10 GOVERNING THROUGH PREVENTION
Lifestyle and the Health Field Concept

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Introduction

According to the World Health Organization (WHO), dementia affected 47 million people globally in 2015, and this number is expected to increase to 132 million by 2050 (WHO 2017). The WHO estimated the direct medical, social, and informal care costs in 2015 at US$818 billion, or 1.1 percent of global gross domestic product, and these costs are expected to rise to US$2 trillion by 2030. Seen against the backdrop of increasing financial pressure on the health-care system, the WHO declared dementia a "public health priority." Furthermore, no definitive pharmaceutical solution for the treatment of dementia exists, and so far, more than two hundred drugs have failed in development in the last thirty years (Solomon et al. 2014). Even newer anti-amyloid therapeutic trials of drugs for Alzheimer's disease have also led to upsetting results (Doody et al. 2014; Karran and Hardy 2014; Salloway et al. 2014). Some scholars (Feldman and Estabrooks 2017) warn that many pharmaceutical companies are leaving the field of research given the costs of development failure. These dire predictions are coming at a time when social services, including health-care systems, are being transformed all over the (Western) world through the injection of "economic rationality into social spheres and practices that previously were primarily free of economic logics and pressures" (Hardt and Negri 2017: 219). Large parts of populations are experiencing increasing precarity with the creeping privatization of formerly publicly funded and administered social and health-care services. Health-care professionals are being replaced by unlicensed assistants or underqualified personnel.

The WHO's (2017: 4) action plan is meant to help realize a "world in which dementia is prevented," a somewhat surprising statement given that until recently, dementia was diagnosed after first symptoms were detected. Treatments tend to start only postdiagnosis and generally consist of med-

ications in combination with psychiatric drugs, and sometimes psychosocial interventions. The WHO's somewhat optimistic vision is based on newer research that demonstrated a correlation between the development of cognitive impairment and what the action plan calls "lifestyle-related risk factors." Related also to chronic diseases like diabetes (especially type 2) and hypertension, these risk factors include physical inactivity, obesity, an unbalanced diet, tobacco use, and abuse of alcohol. Risk factors specific to dementia include midlife depression, low educational attainment, social isolation, and cognitive inactivity. In order to attain its ambitious goal, the action plan emphasizes the need to reduce the level of exposure of "individuals and populations to these potentially modifiable risk factors, beginning in childhood and extending throughout life," by supporting them "to make healthier choices and to follow lifestyle patterns that foster good health" (WHO 2017: 18) .

Thus, the WHO's ideas on prevention of dementia is closely related to its Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Dementia, once considered a person's fate, is now understood as preventable, provided the individual engages in a lifelong process that begins in early childhood. This process not only alludes to a physically healthy lifestyle but touches on all aspects of life. For example, individuals are encouraged to pursue activities to stimulate the brain, like learning to play a musical instrument, reading a book, or going to the theater. They should be socially active, participating in service clubs or doing volunteer work (Alzheimer Society Canada 2018). Some research emphasizes the strong correlation between dementia and poor social engagement (Vernooij-Dassen and Jeon 2016), whereas other research (Ihle et al. 2016) suggests that even a cognitively engaged lifestyle is not enough because it does not consider the personality dimension of the individual. Individuals with a high openness to experience may have been more engaged in stimulating activities in early life, increasing their cognitive reserve, which in turn enhances their cognitive performance level in old age. A Finnish randomized controlled proof-of-concept trial (Ngandu et al. 2015) confirmed the association between the different risk factors and concluded that one-third of Alzheimer's cases worldwide are attributable to seven modifiable factors (see also Feldman and Estabrooks 2017). The findings of the Finnish FINGER study suggest that it is not enough to focus only on one aspect of lifestyle change, but that all the different dimensions need to be addressed at the same time if dementia is to be successfully prevented. Thus, recommendations for the prevention of dementia comprise normative and moral requirements of how subjects should behave responsibly in living their lives. The idea of responsibility thereby refers not only to one's personal way of life, but also to society at large, given the financial burdens

arising from the increase of dementia. Furthermore, the responsible self has to engage in continuous work of the self on the self. Health insurance in Canada and other countries increasingly use reward systems to promote healthy lifestyles. Under the slogan "Do More—Get More. Get Apple Watch. Get Active. Get Rewarded," insurance companies like Manulife in Canada encourage policyholders to track their physical activities to earn so-called vitality points, allowing them discounts on their health insurance (and incidentally providing the insurer with valuable personal data free of charge) (Manulife 2019).

What is strangely missing in these concepts are socioeconomic conditions and the so-called social determinants of health, despite the fact that the prevalence of dementia is not equally distributed globally or locally throughout all segments of populations. In the WHO action plan, the term "social determinants of health" is mentioned only once and socioeconomic factors are not discussed at all; likewise, in much of the research on risk factors, social determinants of health are mentioned only in passing, if at all. Studies of dementia in Canada, for example, have demonstrated not only higher prevalence rates in First Nations communities as compared to others, but that this rate also rose more quickly, and disproportionally affects younger age groups and males, in First Nations populations (Jacklin, Walker, and Shawande 2013). Research from Australia on the prevalence of dementia among Indigenous peoples there came to comparable conclusions (see, e.g., Smith et al. 2008). Nearly 60 percent of people living with dementia currently live in low- and middle-income countries, and most of the expected new cases (71 percent) will occur in these countries (WHO 2017). The omission of socioeconomic factors is not attributable just to neglect on the part of authors but is more due to the (neo)liberal rationale, in which societal disparities are part and parcel of a society that is based on competition, and where citizens are conceptualized as autonomous rational actors (*homo oeconomicus*) with personal responsibility for their health.

In this paper, I develop a critical perspective on the concept of lifestyle by providing what Foucault called the "history of the present" (see, e.g., Foucault 1980, 1995; Foucault and Perrot 1980). This genealogical inquiry aims to critically question how the concept of lifestyle evolved into such a taken-for-granted assumption in the context of the prevention of chronic diseases—including dementia. In order to determine what is politically at stake if dementia is thought of as a disease determined in large part by the way of life one lives, it is necessary to better understand the rationale that led to the adoption and implementation of this way of thinking in public health and the political and economic conditions within which it became the leading paradigm. Thus, I will trace how the concept of lifestyle, based on the idea that people did not die because they lacked access to medical

care but because they lived a life prone to personal risk taking, was integrated into a new preventive strategy in the Canadian context.

In 1974, the Long Range Health Planning Branch (LRHPB) of the Department of National Health and Welfare released a green paper titled *A New Perspective on the Health of Canadians: A Working Document*. This report, better known as the Lalonde Report after the health minister at that time, was not a policy declaration but rather a thought experiment meant to formulate perspectives on health for then prime minister Pierre Trudeau's liberal government. As McKay (2000: 3) contends in her study, *Making the Lalonde Report*, the report officially inaugurated a "paradigm shift" by "giving birth to health promotion." She rightfully emphasizes that "fate was replaced by risk" (17). I choose the Lalonde report as the starting point of my analysis because even though this document did not receive much media attention in Canada, Hubert Laframboise, the director general of the LRHPB, stated that by 1978, "the Working Document had become an integral element of health policy planning not only in Canada but in many other countries" (Laframboise 1978 as cited in McKay 2000: 2). And indeed, the main concepts and ideas developed in this report became the foundation of public health policies in many different European countries and the United States (see, e.g., Larsen 2012) at a time when neoliberalism became the underlying rational in the transformation of the welfare state in general, and health-care systems more specifically.

However, the concept of lifestyle was only one component in what the authors of the Lalonde report called the Health Field Concept, which connected lifestyle with the subjects' environment, biology, and the organization of the health-care system. Improving public health, according to the Health Field Concept, meant for public health authorities to adopt specific strategies in order to govern the respective four dimensions, maintaining the state as an important player despite delegating responsibility for healthy lifestyles to the individual. Already in 1988, the WHO adopted the Canadian conceptualization of health prevention, and since then it has been perpetuated in the organization's global strategies for the prevention of chronic diseases and dementia prevention.

Although I agree with scholars who criticize the use of the concept neoliberalism in the context of public health, turning it into a "totalizing and monolithic" entity and "reifying it into a globally dominant force or stage of history" (Bell and Green 2016: 240–241), I am convinced that "naming neo-liberalism is *politically* necessary to give the resistance to its onward march content, focus, and a cutting edge" (Hall 2011: 206; see also Peck 2010). From my perspective, neoliberal governance is a "governing rationality that cannot be understood merely in terms of its general economic policies: the privatization of public services and industries, the deregulation

of markets and firms, the destruction of labor unions, and so forth" (Hardt and Negri 2017: 222). Instead, neoliberal transformations have changed the way we understand ourselves and our health, and have emphasized our responsibility to stay healthy through everything from mindful practices like yoga and meditation to regular workouts in the gym. These transformations also have changed our perception of what causes chronic illnesses and how we should conduct ourselves to prevent them.

Thus, the Lalonde report assumed that health is no longer something that happens to a person but is created through a personally chosen lifestyle; one is expected to assume responsibility for one's behavior (see, e.g., Glouberman 2001). Stephen Katz (2013), who analyzed the use of lifestyle in the discourse of successful aging, concludes that lifestyles are conceptualized "as volitional and discretional; an assumption buoyed by empirical data favoring individualistic principles of choice and identity over processes of social constraint and historical contingency" (53), and "as a narrow and individualistic set of practices overdetermined by their relationship to empirically driven pre-dictors of successful aging" (61). Others, using Foucault's notion of biopolitics, assert that "the biopolitical rationality operating in lifestyle and in new public health strategies stresses individual responsibility for establishing a healthy lifestyle that conforms to biomedical norms despite structural forces that may or may not influence these choices" (Mayes 2017: 65). According to this perspective, the concept of lifestyle combines freedom, choice, and responsibility of citizens (see also Larsen 2012). Health becomes an infinite project that the individual must actively pursue and seek to perfect for "oneself and for the security of the population" (Mayes 2017: 65) Thus, "the lifestyle network makes a healthy lifestyle a visible indicator of the neoliberal subject's success or failure to take responsibility for their own future and that of their family and society" (65). The (neoliberal) state, so the critique goes, uses the concept of lifestyle to withdraw from health policies by empowering the subject to do what, before, the state would have done. The task left for the state is to educate individuals in order to prevent chronic diseases. According to this critique, "The individual [becomes] the *only* actor to reduce the economic and social costs of chronic disease" (62, original emphasis).

By linking health to lifestyle, individual responsibility, and self-control, other scholars have also noticed the privatization of risk management (see, e.g., LeBesco 2011; Peterson and Lupton 1997; Rose 2005, 2007a). Privatized risk management, according to these scholars, became an obligation for responsible citizens and should result in lifestyle modification based on "rational choices between healthcare needs and scarce resources" (Bell, McNaughton, and Salmon 2011: 3). Despite the fact that these authors

were well aware that the new public health approach implied a conceptualization of risks outside the individual's control, like the environment, most of them concentrated on the privatization of risks.

While I agree with these critiques, I argue that important political aspects of the concept of lifestyle are lost if it is reduced solely to the subject's responsibilization without analyzing how preventive, healthy behavior is actually produced in the first place. In other words, critiques of lifestyle tend not to analyze in much detail the fact that governments actively influence and restrict fields of possible action, making some individual choices more likely or attractive than others and sometimes prohibiting others. Thus, the concept of lifestyle must rather be understood as part of a strategy aimed at influencing the preventive behavior of individuals without necessarily forcing or coercing them; it is more about changing "individual behavior in a democratic fashion" (Lalonde 2002: 150).

Considering that the element of lifestyle was only one of four elements that made up the original comprehensive Health Field Concept of the Lalonde report, which in 1988 also became the foundation for the WHO's Global Health for All Strategy, it becomes clear that the significance of "the state" did not diminish as some critiques suggest. I would even say that quite the opposite might be true.

The decisive difference to the former politics of the welfare state was that "the state" did indeed reduce its financial investments in the provision of health-care services but was and still is heavily engaged in the three other areas of the Health Field Concept, both through legislative and regulative measures, and through research funding and interventions in organization of the health-care system. Thus, the second central point of this chapter is to contribute to a better understanding of the role the state and international organizations like the WHO played and still play in the neoliberal management of public health in general and dementia in particular. Indeed, the concept of lifestyle cannot be perceived as merely evoking the absence of the state. Only through the complex interplay among different forms of power is a politics of lifestyle feasible.

The report recommended what Laframboise (1990) called "specific courses of action" (319) and proposed five strategies (health promotion, regulatory, research, health care efficiency, and goal-setting), and seventy-four possible courses of action (Lalonde 2002). Glouberman (2001: 13) emphasized that "a great deal of health policy over the next 25 years could be described in terms of these tools. . . . [T]he tool of reorganization has been applied to every system of health care organization in Canada." Many of the recommendations made in the report became guiding principles for other governments in the transformations of their respective health-care systems (see, e.g., Larsen 2012).

These tools became as well part of the WHO strategy for the prevention of dementia. Its action plan was preceded by different global political initiatives. The 2013 G8 dementia summit held in London, for example, underscored the key nature of prevention in reducing the human, social, and economic burdens of dementia. The ministers of health particularly agreed to explore the "possibility of developing a private and philanthropic fund to support global dementia innovation" (G8 Health and Science Ministers 2013: 1) and committed to carry out twelve dementia public health policy actions, with France and Canada leading the initiative.

In what follows, I will describe what McKay (2000) called a paradigm shift of health promotion, but I will also emphasize that the Lalonde report also clearly demonstrates Foucault's definition of governmentality (see, e.g., Bröckling, Krasmann, and Lemke 2011b; Dean 2010; Foucault 2007; Walters 2012). Government understood as the "conduire des conduites" (conduct of conduct) (Foucault 2001: 1056) comprises strategies and tactics to change behavior according to specific norms and particular ends (Dean 2010). The report must be understood as a *dispositif*, something that Foucault (1994) defined as a "heterogeneous ensemble" of differential elements like discourses, institutions, architectures, regulated decisions, laws, etc.—the spoken as well as the unspoken—and a kind of operator to deal with and to resolve problematic social questions. Lalonde (2002) clearly identified the social "emergency" to which the "comprehensive Health Field Concept" was the strategic response: the rising costs of the health-care system at that time and the concern that the health status of the population was not improving in proportion to the increasing costs of health care. And, I would add, it was also the (neoliberal) conviction, as formulated by UK Secretary of State for Health and Social Security Patrick Jenkin (1981: 240), that it is not the responsibility of the authorities "to care for us from the cradle to the grave so that we have no responsibility."

Using the idea of prevention, the report contributed to a neoliberal transformation of health care despite the fact that the Canadian system of Medicare was based on the idea of universality, meaning citizens had equal access to health care independent of their socioeconomic situation. As I will demonstrate, the Lalonde report undermined this foundation and initiated a profound reorientation, not only of the health-care system, but even more importantly, it radically changed the way we think about our behavior around health-related issues. This chapter will therefore discuss this dimension of the report in some detail and relate it to Foucault's notion of subjectivity and technologies of the self. An analysis of the report also enables a better understanding of the emergence of neoliberalism as a leading governmental rationality. Instead of understanding neoliberalism as a monolithic strategy of capitalism, the Lalonde report, published before

neoliberalism became a leading rationale, demonstrates that neoliberalism must rather be understood as the result of the merging of different practices. The report also shows that often surprising coalitions emerge; in this case, the discourse about an ineffective health-care system merged with the anti-biomedical movement opposed to the unrestricted power of medicine.

In the following section, I describe the Lalonde report and the context in which it emerged. In the second section, I propose governmentality as my theoretical frame of reference for the analysis of the Health Field Concept, which will be followed by the genealogy of the concept and the significance of the lifestyle element for governing the health of populations through prevention. I will discuss the theoretical shift the authors of the Lalonde report performed by replacing the traditional historical narrative about preventive medicine with a particular biohistory based on demographic/epidemiological data. This narrative was then linked to the neoliberal reorientation of health promotion with the idea of responsibilization of individuals and the population at large for their health.

The Making of the Lalonde Report and Its International Significance

As mentioned in the introduction, the Lalonde report was named after Marc Lalonde, minister of national health and welfare between 1972 and 1977 under Pierre Trudeau's liberal government. Lalonde, who was a lawyer, was minister of justice in 1978, and in 1980 minister of energy, mines and resources. In an article in which he retrospectively evaluated the significance of the Lalonde report, he identified two major concerns the liberal government had been confronted with in the 1970s that had resulted in a necessary paradigm shift in the government of public health: the spiraling health-care costs and their failure to lead to the improved health of the population (Lalonde 2002). Mandated by Lalonde, Hubert Laframboise, a high-ranking civil servant in the federal health ministry, formed the Long Range Health Planning Branch (LRHPB) to redefine the approach to public health. The LRHPB was conceptualized as a "free-wheeling think tank" composed of epidemiologists, policy consultants, statisticians, and accountants (Laframboise 1990: 320). Basing their work on the WHO definition of health, the LRHPB committee members were tasked to "think outside the box" (Lalonde 2002:149). The result was the Lalonde report, which introduced the Health Field Concept, or a "sort of map of the health territory," as an overarching conceptual framework that included four elements: lifestyle, environment, health-care organization, and human biology (Lalonde [1974] 1981: 31).

Many of the arguments made in the 1970s regarding the inefficiency and ineffectiveness of health-care systems are similar to the ones made today in the context of dementia. As was the case in the 1970s, public health experts complain that too much money is spent on people who are already sick and not enough resources are provided for the prevention of dementia. And as was the case at the time of the Lalonde report, it is predicted that these costs will "only trend upwards" (Chow et al. 2018: 3).

International Significance of the Health Field Concept Today

As I will discuss in more detail in my analysis of the Health Field Concept, even before the official launch of the report, the concept was already aligned with both the WHO and the Pan American Health Organization (PAHO). Lalonde himself received the WHO Medal for his contribution to health policy in 1988 and became one of twelve "Public Health Heroes who have shaped the past 100 years of international public health" as selected by PAHO on the occasion of the one hundredth anniversary of the organization (Canadian Medical Association 2004). Lalonde was appointed an Officer of the Order of Canada in 1989 and was inducted into the Canadian Medical Hall of Fame in 2004.

However, the Lalonde report did not receive much media attention in Canada itself despite the fact that the government distributed fifty thousand copies of it. On the occasion of his nomination by PAHO, Lalonde (2002: 150) described the launch of the report as a "non-event." The opposition in Canada criticized the paper as "being against sin and for motherhood," and some argued that they had already known that it "was better to be slim than fat." But the reaction outside Canada was more enthusiastic, with Lalonde stating that the report was a "Canadian government 'best-seller,'" with well over two hundred thousand copies distributed. Sir George Godber, the former chief medical officer of Britain's Department of Health and Social Services, praised the report for its "worldwide effect" on governments (Godber as cited in Laframboise 1990: 316). Laframboise (1990: 316) argued that "reviews and citations in professional journals were myriad and enthusiastic," and authors such as Milton Terris (1984: 327), former president of the American Public Health Association, called the report a "world-class document" that "was and remains one of the great achievements of the modern public health movement." He even went so far as to categorize the report as a "second epidemiological revolution" that provided a "framework of an overall philosophical outlook" (327). According to Lalonde (2002: 150), French minister of health Simone Veil (1974–1979) and US secretary of health, education, and welfare under Jimmy Carter, Joseph A. Califano (1977–1979) both announced shortly after the report's publi-

cation that they would "pursue an approach similar" to the Health Field Concept. It was after the publication of the US surgeon general's report, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention 1979*, that the US government officially implemented the shift to "epidemiologically oriented health planning [and] to planning for outcomes" as propagated by the Lalonde report, and followed its "goal-setting strategy." As in the case of Canada, the Reagan-Bush administration made serious cuts in federal funds for public health services and social programs (Terris 1992: 192; see also Terris 1999).

The United States was only the first country to adopt the recommendations of the Lalonde report (Terris 1984); many other Western governments followed. At the same time as the United States shifted its policies, in the United Kingdom the Thatcher government implemented a lifestyle-oriented health policy, and Secretary of State for Health and Social Security Patrick Jenkin (1979–1981) emphasized the importance of individual responsibility and control for one's life and health. In 1979, the Australian federal minister for health, Ralph Hunt, announced, "During my period of office as Minister of Health I have become more and more convinced that continued concentration on traditional curative medicine, with its associated high costs both to the Government and the individual, can add little to improving the nation's health status. *I believe this can be achieved only by motivating individuals to take a responsible attitude for their own personal health care*" (Ralph Hunt on 25 May 1979 as cited in Mayes 2017: 61, italics in original). The government's task was to "motivate individuals and to provide the conditions for individuals to adopt a 'responsible attitude' for their own health" (Mayes 2017: 61).

However, even more important was and is the role of the WHO in the dissemination of the approach. By the 1970s, not only had the director-general of the WHO at that time, Dr. Halfdan Mahler, endorsed the concept of the Lalonde report, but it had also become the foundation of the WHO Global Health for All strategy in 1988. Since then, the Health Field Concept has been enlarged and broadened as a "holistic approach" to health. As Lalonde (2002) concluded, the WHO has over the years initiated a number of programs, pushing the concepts of "healthy public policies," "healthy cities," and "healthy communities." The first WHO International Health Promotion Conference, held in Ottawa in 1986, "led to the adoption of the now famous *Ottawa Charter on Health Promotion*" (Lalonde 2002: 150, italics in original). Baum and Saunders (2011: ii) described the charter as "the new public health Bible" because public health was not understood as solely dependent on individual healthy choices but through "government policies that change the structures people live, work and play in." Thus, these policies imply an ethical judgment about what a healthy lifestyle

should look like and how a responsible citizen should behave. I will discuss this new ethical politics as a specific dimension of neoliberal governmentality in the following section.

Governing Individuals and Populations

I use governmentality to examine the Health Field Concept as a way to exercise power as the "conduct of conduct" (Foucault 2000: 341; 2008: 186). According to Walters (2012: 11), governmentality is a "framework for analysis that begins with the observation that governance is a very widespread phenomenon, in no way confined to the sphere of the state, but something that goes on whenever individuals and groups seek to shape their own conduct or the conduct of others (e.g., within families, workplaces, schools, etc.)." However, for the genealogy of prevention, understood as the choice of a responsible lifestyle, I will focus on (neo)liberalism as a particular form of governmentality. The specificity of liberal forms of governments is that they "replace external regulation by inner production" (Bröckling, Krasmann, and Lemke 2011a: 5). Liberalism "organizes the conditions under which individuals can make use of their freedoms," or in other words, freedom is not contrary to liberal governmentality but rather one of its tactical starting points of action. To make use of freedom as a mechanism of liberal governmentality means that the one governed is comprehended as an autonomous actor who is able to act and reason in numerous ways that are often unpredictable by authorities. Thus, to govern is to influence the field of possible actions and to work on the abilities to act—of selves and others (Miller and Rose 2009b; Rose 2005; Rose and Miller 1992). It involves the reinforcement and modeling of energies in both individual bodies and the population at large that seem otherwise to be unproductive or even self-destructive (Dean 2010). Therefore, government "is any more or less calculated activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through the desires, aspirations, interests and beliefs of various actors, for definite but shifting ends and with diverse sets of relatively unpredictable consequences, effects and outcomes" (Dean 2010: 18). According to Foucault (2000: 341), this form of governing "incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less . . . but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions."

Thus, liberal governmentality embraces the idea of the individual problematizing his or her conduct; governmentality is not only about the exer-

cise of authority over others but also implies the ability to govern oneself. This becomes the ethical dimension of governmentality: the action of the self on self (Rose 1993, 2005; Rose and Miller 1992). Therefore, government does not merely imply power relations and an external authority but additionally raises questions around identity and self. The focus of an analysis of governmentality is therefore on "the interrelations between regimes of self-government and technologies of controlling and shaping the conduct of individuals and collectives" (Bröckling et al. 2011a: 13). As I will demonstrate in my analysis of the Health Field Concept, the fundamental idea of the Lalonde report is how to convince and direct citizens to live healthier lives—not primarily through coercive and disciplinary means but through their free choice. Rose (2005: 170) emphasized that this form of governmentality is linked to ethico-politics, which mediates between the respect of subjects' autonomy and the need to implement authoritative judgments about right and wrong. The Lalonde report must be understood as a specific "technology of government" (Dean 1996) that enabled the realization of this ethico-politics through the inscription of knowledge within practices by merging "cultural aspirations, images and desires about a healthier way of living ... to a whole host of very quotidian techniques of inscription and self-management" (Walters 2012: 62). In what follows, I will demonstrate that the ethico-political governing of public health through the responsibilization of citizens was only made possible through the complex interplay within the concept of lifestyle, which in turn was linked to epidemiological data, social marketing, biomedical research, regulations, and the law.

However, in recent years scholars have criticized the "state phobia" in many studies of governmentality, meaning that the diagnoses of "neoliberal" or "advanced liberal government" (Miller and Rose 2009a, 2009b; Rabinow and Rose 2006; Rose 2005, 2007b), particularly in the earlier works on governmentality, often neglected the role of the state as the "center of control by political agents or classes and the exercise of power" (Dean and Villadsen 2016: 2; see also Alliez and Lazzarato 2016; Harcourt 2018; see also Villadsen and Dean 2012). Instead, these scholars often focused on programs, strategies, and rationales that are realized through the interplay between multiple experts and actors like community groups and for-profit and not-for-profit organizations, etc., in order to instill forms of self-government and responsibility, as is the case with the lifestyle analyses mentioned earlier (see, e.g., Larsen 2012; Mayes 2017). These analyses provided valuable and different critical perspectives on how power is exercised in our societies, but the question remains whether these authors "went too far in the evacuation of the form of the state in political analyses and displacement of sovereignty" (Dean and Villadsen 2016). The Lalonde report and the

dementia prevention strategies of the WHO clearly demonstrate that prevention is only thinkable and feasible through and with the support of "the state" or international governance structures—despite the fact that these programs aim to shift responsibility to individuals.

The Health Field Concept: Changing the Historical Narrative on Prevention and the Lalonde Report's Regime of Truth

Both in the introduction to the official Lalonde report and in Laframboise's publications on its making, the work of demographic historian McKeown and colleagues (McLachlan and McKeown 1971; McKeown 1971; McKeown, Brown, and Record 1972) is mentioned as the decisive theoretical foundation. Their work also became the central argument against the universally funded Canadian health-care system, which had been based on the idea that the health of the population would improve through the development of medical services and universal access to them. McKeown and colleagues reversed the predominant narrative in the 1970s, arguing that the history of prevention was basically a heroic history of medical discoveries. Medical historians such as Harry Wain (1970: 187) described the emergence of germ theory as the "basic medical discovery that changed the course of the world by introducing it to the concept of disease prevention," enabling the first immunology work of Edward Jenner. According to this perspective, the history of preventive medicine can be captured as the scientific development of immunology and a deeper understanding of the underlying mechanisms of communicable diseases that led to modern epidemiology. According to Wain and others, scientific epidemiology succeeded in preventing diseases such as smallpox and typhoid and justified a certain optimism that medicine would be able one day to prevent and eradicate all communicable diseases. Again, following this narrative, the success of this preventive medicine, combined with the economic upturn in most Western societies after WWII, led to decreasing mortality rates in most so-called developed countries of the Western world. Thus, as the demographic composition of these societies shifted to an aging population, chronic, degenerative diseases slowly increased. This shift made a change in prevention strategies necessary, and it was in this context that the concept of lifestyle emerged that connected chronic degenerative diseases to people's way of life.

McKeown, Brown, and Record (1972) disputed this view. Based on epidemiological data, they explicitly denied that "the continued growth of population in the late nineteenth and twentieth centuries in the presence of a declining birthrate is explained by the reduction of mortality largely

from infectious disease brought about by hygienic improvements from about 1870 and by specific medical measures after the introduction of chemotherapy in 1935. The enormous growth of population between the 1700s and the mid-nineteenth century" could only be explained through the complex relationship "between agricultural and industrial developments or between both and the general improvement of living" (McKeown, Brown, and Record 1972: 357). McKeown (1971: 29) also provided a fundamental critique of medical knowledge:

> Nature was conceived in mechanistic terms, which in biology led to the idea that a living organism could be regarded as a machine which might be taken apart and reassembled if its structure and function were fully understood. In medicine the same concept led further to the belief that an understanding of disease processes and of the body's response to them would make it possible to intervene therapeutically, mainly by physical (surgical), chemical, or electrical methods.

Laframboise (1990: 318) argued McKeown "proved that the improvement of the health status of the people was far more a consequence of changes in lifestyle and the environment than it was a consequence of advances in medical sciences." This would also explain that whereas Canadian statistics showed significant improvements in health during the 1950s and 1960s, the correlation between expenditures and health improvement became less direct after the 1960s, despite the fact that public hospitals and health insurance (Medicare) had been implemented (Lalonde 2002). Thus, in a first step, LRHPB epidemiologists and policy analysts produced a series of pie charts in 1973 titled "Panorama of Mortality in Canada, 1971," that later became the visual centerpiece of the Lalonde report. These charts, compiled from statistical and epidemiological data on the causes of death according to age and sex, provided, according to Laframboise (1990: 318), "stunning proof that premature deaths derived principally from individual self-imposed hazards. [Seventy-five percent] of deaths between the ages of 5 and 30 were found to be due to automobile accidents, other accidents and suicide," and twice as many men compared to women died. As McKay (2000: 7) stated, McKeown had argued that "people were not dying due to a lack of access to medical care but "because they lived a life prone to personal risk taking. People did not live longer because of advancements in bio-medical knowledge; the increase in longevity was rather linked to the way of living and the environment." In short, "medical intervention could do little to save victims of traffic accidents, coronary artery disease or suicide" (McKay 2000: 7).

In cooperation with Statistics Canada, the policy consultants developed a formula for ranking the gravity of various causes of death. Each

cause of death was factored in "to obtain the Potential Years of Life Lost (PYLL) relative to age 70." Laframboise (1990: 318) argued that if someone died at age 20 from "individual self-imposed hazards," the loss of 50 years of potential life "far outweighs, in gravity, a death from a stroke at age 65." Based on these epidemiological data and the demographic historical perspective, the authors of the report assumed that health care had advanced to the point that it could no longer contribute to the improvement of health. Political planning consultant Joe Hauser (as quoted in McKay 2000: 8) stated that "in spite of a large infusion of funds into the health care delivery system, the overall health status of Canadians did not appear to have significantly improved." As I will discuss later in more detail, this statement anticipated the neoliberal argument about the inefficient and costly delivery of social services and provided a rationale for the cutbacks in federal funding of Medicare. Before the report was tabled in the House of Commons, the LHRPB performed several "preliminary tests of the concept" with "specialized groups," such as the 1973 WHO conference in Geneva and the Pan American Health Organization (PAHO) conference in Ottawa. It was also already endorsed by the federal-provincial conference of health ministers in Canada in 1974 (Lalonde 2002: 150).

The Four Elements of the Health Field Concept

Lifestyle, Power, and Subjectivation

With the idea of "individually self-imposed hazards," the LRHPB developed the concept of "lifestyle," connecting personal behavior and habits to the individual health condition. Laframboise (1973: 388) contended that this element was the "most neglected aspect of health," defining it as "the agglomeration of decisions taken by individuals which have a significant effect on their health." The problem for him was that these decisions were based on "social values, many of which have been inherited from the past but some of which are shaped by contemporary society" (388). Thus, the basic idea of lifestyle was that individual "behaviour was an area of self-determination that could be changed" (McKay 2000: 9)—or, from a governmentality perspective, lifestyle was based on the idea of the "conduct of conduct" and "technologies of self," as I discussed in the theoretical section.

Congruent with this definition of lifestyle is the (neo)liberal conceptualization of subjects as rational actors with the vision to use empowerment in order to initiate social change. Lifestyle is, according to Laframboise (1973:

389), "at least partly related to morale," and the enemy of lifestyle health is "private pleasure, what Odin Anderson called 'a short-range hedonistic model.'" Thus, the Lalonde report is the materialization of what I called, with reference to Rose (1999), the "ethopolitical" governing of societies. The Lalonde report summarized this perspective as follows: "Most Canadians by far prefer good health to illness, and a long life to a short one but, while individuals are prepared to sacrifice a certain amount of immediate pleasure in order to stay healthy, they are not prepared to forego all self-indulgence nor to tolerate all inconvenience in the interest of preventing illness" (Lalonde [1974] 1981: 15). Furthermore, Laframboise (1973: 389) argued, North Americans in particular had too much faith in the "restorative power of doctors, hospitals and medical technology." The problem, said Laframboise (1973: 389) was that the "technological advances of clinical medicine, the prepayment and organization of health services and the removal of health pollutants, have little effect on the decision of an obese person to reach for another piece of strawberry shortcake."

Interestingly, Laframboise (1973) explicitly connected the concept of lifestyle (and victim blaming) with a critique of the "prepayment" of health services—again anticipating the neoliberal critique of Medicare. However, his critique was even more pronounced when he emphasized that the "system often seems to demand that a person first be sick before he [*sic*] becomes an object of concern, and the preponderance of attention and resources is given to the 'sick care' system" (Laframboise 1973: 389). However, these ideas also highlighted the fact that sometimes surprising coalitions emerge. Ivan Illich (2007), one of the most distinguished and radical social critics of medical power in the 1970s, who had criticized the biomedical management of living and the power of medicine in Western societies, mentioned the report in a footnote in his book, *Medical Nemesis*. The report demonstrated the necessity of a complex interplay of different technologies to combat "short-range pleasure" with "long-range health" perspectives.

Joe Hauser, the Planning Consultant for Lifestyle, along with other policy consultants in the LRHPB, directed many qualitative and quantitative studies to prove that personal health habits were the underlying causes of ill-health. Investigations between fatal motor-vehicle accidents and the use of seat belts, for example, concluded that seat belts save lives. Other research studied the impact of tobacco on cardiovascular disease or the consequences of alcohol abuse. "In each instance, whether seatbelts, alcohol or tobacco, it was individual lifestyle choices that were seen to cause or avoid illness and death" (McKay 2000: 9). The big challenge for governing the health of the population through lifestyle was how to convince people to pay the price for

good health "in terms of discipline and sacrifice," both of which depended on societal and individual values (Laframboise 1973: 393).

Studies of governmentality can help clarify the rationale through which the Lalonde report envisioned behavior modifications. The policy consultants of the LRHPB understood that lifestyle decisions could not be influenced through legislative measures alone but that they needed to be complemented by a complex interplay of different technologies and techniques. Television as a technique of persuasion could be "employed to modify behaviour," and "social marketing was promoted as a new hope that could change self-destructive health habits of Canadians" (McKay 2000: 9). "The philosophical issue" was "whether, and to what extent, government can get involved in the business of modifying human behaviour, even if it does so to improve health"; the Lalonde report concluded that "society, through government, owes it to itself to develop protective marketing techniques" (Lalonde [1974] 1981: 37). In 1973, for example, the Department of National Health invested in research on the possibility of changing the behavior of obese people through social marketing. One of the first proponents of using mass communication was research psychologist G. D. Wiebe (1951: 679), who had argued that it was possible to "'sell' broad social objectives via radio or television" and that media could be used to mold behavior and habit in "areas like citizenship responsibility and community participation." He contended that, in principle, it was possible to sell rational thinking like soap (679). He concluded that "given a reasonable amount of receptivity among audience members, radio or television programs can produce forceful motivation," and if certain conditions are met, the results expected could be "comparable with those of a commercial sponsor" (691).

These insights were developed further in the context of public health under the label of "health marketing," which referred "to health promotion programs that are developed to satisfy consumer needs, strategized to reach as broad an audience as is in need of the program, and thereby enhance the organization's ability to effect population-wide changes in targeted risk behaviors" (Lefebvre and Flora 1988: 302). Marketing should be oriented toward growing consumer satisfaction by producing a better quality of life and wellbeing, higher self-esteem, more social contacts, etc., while simultaneously increasing benefits to health promotion agencies by meeting organizational goals and increased funding for more research (Lefebvre and Flora 1988: 303). Thus, the proponents emphasized, social marketing is not about "blaming the victims" but rather about more effective and efficient use of resources through analysis, planning, implementation, and control of agency operations. But persuasion had to compete with all the

other "behaviour modification measures" underway. Laframboise (1973: 389) suggested that new, "largely unexplored," legislative measures should also be tried, "such as the compulsory treatment of drug abusers and the compulsory use of seat belts." He concluded that these measures would "not prevent all people from slow self-destruction but they can reduce the number and put breaks on the process" (389).

The last dimension of the lifestyle approach was the idea of empowerment. The consultants of the LRHPB recognized a surge of interest in fitness and health clubs. Joe Hauser, who organized the First National Conference on Fitness and Health in 1972, undertook a study tour to Sweden with the Fitness and Amateur Branch in order to observe how that government supported lifestyle modifications through the construction of bicycle paths and sport facilities. Sweden was the paradigm for the LRHPB because its population was prepared to make personal sacrifices to prevent diseases and therefore was the leading nation in regard to health status indicators.

The idea of using empowerment in a systematic way in order to activate citizens to modify their lifestyle was institutionalized in Canada in 1978/79 with the creation of the Health Promotion Directorate (HPD). The directorate's mandate was the development and implementation of programs that "promote health and encourage the avoidance of health risks" (Health Promotion Directorate 1988: 42). The directorate developed crosscutting health promotion initiatives that focused attention on healthy lifestyle choices with national, provincial, and local governmental agencies and in partnership with professional and voluntary organizations and community groups. The way empowerment is invoked in the report is an example of how power works "beyond the state" (Miller and Rose 2009a, 2009b; Rose 2005). In her book, *The Will to Empower*, Barbara Cruikshank (1999: 1, 152) argued "that individuals in a democracy" are transformed "into self-governing citizens through" what she called "technologies of citizenship," such as "discourses, programs, and other tactics aimed at making individuals politically active and capable of self-government" through everyday practices of "voluntary associations, reform movements, and social service programs." As in the case of the HPD, empowerment is always a rapport founded on expertise and is a "democratically unaccountable exercise of power in that the relationship is typically initiated by one party seeking to empower another" (Cruikshank 1999: 72). Thus, the HPD materialized the dimension of liberal governmentality that governs through freedom. Subjects need to first of all perceive themselves as actors with the capacities to act and think, because only then a field for possible action opens up that can be governed though indirect means—by structuring the field of possible actions.

Environment

Closely related to the question of how to modify health behavior is the physical and social environment "under which an individual [lives] and [in] which she or he has little or no personal choice in avoiding, such as the air breathed" (Laframboise 1973: 388). The Lalonde report suggested that food, water, and other aspects of the environment that affect humans should be controlled and safeguarded (Lalonde [1974] 1981: 32). Laframboise (1973: 389) emphasized that environmental elements are often considered "'trade-offs' between health protection, on the one hand, and economic, technological, social or personal advantages on the other"; for example, the control of pollutants in automobile emissions will raise the cost of cars. But he also emphasized that control of the environment was almost all under the power of the government through legislative measures. However, he warned against corruption, because "governments are especially vulnerable to pressure groups" who might "[over-react] to a health hazard, causing grave economic or social damage in order to protect the public against a relatively minor hazard" (Laframboise 1973: 389). The way the Lalonde report approached the question of prevention, health promotion, and health care through the environment is congruent with how Foucault (2008: 3–4) described the "art of governing" as a "complex of means and things" discussed in the theoretical considerations.

Health-Care Organization

This element of the health-care system is traditionally considered the most important aspect of population health and prevention and has been subjected to many analyses and reports. In the Lalonde report, this element was "limited to the quantity, quality, arrangement, nature, and relationships of people and resources in the field of health case [sic] services" (Laframboise 1973: 388). Despite the large amount of data outlining its shortcomings, the health system had been unresponsive to the recommendations made in many reports, which Laframboise attributed to the weak demand for major reforms by the public, health professions, and health institutions. According to him, the only ones who were concerned about the rising health-care costs were elected representatives and bureaucrats.

The authors of the report identified several major problems of the Canadian health-care system. The most important was the rate of cost escalation that was "far in excess of the economic growth of the country." Another was the shared cost formula between the federal and provincial governments that encouraged the construction and use of hospitals, with expensive acute-care beds, without considering alternative health-care fa-

cilities and treatments. The focus remained on treating existing illnesses without any increase in funding for spreading information on health preventive measures. The authors also believed that the Canadian health-care system harbored "conflicting goals," especially with the aim of "trying to control costs while removing all incentives to patients, physicians and hospitals to do so." They argued that the fee-for-service system led to "many physicians and dentists carrying out tasks which could be done by others, at a lower cost." They also stated that physicians were unevenly distributed among the specialties "as well as between urban and rural areas" (Lalonde [1974] 1981: 28–29). To address these problems, Laframboise (1973: 390) suggested lowering costs by reducing the number of acute hospitals beds as well as the number of expensive clinical personnel, along with finding alternatives to fee-for-service payments for them. He also advocated for establishing district boards headed by nonmedical personnel with authority over the provision, levels, and standards of care of all medical services, and for community clinics run on a team-medicine basis. Most tellingly, he wanted people involved in looking after their own health (Laframboise 1973: 390). Both Laframboise and the Lalonde report also proposed that the federal government should increase pressure on the provinces to pursue these health-system reforms by putting "federal financing on a per capita basis" (Laframboise 1973: 390). Instead of using its financial power to enforce the foundational principles of Medicare of universality, comprehensiveness, and portability, implementing the new cost-sharing agreements would reduce the influence of the federal government on the provinces and would allow for variation among them (McKay 2000: 13).

This section clearly demonstrates one of the actual intents of the Lalonde report: transform Medicare by implementing elements of new governance through undermining the licensure system of professionals, introducing free market principles through financial incentives, shifting responsibility from the health-care and social system to individual citizens, reducing "big government" through regionalization, and using economic incentives to reduce the costs of health-care provision. The "problems" identified in the report and the remedies proposed thus follow the neoliberal script, and ongoing transformations of Medicare are still using the arguments made in the Lalonde report (see, e.g., Clemens and Nadeem 2014; Kirby 2003; Romanow 2002). I mention this aspect here because programs like the WHO action plan against dementia also always include demands for the transformation of health-care systems, in particular by calling for more public private partnerships (3Ps) and more research collaboration with the drug industry. The meta-analysis by Chow et al. (2018), *National Dementia Strategies: What Should Canada Learn?*, explicitly demands public private partnerships (174) and the implementation of new governance models in public health (205).

Human Biology

This element included all aspects of an individual's physical and mental health developed as a result of basic human biology (Lalonde [1974] 1981: 31). The section was devoted to medico-technological research—the development of vaccines and antibiotics, or chemotherapy for mental illness or organ transplants—and explicitly referred to the "applied research in the lifestyle, environmental and health care organizational categories" (Laframboise 1973: 391).

At the beginning of the 1970s, the LRHPB completed a "Delphi study on the future of genetics," which "foresaw an explosion of knowledge and interest in the micro aspects of *human biology*" (Laframboise 1990: 318, emphasis in original).

The Conceptual Model as a Mode of Governing

These four elements are brought together in what Laframboise (1973: 389) called a "comprehensive" conceptual model that could be used as a tool for analysis. All activities and problems could be allocated to one or another of the four elements, and each element or quadrant could be linked to specific policy instruments. To solve lifestyle health problems, "organized persuasion" (390) was the adequate policy instrument; protection of health from environmental factors depended mainly on legislation; improvement of the health-care system would come from reorganization; human biology was connected to scientific methods.

In order to demonstrate how the model could be used in practice, Laframboise (1973) applied the model to automobile accidents. According to him, data clearly demonstrated that deaths and injuries from automobile accidents could "be attributed to a large extent to the behaviour of individuals. Lifestyle choices of speeding, careless driving, impaired driving and failure to use seat belts" (391) were the primary factors. However, the gravity of these accidents also depended on environmental factors, like the construction of vehicles and the design of highways. Organization, with its focus on health-care delivery, provided ambulance services and helicopters, as well as treatments in emergency departments. And finally, human biology concerned the development of "new life-saving technologies, treatment methods, attention to accidents in medical school curricula" (391), and the like. However, the analysis clearly revealed that lifestyle was the principal underlying cause. Thus, Laframboise concluded that "if, as can be foreseen, acts of individuals dominate, measures for using persuasion or coercion to alter the pattern of individual decision can be considered as well as legislative measures for protecting the individual against himself

[*sic*]" (391). To mitigate deaths and injuries due to automobile accidents therefore required "a whole array" of measures "including the compulsory use of seat-belts, enforcement of traffic laws, random roadblock breathaliser tests, compulsory completion of a defensive driving course before licensing and so on" (391).

The WHO's (2017) *Global Action Plan on the Public Health Response to Dementia* uses a similar way to analyze dementia (and other noncommunicable diseases) as a public health problem. The plan identifies four groups that need to be included for the realization of goals in different "action areas": development agencies on the international, regional, and subregional level; academic institutions and research agencies; "civil society, including people with dementia"; "the private sector, health insurance, and the media" (WHO 2017: 3–5). According to the WHO (2017: 6), the "roles of these four groups often overlap and can include multiple actions cutting across the areas of governance, health and social care, promotion of understanding and prevention in dementia, and information, evidence and research." These roles encompass the four elements of the Health Field Concept. Governance is part of the element of environment, which is linked to legislation; health and social care is part of the element of health-care organization, which needs to be reorganized in order to face the challenge posed by dementia; civil society is part of lifestyle and can be influenced through information campaigns in the media; and evidence and research is part of human biology.

Here we have another clear example of what is implied in governing, understood as the right disposition of things; governing means to influence the context of subjects in order to change their behavior in the right direction. Last but not least, the way governing is defined here also highlights the complex interplay of very different kinds of power and instruments used for the governing of individuals and populations. The measures listed in the Laframboise article and in the WHO action plan are a combination of disciplinary means targeting the individual (educating the individual to choose a healthy lifestyle in order to prevent dementia), sovereign power (legislating against smoking in public spaces or increasing taxation on cigarettes, etc.), and government (using social marketing, empowerment, and, most important, persuasion or technologies of the self to convince the subject to behave in a responsible way or to commit to personal sacrifices to prevent disease). This complex interplay of different forms of power is what characterizes governmentality. Foucault (2007) emphasized that his analysis was not meant to imply that societies of sovereignty were replaced by disciplinary societies, which were then replaced by societies of governance. He used the image of the triangle to show the interplay of "sovereignty-discipline-government, which has as its primary target the population and as its essential mechanism apparatuses of security" (Foucault 2007: 219).

Conclusion

The last sentence brings my argument full circle. I began my chapter by outlining the "new" preventive approach to dementia as formulated in the WHO Global Action Plan and ended my discussion by demonstrating how the Canadian "Health Field Concept," better known as the Lalonde report, became the foundation of global public health policies—basically understood as preventive. I also wanted to show that it is not enough to focus merely on the element of lifestyle, often understood as the responsibilization of citizens for their own health by implementing the idea of prevention in their everyday life. Although important, this critique often emphasizes the withdrawal of the state in the managing of public health. Rather, I wanted to show that lifestyle is better understood as part of a dispositif, meaning it is the result of a complex interplay of institutions, legislation, scientific discourses, experts, community groups, governments, etc. If seen from this perspective, the significance of "the state" in prevention politics does not diminish, but its role changes.

A genealogical analysis of the Health Field Concept enables us to better understand how the notion of prevention is part of a neoliberal rationale on how to govern the health behavior of a population. It seems that most studies in the area of the prevention of dementia do not question the concept of lifestyle because it has become a taken-for-granted assumption. A genealogical analysis of the Lalonde report highlights the specific historical (power) formation behind the Health Field Concept. In doing so, the analysis asks how our present understanding of the prevention of dementia is formed and thus "enables us to realize that what has become our reality was only one option that prevailed by ruling out other options" (Scott 2007: 28).

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This chapter uses sections of an article published first in *Nursing Philosophy* 19, no. 4 (2018): e12222, Epub 11 September 2018, DOI: 10.1111/nup.12222, that discussed the Lalonde report as a technology in the transformation of liberal democracy through the ideas of new governance.

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References

Alliez, Éric, and Maurizio Lazzarato. 2016. *Wars and Capital*. Translated by Ames Hodges. California: Semiotext(e).

Alzheimer Society Canada. 2018. "Brain Health." Accessed 11 September 2018, http://alzheimer.ca/en/Home/About-dementia/Brain-health.

Bell, Kristen, and Judith Green. 2016. "Editorial: On the Perils of Invoking Neoliberalism in Public Health Critique." *Critical Public Health* 26 (3): 243.

Bell, K., D. McNaughton, and A. Salmon, A. 2011. "Introduction." In *Alcohol, Tobacco and Obesity: Morality, Mortality and the New Public Health*, edited by K. Bell, D. McNaughton, and A. Salmon, 1–17. London: Routledge.

Bröckling, Ulrich, Susanne Krasmann, and Thomas Lemke. 2011a. "From Foucault's Lectures at the Collège des France to Studies of Governmentality. An Introduction." In *Governmentality: Current Issues and Future Challenges*, edited by Ulrich Bröckling, Susanne Krasmann, and Thomas Lemke, 1–33. New York: Routledge.

———, eds. 2011b. *Governmentality: Current Issues and Future Challenges*. New York: Routledge.

Canadian Medical Association. 2004. "The Hon. Marc Lalonde and Dr. Maurice LeClair: 2004 Laureates." Accessed 10 January 2019, http://www.cdnmedhall.org/inductees/marclalonde.

Chow, Selina, Ronald Chow, Angela Wan, Helen R. Lam, Kate Taylor, Katija Bonin, Leigha Rowbottom, Henry Lam, Carlo DeAngelis, and Nathan Herrmann. 2018. "National Dementia Strategies: What Should Canada Learn?" *Canadian Geriatrics Journal* 21 (2): 173–209. DOI: 10.5770/cgj.21.299.

Clemens, Jason, and Esmail Nadeem. 2014. *First, Do No Harm: How the Canada Health Act Obstructs Reform and Innovation*. Turning Point Series. Ottawa: Macdonald-Laurier Institute.

Cruikshank, B. 1999. *The Will to Empower: Democratic Citizens and Other Subjects*. Ithaca: Cornell University Press.

Dean, Michael, and Kaspar Villadsen. 2016. *State Phobia and Civil Society*. Redwood City: Stanford University Press.

Dean, Mitchell. 2010. *Governmentality: Power and Rule in Modern Society*. Revised edition. Los Angeles: Sage.

Doody, Rachelle S., Ronald G. Thomas, Martin Farlow, Takeshi Iwatsubo, Bruno Vellas, Steven Joffe, Karl Kieburtz, et al. 2014. "Phase 3 Trials of Solanezumab for Mild-to-Moderate Alzheimer's Disease." *New England Journal of Medicine* 370 (4): 311–321. DOI: 10.1056/NEJMoa1312889.

Feldman, Howard H., and Carole A. C. M. Estabrooks. 2017. "The Canadian Dementia Challenge: Ensuring Optimal Care and Services for Those at Risk or with Dementia throughout the Country." *Canadian Journal of Public Health* 108 (1): E95–E97. http://dx.doi.org/10.17269/CJPH.108.5852.

Foucault, Michel. 1980. "Nietzsche, Genealogy, History." In *Language, Counter-Memory, Practice: Selected Essays and Interviews by Michel Foucault*, edited by D. F. Bouchard, 139–164. New York: Cornell University Press.

———. 1995. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.

———. 2001. "Le jeu de Michel Foucault." In *Dits et Ecrits II, 1976–1988*, edited by Daniel Defert, François Ewald, and Jacques Lagrange, 298–329. Paris: Gallimard.

———. 2000. "The Subject of Power." In *Power: Essential Works of Foucault 1954–1984*, volume 3, edited by J. D. Faubion, 327–345. New York: New Press.

———. 2003. *Society Must Be Defended: Lectures at the Collège de France 1975–1976*. Edited by Mauro Bertani, Alessandro Fontana, and François Ewald. New York: Picador.

———. 2007. *Security, Territory, Population: Lectures at the Collège de France, 1977–78*. Translated by G. Burchell. Basingstoke: Palgrave Macmillan.

———. 2008. *The Birth of Biopolitics: Lectures at the Collège de France, 1978–79*. Edited by Graham Burchell, Michel Senellart, and Collège de France. Basingstoke: Palgrave Macmillan.

Foucault, Michel, and Michelle Perrot. 1980. *L'Impossible Prison: Recherches sur le Système P*énitentiaire au XIXe siècle. Paris: Éditions du Seuil.

G8 Health and Science Ministers. 2013. *G8 Dementia Summit Declaration*. Accessed 11 September 2018, http://www.g8.utoronto.ca/healthG8/g8-dementia-summit-declaration-2013.pdf.

Glouberman, Sholom. 2001. "Towards a New Perspective on Health Policy." In *CPRN Study*, edited by Canadian Policy Research Network Inc. Ottawa: Canadian Policy Research Network Inc.

Hall, Stuart. 2011. "The Neo-Liberal Revolution." *Cultural Studies* 25 (6): 728.

Harcourt, Bernard E. 2018. *The Counterrevolution: How Government Went to War Against its Own Citizens*. New York: Basic Books.

Hardt, M., and A. Negri. 2017. *Assembly (Heretical Thought)*. Oxford: Oxford University Press.

"The Health Promotion Directorate: Health and Welfare Canada." 1988. *Hygie* 7 (3): 43.

Ihle, Andreas, Michel Oris, Delphine Fagot, Christian Maggiori, and Matthias Kliegel. 2016. "The Association of Educational Attainment, Cognitive Level of Job and Leisure Activities during the Course of Adulthood with Cognitive Performance in Old Age: The Role of Openness to Experience." *International Psychogeriatrics* 28 (5): 733–740. DOI: 10.1017/S1041610215001933.

Illich, Ivan. 2007. *Die Nemesis der Medizin. Die Kritik der Medikalisierung des Lebens*. Frankfurt a.M.: C. H. Beck.

Jacklin, Kristen M., Jennifer D. Walker, and Marjory Shawande. 2013. "The Emergence of Dementia as a Health Concern among First Nations Populations in Alberta, Canada." *Canadian Journal of Public Health* 104 (1): e39–44.

Jenkin, Patrick. 1981. "Economic Constraints and Social Policy." *Social Policy & Administration* 15 (3): 241.

Karran, Eric, and John Hardy. 2014. "Antiamyloid Therapy for Alzheimer's Disease: Are We on the Right Road?" *New England Journal of Medicine* 370 (4): 377–378. DOI: 10.1056/NEJMe1313943.

Katz, Stephen. 2013. "Active and Successful Aging: Lifestyle as a Gerontological Idea." *Recherches Sociologiques et Anthropologiques* 1: 75.

Kirby, Michael. 2003. *Reforming Health Protection and Promotion in Canada: Time to Act.* Edited by Science and Technology Standing Senate Committee on Social Affairs. Electronic format: Government of Canada. https://sencanada.ca/content/sen/committee/372/soci/rep/repfinnov03-e.htm.

Laframboise, Hubert. 1973. "Health Policy: Breaking the Problem Down into More Manageable Segments." *Canadian Medical Association Journal* 108 (3): 388–passim.

———. 1990. "Non-Participative Policy Development: The Genesis of 'A New Perspective on the Health of Canadians.'" *Journal of Public Health Policy* 11 (3): 316–322. DOI: 10.2307/3342711.

Lalonde, Marc. (1974) 1981. *A New Perspective on the Health of Canadians: A Working Document*. Ottawa: Minister of National Health and Welfare. Accessed 27 December 2017, http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf.

———. 2002. "New Perspectives on the Health of Canadians: 28 Years Later." *Revista Panamericane de Salud Pública/Pan American Journal of Public Health* 12 (3):152.

Larsen, Lars Thorup. 2012. "The Birth of Lifestyle Politics: The Biopolitical Management of Lifestyle Disease in the United States and Denmark." In *Governmentality: Current Issues and Future Challenges*, edited by Ulrich Bröckling, Susanne Krasmann, and Thomas Lemke, 201–224. New York: Routledge.

LeBesco, Kathleen. 2011. "Neoliberalism, Public Health, and the Moral Perils of Fatness." *Critical Public Health* 21 (2): 153–164. DOI:10.1080/09581596.2010.529422.

Lefebvre, R. Craig, and June A. Flora. 1988. "Social Marketing and Public Health Intervention." *Health Education Quarterly* 15 (3): 315.

Manulife, Manufacturers Life Insurance Company. 2019. "Do More. Get More." Manulife website. Accessed 11 February 2019, https://www.manulife.ca/personal/vitality/apple-watch.html.

Mayes, Christopher. 2017. *The Biopolitics of Lifestyle: Foucault, Ethics and Healthy Choices*. New York: Routledge.

McLachlan, Gordon, and Thomas McKeown, eds. 1971. *Medical History and Medical Care: A Symposium of Perspectives Arranged by the Nuffield Provincial Hospitals Trust and the Josiah Macy Jr. Foundation*. London: Oxford University Press.

McKay, Lindsey. 2000. *Making the Lalonde Report: Towards a New Perspective on Health Project, Health Network, CPRN*. Background paper. Ottawa: Canadian Policy Research Networks (CPRN). Accessed 18 June 2020, https://epe.lac-bac.gc.ca/100/200/300/cdn_policy_research_net/making_lalonde/bmlr_e.pdf.

McKeown, Thomas. 1971. "A Historical Appraisal of the Medical Task." In *Medical History and Medical Care: A Symposium of Perspectives Arranged by the Nuffield Provincial Hospitals Trust and the Josiah Macy Jr. Foundation*, edited by Gordon McLachlan and Thomas McKeown. London: Oxford University.

McKeown, Thomas, R. G. Brown, and R. G. Record. 1972. "An Interpretation of the Modern Rise of Population in Europe." *Population Studies* 26 (3): 345–382. DOI: 10.1080/00324728.1972.10405908.

Miller, Peter, and Nikolas Rose. 2009a. *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge: Polity Press.

———. 2009b. "Political Power beyond the State: Problematics of Government." In *Governing the Present: Administering Economic, Social and Personal Life*, 53–83. Cambridge: Polity Press.

Ngandu, Tiia, Jenni Lehtisalo, Alina Solomon, Esko Levälahti, Satu Ahtiluoto, Riitta Antikainen, Lars Bäckman, et al. 2015. "A 2-year Multidomain Intervention of Diet, Exercise, Cognitive Training, and Vascular Risk Monitoring versus Control to Prevent Cognitive Decline in At-Risk Elderly People (FINGER): A Randomised Controlled Trial." *Lancet* 385 (9984): 2255–2263. DOI: 10.1016/S0 140-6736(15)60461-5.

Peck, Jamie. 2010. *Construction of Neoliberal Reason*. New York: Oxford University Press.

Rabinow, Paul, and Nikolas Rose. 2006. "Biopower Today." *BioSocieties* 1: 195–217.

Romanow, Roy J. 2002. "Building on Values: The Future of Health Care in Canada." Commission on the Future of Health Care in Canada.: Government of Canada, http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.

Rose, Nikolas. 1993. "Government, Authority and Expertise in Advanced Liberalism." *Economy and Society* 22 (3): 283–299.

———. 2005. *Powers of Freedom: Reframing Political Thought*. Cambridge: Cambridge University Press.

———. 2007a. "Biological Citizens." In *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*, 131–154. Princeton: Princeton University Press.

———. 2007b. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press.

Rose, Nikolas, and Peter Miller. 1992. "Political Power beyond the State: Problematics of Government." *British Journal of Sociology* 43 (2): 173–205.

Salloway, Stephen, Reisa Sperling, Nick C. Fox, Kaj Blennow, William Klunk, Murray Raskind, Marwan Sabbagh, et al. 2014. "Two Phase 3 Trials of Bapineuzumab in Mild-to-Moderate Alzheimer's Disease." *New England Journal of Medicine* 370 (4): 322–333. DOI: 10.1056/NEJMoa1304839.

Scott, J. W. 2007. "History-Writing as Critique." In *Manifestos for History*, edited by K. Jenkins, S. Morgan, and A. Munslow, 19–39. Abingdon: Routledge.

Smith, K., L. Flicker, N. T. Lautenschlager, O. P. Ameida, D. Atkinson, A. D'wyer, and D. LoGludice. 2008. "High Prevalence of Dementia and Cognitive Impairment in Indigenous Australians." *Neurology* 71 (19): 1470–1473.

Solomon, A., F. Mangialasche, E. Richard, S. Andrieu, D. A. Bennett, M. Breteler, L. Fratiglioni, et al. 2014. "Advances in the Prevention of Alzheimer's Disease and Dementia." *Journal of Internal Medicine* 275 (3): 229–250. DOI: 10.1111/joim.12178.

Stedman Jones, Daniel. 2012. *Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics*. Princeton: Princeton University Press.

Terris, Milton. 1984. "Newer Perspectives on the Health of Canadians: Beyond the Lalonde Report. The Rosenstadt Lecture." *Journal of Public Health Policy* 5 (3): 327–337. DOI: 10.2307/3342158.

———. 1992. "Healthy Lifestyles: The Perspective of Epidemiology." *Journal of Public Health Policy* 13 (2):186–194. DOI: 10.2307/3342812.

———. 1999. "The Neoliberal Triad of Anti-Health Reforms: Government Budget Cutting, Deregulation, and Privatization." *Journal of Public Health Policy* 20 (2): 149–167. DOI: 10.2307/3343209.

Vernooij-Dassen, Myrra, and Yun-Hee Jeon. 2016. "Social Health and Dementia: The Power of Human Capabilities." *International Psychogeriatrics* 28 (5): 701–703. DOI: 10.1017/S1041610216000260.

Villadsen, Kaspar, and Mitchell Dean. 2012. "State Phobia, Civil Society, and a Certain Vitalism." *Constellations* 19 (3): 401–420. DOI: 10.1111/cons.12006.

Wain, Harry. 1970. *A History of Preventive Medicine*. Springfield: Charles C. Thomas.

Walters, William. 2012. *Governmentality: Critical Encounters in Global Politics*. New York: Routledge.

Wiebe, G. D. 1951. "Merchandising Commodities and Citizenship on Television." *Public Opinion Quarterly* 15 (4): 679–691. DOI: 10.1086/266353.

WHO (World Health Organization). 2017. *Global Action Plan on the Public Health Response to Dementia, 2017–2025*. Geneva: World Health Organization. Accessed 12 January 2019, https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/.