be applied to the total EPF,	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		Liberal Party of Canada *1980 G(147) O(135) Majority 12	Minister 03.03.1980 - 16.09.1984	rather than EPF cash	
1983		<i>Trudeau, Pierre Elliot</i> (1980.03.03 - 1984.09.16) Liberal Party of Canada *1980 G(147) O(135) Majority 12	National Health and Welfare Monique Begin - Minister 03.03.1980 - 16.09.1984	The post-secondary education portion of EPF was limited to 6% and 5% growth for 1983-84 and 1984-85 under the "6&5" anti-inflation programme.	Royal Commission on Hospital and Nursing Home Costs, Newfoundland, (begins April reports February 1984) Comite d'etude sur la promotion de la sante, Quebec La Commission d'enquete sur les services de sante et les services sociaux, Quebec Federal Task Force on the Allocation of Health Care Resources (begins June, ends 1984)

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
1984		<i>Trudeau, Pierre Elliot</i> (1980.03.03 - 1984.09.16) Liberal Party of Canada *1980 G(147) O(135) Majority 12 <i>Turner, John Napier</i> (1984.06.17- 1984.09.16) Liberal Party of Canada *1980 G(147) O(135) Majority 12	National Health and Welfare Monique Begin - Minister 03.03.1980 - 16.09.1984 Jake Epp - Minister 17.09.1984 - 29.01.1989	EPF funding was conditional on respect for the five criteria of the <i>Canada Health Act</i> (universality, accessibility, portability, comprehensiveness, and public administration) and provisions for withholding funding were introduced.	The <i>Canada Health Act</i> was enacted. -
1985		<i>Mulroney, Martin Brian</i> (1984.09.17- 1993.06.24) *1984 G(211) O(71) Majority			Health Services Review Committee, Manitoba begins (ends November)

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		140			
1986	Achieving Health for All: A Framework for Health Promotion	<i>Mulroney, Martin Brian</i> (1984.09.17-1993.06.24) Progressive Conservative Party of Canada *1984 G(211) O(71) Majority 140	National Health and Welfare Jake Epp - Minister 17.09.1984 - 29.01.1989	EPF growth was reduced from GNP to GNP-2% indefinitely.	Health Review Panel, Ontario begins (reports June 1987)
1987		<i>Mulroney, Martin Brian</i> (1984.09.17-1993.06.24)			Premier's Council on Health Strategy, Ontario begins (ends 1991) Royal Commission on Health Care, Nova Scotia (ends 1989) Advisory Committee on the Utilization of Medical Services, Alberta (ends 1989) All provinces in

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
					compliance with the Canada Health Act by April 1
1988		<i>Mulroney,</i> <i>Martin Brian</i> <i>(1984.09.17-</i> <i>1993.06.24)</i> Progressive Conservative Party of Canada *1984 G(211) O(71) Majority 140			Provincial/territorial governments (except Quebec) sign reciprocal billing agreement for physician services provided out-of-province/territory Commission on Direction in Health Care, Saskatchewan (ends 1990) Premier's Commission on Future Health Care for Albertans, Alberta (ends 1989) Commission on Selected Health Care Programs, New Brunswick (ends 1989)
1989		<i>Mulroney,</i>	Health and Welfare	Budget	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		<i>Martin Brian</i> (1984.09.17-1993.06.24) Progressive Conservative Party of Canada *1984 G(211) O(71) Majority 140 *1988 G(169) O(126) Majority 43	Canada Henry Perrin Beatty - Minister 30.01.1989 - 20.04.1991	announced that EPF growth would be further reduced to GNP-3% beginning in 1990-91.	
1990		<i>Mulroney, Martin Brian</i> (1984.09.17-1993.06.24) Progressive Conservative Party of Canada *1984 G(211) O(71) Majority 140 *1988 G(169) O(126) Majority 43	Health and Welfare Canada Henry Perrin Beatty - Minister 30.01.1989 - 20.04.1991	Growth in CAP transfers to 3 non-Equalization provinces (Ontario, Alberta and B.C.) limited to 5% annually for 1990-91 and 1991-92. The EPF per	Royal Commission on Health Care and Costs, British Columbia (ends 1991)

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				capita transfer was frozen for 1990-91 and 1991-92 for all provinces.	
1991		<i>Mulroney, Martin Brian</i> <i>(1984.09.17-1993.06.24)</i> Progressive Conservative Party of Canada *1984 G(211) O(71) Majority 140 *1988 G(169) O(126) Majority 43	Health and Welfare Canada Henry Perrin Beatty - Minister 30.01.1989 - 20.04.1991 Benoit Bouchard - Minister 21.04.1991 - 17.06.1993	Budget extended the EPF freeze and CAP growth limit, introduced in 1990-91, for three more years to 1994-95.	National Task Force on Health Information (federal) - leads to creation of Canadian Institute of Health Information (CIHI)
1993		<i>Cretien, Joseph Jacques Jean</i> <i>(1993.11.04-2003.12.11)</i> Liberal Party of Canada *one year	Benoit Bouchard - Minister 21.04.1991 - 17.06.1993 Bernard Valcourt - Acting Minister		November 4, 1993 , the minister was formally appointed to the existing portfolio (National Health and Welfare) from which the new portfolio (Health) was being created. The

Chronology					
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		completed of first of three terms *1993 G(177) O(118) Majority 59	18.06.1993 - 24.06.1993 Mary Collins - Minister 25.06.1993 - 03.11.1993 Diane Marleau - Minister 04.11.1993 - 2.01.1996		new responsibilities took effect immediately.
1994	Strategies for Health Promotion - Investing in the Health of Canadians	<i>Cretien, Joseph Jacques Jean (1993.11.04-2003.12.11)</i> Liberal Party of Canada *one year completed of first of three terms *1993 G(177) O(118) Majority 59	April Diane Marleau - Minister 04.11.1993 - 24.01.1996	Budget announded that total CAP and EPF transfers in 1996-97 would be no higher than in 1993-94	April Government mandated the <i>Information Highway Advisory Council (IHAC)</i> 1994-1997 to investigate the development and use of the information highway for the economic, cultural and social advantage of all Canadians. October PM launched the

Chronology					
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					<i>National Forum on Health (NFOH)</i> (1994-1997) to advise gov't on ways to improve HC sys.
1995		<p><i>Cretien, Joseph</i> <i>Jacques Jean</i> <i>(1993.11.04-2003.12.11)</i> Liberal Party of Canada *two years completed of first of three terms *1993 G(177) O(118) Majority 59</p>	<p>Health and Welfare Canada</p> <p>Diane Marleau - Minister 04.11.1993 - 24.01.1996</p>	<p>Announced that, starting in 1996, EPF and CAP programmes would be replaced by a Canadian Health and Social Transfer (CHST) block fund.</p> <p>For 1995-96, EPF growth was set at GNP-3 and CAP was frozen at 1994-95 levels for all provinces.</p> <p>CHST was set</p>	<p><i>IHAC</i> presented its final report in Sept. One of its 300 recommendations called for the creation of an advisory council to identify new information technology applications for the health sector.</p>

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				at \$26.9B for 1996-1997 and \$25.1B for 1997-98. CHST for 1996-97 was allocated among provinces in the same proportion as combined EPF and CAP entitlements for 1995-96.	
1996	Towards a Common Understanding: Clarifying the Core Concepts of Population Health	<i>Cretien, Joseph Jacques Jean (1993.11.04-2003.12.11)</i> Liberal Party of Canada *three years completed of first of three terms *1993 G(177) O(118) Majority	Health and Welfare Canada Diane Marleau Minister - 04.11.1993- 24.01.1996 David Dingwall Minister - 25.01.1996-	Announced a 5-year CHST funding arrangement (1998-1999 to 2002-03) and provided a cash floor of \$11B/year. For 1996-97 and 1997-1998,	

Chronology					
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		59	11.07.1996 <i>Health Canada</i> David Dingwall Minister 12.07.1996- 10.06.1997	total CHST was maintained at \$26.9B and \$25.1B respectively. Thereafter the transfer was set to grow at GDP-2%; GDP-1.5% and GDP-1% for next 3 years. A new allocation formula was introduced to reflect changes in provincial population growth and to narrow existing funding disparities, moving halfway to equal per capita	

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				by 2002-03.	
1997		<i>Cretien, Joseph</i> <i>Jacques Jean</i> <i>(1993.11.04-</i> <i>2003.12.11)</i> Liberal Party of Canada *end of first term <i>Election year</i> *1993 G(177) O(118) Majority 59 *1997 G(155) O(146) Majority 9	Health Canada David Dingwall Minister 12.07.1996- 10.06.1997 Allan Rock Minister 11.06.1997 - 14.01.2002		Health Transition Fund Established (HTF) *150M fund which from 1997-2001 supported 140 projects across Canada to test and evaluate innovative ways to deliver health services. (federal money with collaboration between federal, provincial and territorial partners. NFOH report -concluded that a prime objective should be the rapid development of an evidence-based health system in which decisions would be made by health care providers, administrators, policy makers, patients and the public on the basis of

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
					<p>appropriate, balanced and high-quality evidence. -recommended the creation of a nationwide health information system</p> <p>Office of Health and the Information Highway (OHIH) established - Health Canada's focal point for all matters concerning information technology -focused on knowledge development, partnerships and collaboration and federal policy development</p> <p>August Minister of Health established the <i>Advisory Council on Health Infostructure</i> (1997-1999)</p>

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
					September The <i>Canadian Network for the Advancement of Research, Industry and Education</i> (CANARIE) issued a vision paper describing a <i>Health Iway</i> - a virtual information centre that is created and used by communities and individuals across Canada.
1998	Taking Action on Population Health	<i>Cretien, Joseph</i> <i>Jacques Jean</i> (1993.11.04-2003.12.11) Liberal Party of Canada *one year completed of second of three terms *1993 G(177) O(118) Majority 59	Health Canada Allan Rock - Minister 11.06.1997-14.01.2002	CHST legislation put in place a \$12.5B cash floor beginning in 1997-98 and extending to 2002-03. National Child Benefit established - a collaborative	February Health Canada hosted a 2-day meeting of senior government officials to discuss impediments to the application of info management and technology within Canada's health system. The <i>Federal, Provincial, Territorial Chief Info Officers Forum</i> (1998-1999) recognized the

Chronology					
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		*1997 G(155) O(146) Majority 9		tax policy which aims to prevent and reduce the depth of child poverty in Canada, promote labour market attachment by ensuring that families will always be better off as a result of working, and reduce overlap and duplication by harmonizing programme objectives and benefits across jurisdictions.	benefits of intergovernmental collaboration.
1999		<i>Cretien, Joseph Jacques Jean (1993.11.04-</i>	Health Canada Allan Rock	Announced CHST funding increased by	<i>National Children's Agenda (NCA) - an intersectoral and</i>

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		2003.12.11) Liberal Party of Canada *two years completed of second of three terms *1993 G(177) O(118) Majority 59 *1997 G(155) O(146) Majority 9	Minister 11.06.1997 - 14.01.2002	\$11.5B over 5 years specifically for health care. Changes made to allocation formula to move to equal per capita CHST by 2001-02.	intergovernmental policy to ensure that all Canadian children have the best opportunity to develop to their fullest potential. - Four goals: good health, safety and security, success at learning, social engagement and responsibility. <i>Social Union Framework Agreement</i> - a collaborative framework which lays out the principles and process for achieving integrated social policy development with the federal and provincial governments. <i>The Second Report on the Health of Canadians</i> released.

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
					<p>February</p> <p><i>Advisory Council on Health Infostructure</i> released report</p> <p>-affirmed the setting up a nationwide health information highway could significantly improve the quality, accessibility and efficiency of health services.</p> <p>-identified four objectives:</p> <ol style="list-style-type: none"> 1. developing a Canadian vision of a health information system and identifying the specific needs it should meet 2. generating a federal action agenda to implement the most vital components of the system 3. suggesting collaborative mechanisms

Chronology					
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					<p>to achieve a Canadian consensus on an integrated health system</p> <p>4. identifying issues, challenges and barriers to the effective use of information and communications technologies and recommending possible solutions.</p> <p>June The <i>F/P/T Chief Info Officers Forum (1998-1999)</i> evolved into the <i>Advisory Committee on Health Infostructure (ACHI) (1999-2002)</i> at the federal, provincial, territorial Deputy Ministers of Health Conference ACHI has federal, provincial, territorial</p>

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
					<p>representatives (including working groups addressing five priorities:</p> <ol style="list-style-type: none"> 1. strategic planning 2. telehealth, 3. protection of personal health information, 4. health surveillance, and 5. electronic health records <p>Social Union Framework Agreement (SUFA) in force</p> <p>- federal, provincial and territorial governments (except Quebec agree to collective approach to social policy and programme development, including health</p>
2000		<i>Cretien, Joseph Jacques Jean (1993.11.04-</i>	Health Canada Allan Rock	February \$2.5B increase for the CHST	Canada Health Infrastructure Partnership Programme established.

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		<p>2003.12.11)</p> <p>Liberal Party of Canada</p> <p>*first year of last of three terms</p> <p>Election Year</p> <p>*1993 G(177) O(118) Majority 59</p> <p>*1997 G(155) O(146) Majority 9</p> <p>*2000 G(172) O(129) Majority 43</p>	<p>Minister</p> <p>11.06.1997 - 14.01.2002</p>	<p>to help p/t fund post-secondary education and health care (CHST cash - \$15.5B for each of the years from 2000-02 to 2003-04)</p> <p>September</p> <p>First Ministers agreed on an action plan for renewing health care and investing in early childhood development. \$21.1B in additional CHST including \$2.2B for early</p>	<p>(2000-2002) - \$80M, shared-cost incentive programme aimed at supporting collaboration, innovation and renewal in health care delivery through the use of information and communications technology.</p> <p>June</p> <p>CIHR established. designed to link biomedical research, clinical research, health systems and population and public health research. CIHR includes several institutes, including the institute of Population and Public Health, the Institute of Aboriginal Health, and the Institute of Childhood</p>

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
				childhood development over 5 years.	and Youth Health September in support of first ministers agreement the federal government announced that it would invest \$500 Million immediately in an independent corporation mandated to accelerate the development and adoption of modern system of information technology, such as electronic patient records
2001		<i>Cretien, Joseph Jacques Jean (1993.11.04- 2003.12.11)</i> Liberal Party of Canada *1 year completed of last of three terms	Health Canada Allan Rock Minister 11.06.1997 - 14.01.2002		March \$500 million given to <i>Canada Health Infoway Inc.</i> (non-profit) to foster and accelerate the development and implementation of effective electronic health solutions

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		*1993 G(177) O(118) Majority 59 *1997 G(155) O(146) Majority 9 *2000 G(172) O(129) Majority 43			Standing Senate Committee on Social Affairs, Science and Technology review (Kirby Committee) - federal (begins March, reports October 2002) Commission on the Future of Health Care in Canada (Romanow Commission) - federal (begins April reports November 2002)
2002		<i>Cretien, Joseph</i> <i>Jacques Jean</i> <i>(1993.11.04-2003.12.11)</i> Liberal Party of Canada *two years completed of last of three terms *1993 G(177) O(118) Majority	Health Canada Allan Rock Minister 11.06.1997 - 14.01.2002 Anne McLellan Minister 15.01.2002 - 11.12.2003		ACHI evolved into the <i>Advisory Committee on Information and Emerging Technologies</i> *comprised of representatives from federal, provincial, territorial governments as well as six external experts. Its mandate was to address 5 priorities:

Chronology					
Date	Title of Document	Governing Party	Dept. Structure	Funding	Events
		59 *1997 G(155) O(146) Majority 9 *2000 G(172) O(129) Majority 43			1. emerging technologies assessment, 2.genomics, 3. pharmaceuticals strategic advances, 4. strategic directions for a pan-Canadian health infostructure (includes IT) and 5. privacy
2003		<i>Cretien, Joseph Jacques Jean (1993.11.04- 2003.12.11)</i> Liberal Party of Canada *last of final term *1993 G(177) O(118) Majority 59 *1997 G(155) O(146) Majority 9 *2000 G(172)	Anne McLellan Minister 15.01.2002 - 11.12.2003 Pierre S. Pettigrew Minister 12.12.2003 - 19.07.2004	February In support of the 2003 First Minister's Accord on Health Care Renewal, budget confirmed: 1. a 2-year extension to 2007-08 of the 5-year legislative framework put	February in support of the 2003 First Minister's Accord on Health Care Renewal, the 2003 budget announced the provision of an "additional \$600 million to Canada Health Infoway to accelerate the development of EHRs, common information tech standards across the country and the further development of telehealth application which are

Chronology					
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		O(129) Majority 43		<p>in place in Sept.2000 with an additional \$1.8B</p> <p>2. a \$2.5B CHST supplement, giving provinces the flexibility to draw down funds as they require up to the end of 2005-06 and</p> <p>3. the restructuring of the CHST to create a separate Canada Health Transfer and Canada Social Transfer effective April</p>	critical to care in rural and remote areas

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				<p>1, 2004 in order to increase transparency and accountability.</p> <p>March \$900M over 5 years in increased federal support for ELCC. On March 13, 2003 federal and prov. Social Services Ministers reached an agreement on a framework to improve ELCC programmes and services. In 2003-04, funding was</p>	

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				provided through the former CHST and in subsequent years through the CST.	
2004		<p><i>Martin, Paul Edgar Philippe</i> (2003.12.12 - 2006.02.05) Liberal Party of Canada *11 years of Liberal Party governing, first year of first of two terms</p> <p>*2000 G(172) O(129) Majority 43 *2004 G(135) O(173) Minority 38</p>	<p>Health Canada</p> <p>Pierre S. Pettigrew Minister 12.12.2003 - 19.07.2004</p> <p>Ujjal Dosanjh Minister 20.07.2004 - 05.02.2006</p>	<p>January \$2B committed through the CHST supplement for health - notionally allocated equally over 2004-05 and 2005-06.</p> <p>March additional \$75M for early learning and child care in each of 2004-</p>	<p>March additional \$100 million was granted to Infoway to support the development of a pan-Canadian health surveillance system</p> <p><i>OHIH's Privacy Policy division (now the Access to Information and Privacy Division) became part of Health Canada's Health Policy Branch. The remainder of OHIH joined Health Canada's Corporate Services Branch and is known as the Health and the</i></p>

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				<p>05 and 2005-06. funding would reach \$350M starting in 2007-08.</p> <p>April CHST was restructured and 2 separate transfers were created (Canadian Health Transfer - CHT and the Canadian Social Transfer - CST)</p> <p>September \$41.3B in additional funding committed to p/t in support</p>	<p><i>Information Highway (HIH) section</i></p> <p>September First Minister signed the <i>10-Year Plan to Strengthen Health Care</i></p>

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				of the <i>10-Year Plan to Strengthen Health Care</i> *this includes \$35.3B in increases to the CHT through a base adjustment and an annual 6% escalator, \$5.5B in Wait Times reduction funding and \$500M in support of medical equipment.	
2005	The Integrated Pan-Canadian Healthy Living Strategy	<i>Martin, Paul Edgar Philippe</i> (2003.12.12 - 2006.02.05) Liberal Party of	Health Canada Ujjal Dosanjh Minister - 20.07.2004 -	Budget introduced <i>Early Learning and Child Care Initiative</i>	

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		Canada *12 years of Liberal Party governing, second year completed of first of two terms *2000 G(172) O(129) Majority 43 *2004 G(135) O(173) Minority 38	05.02.2006	(ELCC) providing \$5B over five years to p/t to support development of a national ELCC framework.	
2006		<i>Harper, Stephen Joseph</i> <i>(2006.02.06 - present)</i> Conservative Party of Canada *2006 G(124) O(183) Minority 59	Health Canada Tony Clement Minister 06.02.2006 - present	September Budget provided \$3.3 billion through 5 third-party trusts to help provinces and territories deal with immediate pressures in	

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				<p>post-secondary education (\$1 billion), affordable housing (\$800 million), Northern affordable housing (\$300 million), off-reserve Aboriginal housing (\$300M) and public transit capital (\$900M)</p> <p>May Budget replaced ELCC Initiative with the new <i>Universal Child Care</i></p>	

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				<i>Benefit (UCCB)</i> which provides parents with \$100/month for every child under the age of 6 (effective July 1, 2006)	
2007		<i>Harper, Stephen Joseph</i> (2006.02.06 - present) Conservative Party of Canada *2006 G(124) O(183) Minority 59		Budget proposes to restructure the CST to provide equal per capita support to provinces and territories effective 2007-08. Funding to be increased by \$687 million to support new allocation. In 2008-09 increased by	

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				<p>\$800 million for post-secondary education and by \$250 million for the development of child-care spaces.</p> <p>Similar changes to be made to the CHT effective 2014-15 when its current legislation is renewed.</p> <p>Federal support for post-secondary education, social programmes,</p>	

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				and children will be notionally earmarked to make the federal contribution through transfers more transparent.	



