



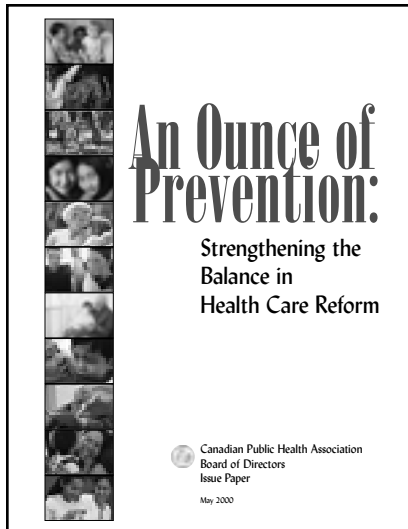
# An Ounce of Prevention:

Strengthening the  
Balance in  
Health Care Reform



Canadian Public Health Association  
Board of Directors  
Issue Paper

May 2000



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# Preface

The Canadian Public Health Association (CPHA) is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions that are necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection and healthy public policy.

The Canadian Public Health Association and its members are concerned about the future of Canada's health system and the health of individuals and communities.

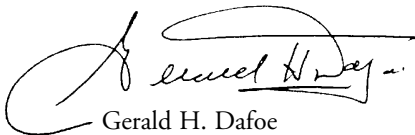
This Issue Paper, *An Ounce of Prevention: Strengthening the Balance in Health Care Reform*, highlights issues and challenges within the Canadian Health System and identifies the critical importance of a public health strategy within health services reform.

In March 2000, the CPHA Board of Directors expressed their growing concern that Canada's health care system, one of the most distinguished and most cherished features of our nationhood, was gradually being eroded.

The CPHA is deeply committed to the preservation and strengthening of the medicare system that is founded on equitable access to comprehensive care. We fully support the five principles of the Canada Health Act.

A CPHA Issue Paper Reference Group from the Board of Directors was formed to guide the development of this issue paper. The Reference Group was chaired by David Butler-Jones and included: Christina Mills, Ian Gemmill, Marilyn Keddy, Mary Martin-Smith, Joan Riemer, and Brian Bell, The Alder Group.

The Association wishes to thank the Reference Group for the expertise and time they provided in the development of this paper.



Gerald H. Dafoe  
Chief Executive Officer



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# Executive Summary

The current debate about health care funding is important to preserving our health care system. However, funding and the issue of privatization have effectively highjacked critical public debate in Canada about what's really at stake: funding is the wrong diagnosis for the real challenges ahead and privatization is most certainly the wrong prescription. What is needed is a commitment on the part of all Canadians to an overhaul of the structure of our health system so it can meet the demands of the 21st century.

Developments in health over the twentieth century have been remarkable and yet, as we enter the 21st century, significant challenges persist. The financing and restructuring of a sustainable system of medicare needs to take account of these challenges – and to build on the opportunities afforded by past successes, improved information, knowledge and research capacities, and technological advances.

Lasting health gains for the Canadian population can only be achieved through creation of a sustainable health system that builds on:

- a focus on the broader determinants of health that gets at the root of the real health issues in Canadian society;
- maintaining the vision and values that form the basis of our current medicare system while instituting significant changes to the balance and delivery of services within medicare;
- recognizing that increased privatization will only shift rather than contain future health care costs and that funding decisions would be better informed by different kinds of strategies, focused on reliable evidence, improved efficiencies across the full spectrum of health care and prevention;
- investing in and developing a range of health services, from public health and community care through to hospitals and long-term care facilities and strengthening primary care as the point of initial contact of individuals, families and communities with the health system.

Public health is uniquely positioned to contribute to renewing and reorienting the health sector. It is an integral component of the current system, providing critical disease and injury prevention, health protection and health promotion strategies that mitigate the need for care in the first place and contribute to an improved quality of life for Canadians. Public health also plays a key role in creating effective alliances with other sectors instrumental in the development of public policies that produce and maintain health.

This Issue Paper suggests that the building blocks required for Canada's health system for the 21st century must extend considerably beyond funding measures, represent a better balance among a number of important factors and include:

- federal leadership and intergovernmental cooperation to create appropriate solutions to the immediate issues as well as the need to modernize the system and ensure its sustainability;
- a broad vision for health care for the 21st century that identifies an integrated continuum of services and is focused on population health and the full range of factors that affects it;
- enriched CHST funding and the development of an appropriate escalator to ensure ongoing, adequate financing of and stability for the health care system;
- federal financial participation in non-insured services including public health, primary care, and community and home care – all essential components of a comprehensive health system;
- strategies to strengthen the transparency and accountability of government health care funding including measures to strengthen information-sharing and best practices, services and system performance and public reporting on outcomes;
- measures to strengthen the development and delivery of public health within the broader health services continuum, including knowledge and skills development; human resources development and utilization strategies; alliance-building and intersectoral collaboration; performance and outcome indicators; and community-based governance systems;
- strategies for allocating more appropriate levels of public resources for public health and disease and injury prevention, health protection and promotion activities, from within global government budgets; and
- a moratorium on further privatization of Canada's health system until there has been a public analysis of the appropriate mix of public and private funding and delivery that is desirable and sustainable within a renewed health care system.

# I. A Prescription for Reform

Statistics Canada's special issue of *Health Reports: How Healthy are Canadians?* indicates that Canada has made substantial progress in improving the health of its population, as demonstrated in increases in life expectancy, reduced infant mortality and a better quality of life for middle-aged and older Canadians.<sup>1</sup> Our life expectancy is among the highest in the world. Canada continues to rank first among all nations on the United Nations Human Development Index, although this standing drops to tenth when the Human Poverty Index for industrialized countries is applied.

This contrasts dramatically with the daily portrayal of Canada's medicare system by the media and many of Canada's physicians and politicians. By their accounts, we are facing what is perhaps the most acute crisis in funding – and in medicare itself – since the time of its inception in 1968.

The National Forum on Health considered how to allocate society's limited resources “to best protect, restore and promote the health of Canadians.” The Forum suggested the need for balance among three fundamental dimensions: the balance of the health sector in relation to the rest of the economy; the balance of services within the health sector; and the balance of public and private funding.<sup>2</sup>

The Board of Directors of the Canadian Public Health Association (CPHA) believes that funding is a very important issue for preserving our health care system and that stability of funding is critical for the long term. Nevertheless, funding is the wrong diagnosis for the challenge that faces our health care system and privatization is most certainly the wrong prescription. More than ever before, balanced debate and balanced solutions are called for.



## 2. Reassessing Health

*“Whoever wishes to investigate medicine properly should ... consider ... the mode in which inhabitants live, and what are their pursuits, whether they are fond of drinking and eating to excess, and given to indolence, or are fond of exercise and labour.”* (Hippocrates, On Airs, Waters and Places. 5<sup>th</sup> century BC)

In the latter half of the nineteenth century and in the early decades of the twentieth century, “health policy was public health policy.”<sup>3</sup> Public health initiatives – including the removal of raw sewage and the provision of safe water and food, programs for maternal and child health, improved housing and access to education – were considered to be central health issues and public health measures significantly reduced the incidence of infectious diseases and injury.

Health care services, by contrast, were “rudimentary in range and sophistication” and “more often than not, death was the result from hospitalization.”<sup>4</sup> Hospitals were places for quarantine and care of the indigent who could not afford good care at home. However, with major advances in the biological sciences, “improved knowledge of human biology and pathology led to the development of scientifically based medicine.” By the 1920s and 1930s, governments and the public were becoming convinced about the importance and benefits of modern health care and “tended to credit doctors and hospitals for improvements in health status.”<sup>3</sup>

Federal and provincial/territorial governments, individually and together, devoted significant resources to the development of health care services and the progressive implementation of a system of medicare: universal, publicly funded health care insurance. These efforts culminated in the passage of the Canada Health Act (CHA) in 1984. The Act continues to provide the parameters for the transfer of federal funds to the provinces in support of hospital and medical services, providing their plans comply with the five principles of universality; accessibility; comprehensiveness; portability; and public administration. Throughout this era, medical care and institutional services dominated thinking and decision-making around the funding of health interventions designed to promote and maintain the health of Canadians.

Beginning in the 1970s, a number of national and international developments precipitated changes in our understanding of what makes people healthy and the factors that effect lasting health gains for the population as a whole. These include:

- *A New Perspective on the Health of Canadians* (1974) that argued that health was determined by the interplay of human biology, health care organization, environment, and lifestyle;
- The *Declaration of Alma-Ata* (1978) that stressed the importance of primary health care as the first element of a continuing health care process at the community level;
- The *Ottawa Charter for Health Promotion* (1986) that identified fundamental conditions or “prerequisites” for health and proposed five key strategies for the new public health (viz. building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services);
- *Achieving Health for All: A Framework for Health Promotion* (1986) that presented a matrix of health promotion challenges, mechanisms and strategies to guide health promotion research, policy and action in Canada.

These developments derive from many of the fundamental premises of the public health movement. They argued that if we were to get to the root of much of the illness and the other major health problems in Canada and the developed world, we would have to take action on the broader determinants of health, including peoples’ living and working conditions. The ideas form the underpinnings of public health today and are expressed in the “population health” approach. This seeks to improve the health of Canadians through acting on the factors in the environment that enable Canadians to be healthy and by reducing inequities in the conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health.<sup>5</sup> Major factors, or “determinants” of health, include the socioeconomic environment; the physical environment; biology and genetic endowment; healthy child development; personal health practices; and health services themselves.

### 3. The Enigma of Medicare

*When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to recognize and revamp the whole delivery system - and of course, that's the big item. That's the thing we haven't done yet.* (Tommy Douglas)

Many people would have us believe that the medicare system is no longer workable. This is not so. Nevertheless, there clearly is a need for significant health care reform. The changing understanding of what makes some Canadians healthy and others sick creates a useful backdrop to consider some of the real vulnerabilities of medicare today. These include erosion of the vision of medicare and its commitment to compassion and fairness for Canadians; conflicting expectations around its scope; growing and costly inefficiencies in the current system and fears that there is no end to the demands that a public health care system will place on future government resources.

- *The eroding of the vision and values of medicare.* Events of the 1930s and the 1940s suggested that governments should play a central role in ensuring access to needed health services for all Canadians. A centrepiece of medicare was the conviction that health care is a public good, that there should be equity of access to care and that an individual's ability to pay for needed treatment should not be a determining factor for receiving health services. Today this vision is increasingly being held ransom to arguments that these convictions no longer have currency in a global marketplace, or that while they are desirable, they are no longer maintainable because of costs.
- *The limited scope of medicare.* Medicare was seen by many of its creators as eventually applying to the full spectrum of health services. Nevertheless, it was launched within a considerably narrower view of health care and remains so today. Thus, while the Canada Health Act speaks of the primary objective of Canadian health care policy as being broader, the provision for funding of services is limited. For example, it is simply taken for granted that public health services (including disease and injury prevention, health protection and health promotion) will continue to be supported by governments. At the same time, the definition of medically necessary or required services is growing increasingly troublesome with de-listing or de-insuring and there continues to be very inequitable access to other important health services (including dental care, pharmaceuticals, community and home care) that simply are not insured.
- *Inefficiencies in the system.* The National Forum on Health identified one of the key challenges for the health sector as being the establishment of a culture of evidence-based

decision-making. It observed that often high-quality evidence simply does not exist, while in other circumstances the evidence used is inappropriate or decisions are made without recourse to the relevant information.<sup>6</sup> Yet emerging data in the provinces of Saskatchewan and Manitoba suggest that significant improvements in efficiencies and effectiveness can be made within the publicly funded system.<sup>7</sup>

- *Inadequate funding.* Canada already has one of the most expensive health systems in the world: we spend about \$86 billion, ranking third among seven other OECD nations in (1996) health expenditures per capita and fourth in terms of percentage of GDP (9.3%) devoted to health care.<sup>5</sup> International comparisons also caution that enhancing health goes far beyond how much money is spent on health services. Countries with the highest health expenditures do not necessarily have the best health outcomes.<sup>5</sup> The National Forum on Health concluded that “Canadians are spending enough through their taxes and private payments to support access to needed health care,”<sup>6</sup> although members later qualified this position and advocated for stability in funding along with the need for additional investments to extend the range of publicly funded health services available. Thus, if more money is indeed needed, it is not clear how much more is required and equally important, where this money should be going.



## 4. Funding: From Cooperation to Acrimony

*“...the very powerful incentive driving for-profit organizations is to make a profit. Period. It is not to improve the efficiency of the health care system, or to provide high quality care, or to advance the health of the population. If these turn out to be profitable strategies, well and good, they will be pursued as a means to the overriding end. But they have no intrinsic value in themselves to the for-profit organization.”<sup>8</sup>*

Issues of funding have hijacked important debate on the kind of system that Canada needs for the 21<sup>st</sup> century. Rhetoric has stuck on the perceived pressure points in the system and on the suggestion that more money will resolve these pressures. Yet governments’ inability to agree on very basic funding questions has contributed to anxiety among Canadians about their capacity to work together to maintain Canada’s publicly funded care system. This is ironic – and quite disheartening – in the era of the new Social Union Framework Agreement and the commitment of governments to work collaboratively in policy-making across a variety of social programming, including health care.

### 4.1 The Growing Instability of Federal-Provincial Transfers

In 1997, the American political scientist Aaron Wildavasky formulated the Law of Medical Money: ‘... costs will increase to the level of available funds.’<sup>8</sup>

Total health care spending has increased significantly over the past decades; it is now \$86 billion – about 50% higher than twenty years ago. There was steady growth in spending from about 1975 through 1993, followed by several years of government restraint in the mid-1990s. This resulted in “a modest, but unprecedented, decline in real expenditures per person. Since 1997, both total (and government) health care spending have again been rising.”<sup>7</sup>

A review of federal-provincial financial arrangements for health care paints a parallel picture of change over 1975-1995, one that saw the federal share of health care spending drop from about 39% to 33% (in direct spending and tax transfers). It is a period characterized by shifts from cost-sharing to block funding arrangements; from unlimited federal matching grants to the federal imposition of unilateral controls; and from rising to declining (and again rising) federal cash payments. Throughout, the arrangements have also been characterized by a diminishing capacity (and in fact, now, no capacity) to track – or account for – the cash transferred.

Since the introduction of the Canada Health and Social Transfer in 1996-1997, particular acrimony has accompanied the decline of the federal contributions. This has been accompanied by strong and convincing arguments from many quarters for the establishment of an “appropriate” floor for federal cash transfers. The federal reductions have often been blamed for creating additional pressures on provincial treasuries. The provinces have also had to make cost-containment and reduction efforts to curb the cost of health care increases and to support deficit reduction.

Thus, it is little wonder that public confidence in the health care system has declined. It has undoubtedly also contributed to people’s believing that the solution to the perceived “crisis” of medicare can be found in privatization!

## 4.2 Health Care Privatization

Canada’s health care system always has been a mix of public-private dimensions: this mix is a feature of the financing and delivery of virtually all services. For example, public health is primarily publicly financed and publicly delivered. Hospitals are primarily publicly funded and largely publicly delivered. Dental and optometry services, by contrast, are primarily privately funded and privately delivered.

This mix of public and private is not unique. Nor is the degree of public funding in Canada imbalanced, by international standards. On average, about 80% of health care expenditures in OECD countries come from the public sector. Until the early 1990s, the split in Canada hovered at 75:25. However, by 1999, almost 30% of total health costs in this country were paid privately. Thus, Canada’s private share of health spending is already comparatively high, and in 1997 was second only to the United States among the G-7 countries.<sup>7</sup>

On the surface, the privatization debate may appear to be largely an ideological issue. In part it is. However, it is also an issue of values and evidence. Accordingly, there is a pressing need to shift the public debate onto these fronts. Perhaps one of the most useful platforms on which to carry out the debate is the question posed several years ago by the National Forum on Health: “At what point does the existence of a parallel, publicly funded ‘second’ tier of health care services affect the integrity of medicare?”<sup>9</sup> The answer may be that we are getting very close to that point today!

Some of the strongest arguments for privatization include the suggestion that the current system is underfunded; that privatization will address unmet health care needs; and that private facilities are cheaper and more efficient than public ones. The emerging evidence suggests otherwise. There is little evidence to suggest that more money will solve the

problems of medicare: for example, a recent study observes that “thirty-five years of adding even more money to the health care system was not sufficient to ‘meet the needs’ or end the underfunding crisis. Nor has it in any other country in the developed world.”<sup>8</sup>

Nor does the argument that additional funding is required to deal with growing waiting lists and service shortages bear up under scrutiny. Overall, unmet health care needs in Canada remain low (5%), although there has been some slight increase across all provinces.<sup>5</sup> And reports on waiting times and lists for care are inconclusive at best. Some of the recent evidence suggests that some waits are actually down rather than up. Other data suggest that increasing the flow to the private system can actually lengthen waiting lists if those funds could otherwise have gone to the public system. Alberta’s experience with cataract surgery confirms this.<sup>10</sup> Finally, the argument that the private sector affords an opportunity to provide a more efficient, less costly way of increasing service capacity and that private facilities will “yield more bang for the buck” does not appear to hold up either. Data again suggest that privatization simply shifts total health care costs and does not contain them. For-profit delivery systems are generally more expensive and less efficient than not-for-profit organizations.<sup>8</sup>

Conversely, the arguments against privatization are considerable. Some of the most salient are that health care is a case of market failure and the market forces simply do not work with health care as they do with most commodities and services; access and quality of services does not improve under privatization and in the longer term there could be reduced access to services; a private system costs more, is more complex to market and administer and contributes to rising costs in the public system and creates a parallel “publicly subsidized private tier” of health care delivery and payment; the motives of providers and professional-patient trust may be eroded and the best health professionals may gravitate toward privately funded facilities; and privatization may erode public support for the current health care system. There is also uncertainty around the impacts of further privatization on NAFTA and other international trade agreements because the health sector is currently exempted from competition by its designation as an area of public intervention.

Thus, increased privatization of Canada’s health system invites critical questions and needs far more consideration before it affords any solution to health system reform. Clearly, we need to ensure that insured services continue to be funded. However, we also need to develop a plan to ensure that further health investments are made in the most cost-effective and sustainable way.



## 5. The Right Diagnosis: Toward a Balanced Health System for the 21<sup>st</sup> Century

*Years of patchwork repairs have not addressed the problems in our health system. Just as it makes sense to renovate, rather than maintain a drafty building, our health system needs substantial renovations, not just minor changes. It is far too costly for the health results we have been achieving. There is a lack of evaluation, funding is not based on outcomes, the system is fragmented and there is waste and duplication. Spending on services continues to go up, but our overall health has not significantly improved. The health system doesn't just need a new paint job, it needs to be redeveloped and modernized.<sup>11</sup>*

If we were to set up the most effective system possible to address the present and anticipated health needs of Canadians, it would look and operate much differently from the system that has evolved to date. It would most certainly include a strong component of physician and facility-based services to provide care and treatment for those who are injured and sick. However, it would also include a number of additional – and equally important – components within an integrated and accountable continuum of health services. It would focus on population health and the broad range of factors that affect it and would be designed to provide “the right services to the right people, at the right time, in the most effective and efficient manner.”<sup>7</sup>

Restructuring efforts have been underway in the provinces and territories since the 1980s in various forms. All have stressed the need for major structural reform of the health care system. Common themes have included: a vision of health that focuses on population health and its determinants; the corresponding need for an integrated health care system that emphasizes alternatives to institutional care and reallocation of funds to more community-based services; and efforts to bring the planning and delivery of health services closer to residents.<sup>7</sup>

In light of what we know about the factors that contribute to significant health gains for Canadians, reform and rebalance call for action on a number of fronts. These include:

- *A guiding vision.* This would include a publicly understood and endorsed set of values or principles that would inform the transition. There is no reason why the vision of medicare and the principles of the CHA cannot continue to play a leading role here.

- *Better information.* Some very promising initiatives are already underway and these need to be continued. Examples include the creation of the Canadian Institutes for Health Research and the Health Information Roadmap Initiative; the recent Statistics Canada/Canadian Institute for Health Information (CIHI) reports on the health of the population and the performance of the health care system; and the Canadian Population Health Initiative and Canadian Health Services Research Foundation's efforts to improve knowledge transfer to decision-makers and the public. Better information must be used, among other things, to examine how current health services are organized and delivered and to inform efforts around the afore-noted questions of what works best for whom, when and with what risks and benefits.
  
- *A seamless continuum of health services.* This continuum must extend from re-invigorated public health services, through more efficient and effective hospitals and long-term care facilities to more responsive community-based services. Its components include disease and injury prevention, health protection and promotion; health/wellness maintenance and self-care and mutual support; facility-based care; specialized institutional care; and community-based care, including home care.<sup>12</sup> Funding within such a system should follow the individual, across the spectrum of services. Concurrent with this transition is the need to continue to bring the planning and delivery of health services closer to Canadians in their places of work and residence and to engage them meaningfully in these tasks.
  
- *Primary care.* Primary care is the first step in the health service continuum. It provides the initial contact for individuals, the family and the community with the health system, bringing health as close as possible to where people live, work and play.

## 6. The Public Health Contribution to Health Services Reform

*By World War II public health had successfully demonstrated the potential impact on the health of the population of bringing to bear a combined knowledge and techniques of sanitation, bacteriology, through the close collaboration between research and practice, public education, and the enhanced professional training of public health personnel, and an astute and unrelenting commitment to public health reform.<sup>4</sup>*

### 6.1 An Ounce of Prevention

In September 1999, the Federal, Provincial and Territorial Advisory Committee on Population Health called for a “comprehensive and collaborative approach to improving the health of Canadians that addresses the root causes of illness and early death.”<sup>5</sup> In doing so, their report to Ministers of Health identifies three priorities for action:

- renewing and reorienting the health sector;
- investing in the health and well-being of key population groups including children, youth and Aboriginal people; and
- improving health by reducing inequities in the distribution of literacy, education and incomes in Canada.

Public health is uniquely positioned to contribute across all of these priorities, and has done so historically. Public health services are an integral component of the health care system, providing critical disease and injury prevention, health protection and health promotion strategies that mitigate the need for care and treatment in the first place and contribute to an improved quality of life for Canadians and communities.

The US Centers for Disease Control and Prevention prepared a series of reports over 1999 regarding the ten great public health achievements of the century. These include: the impact of universally recommended vaccines for children; safer and healthier foods; motor-vehicle safety; improvements in workplace safety; control of infectious diseases; fluoridation of drinking water to prevent dental caries; decline in deaths from heart diseases and strokes; healthier mothers and babies; family planning; and tobacco demand reduction and control.<sup>13</sup>

Canada has experienced similar successes. Life expectancy in 1996 was 78.6 years, up considerably from 50 years at the turn of the century. Factors in this improvement include

immunization, sanitation and clean water, pasteurization, improved nutrition, and adequate housing. The importance and cost-effectiveness of prevention, protection and promotion is apparent in the development of vaccines. Since they were first introduced, Canada has experienced a 95% reduction in preventable diseases among children and the total elimination of polio. Another example is injury prevention. Canadians spend \$8.7 billion annually to treat about 2 million injuries that for the most part could have been predicted and prevented. Protective and prevention measures such as seatbelts and bicycle helmets and speed controls and highway redesign have helped to reduce the overall rates of injury deaths. By implementing these kinds of prevention strategies, there could be 22,000 fewer injuries and permanent disabilities and about \$500 million in net savings in health care costs annually.<sup>14</sup>

Nevertheless, despite successes in certain areas in our health care system, including public health, the adverse effects of certain other factors operating largely outside of the health system continue to limit individual and population health gains. While Canadians generally have equal access to medically necessary health services, they do not all have equal access to good health. Health status is not evenly distributed and significant health inequalities persist: low-income Canadians are more likely to suffer more illness and to die earlier; Aboriginal people die earlier than non-Aboriginal people; and infants and children who are neglected or abused are at higher risk for injuries, later behavioural, social and cognitive problems and death.<sup>5</sup>

Public health also plays a very significant role in creating and maintaining effective alliances with important “health-determining sectors” that operate outside of the health system. These sectors are often instrumental in the development and implementation of public policies that produce and maintain health (along with prosperity and well-being). This includes, among others, fiscal and economic policy, social services, education, justice, housing and transportation.

Here again, disease and injury prevention, health protection and promotion measures have been demonstrated to be important and cost-effective. While work in this area is at a comparatively rudimentary stage, the potential impacts are very significant. For example, we have come to accept that the quality of nurturing and stimulation available to preschool children is a key determinant of healthy child development. On the issue of income, a summary report of a recent study on income inequality and mortality suggests that a hypothetical 1% increase in the share of income to the bottom half of the [income] distribution would result in an associated decline in the mortality rate of 21 deaths per 100,000. This suggests that the effect, in public health terms, is nearly equivalent to the mortality gains that could be achieved by eliminating deaths from both motor vehicle accidents and breast cancer among people of working age.<sup>1</sup>



## 6.2 A Public Health Strategy within Health Services Reform

In a more integrated and balanced health system, public health along with disease and injury prevention, health protection and promotion, and healthy public policy would be endorsed as a critical component and public health policies, programs and services would be planned, funded and delivered accordingly.

In February 1996, the CPHA Board of Directors published an Issue Paper, Focus on Health: Public Health in Health Services Restructuring. This paper described the key features of public health practice:

- a comprehensive approach that encompasses disease and injury prevention, health protection, health promotion and healthy public policy and that embraces strategies of empowering, advocating, cooperating and collaborating in working with individuals and communities both within the health system and in other sectors;
- a unique combination of perspectives, skills and knowledge that are applied in a variety of ways including disease surveillance and control, addressing the health of individuals in the context of communities, building intersectoral partnerships and advocating for the health of the public;
- a broad range of services, programs and strategies extending from administration, planning and evaluation through communicable disease control to community organization and mobilization;
- a multi-disciplinary group of practitioners including child care workers, epidemiologists, midwives, physicians, nurses, public health inspectors, occupational health and safety specialists, economists and community health representatives;
- working links with individuals, communities, the broader health system and other public and private sectors ranging from health units and departments and regional and district health authorities to colleges and universities, governments, employers and so on.

In order to contribute to future reform and restructuring initiatives, the public health system needs to be organized around a number of critical elements within the health care system:

- a continued focus on the broad range of factors that affect health;
- a strengthened public health knowledge and skill base, informed in part through consensus on a core of essential and accountable public health programs and services;

- an enriched capacity for multi-disciplinary practice and alliance-building;
- an enhanced system of accountability built on new indicators for health outcomes that capture disease and injury prevention, protection, promotion and public policy interventions across the broad determinants of health;
- a reallocation of resources across the full continuum of health services. This must effect a more equitable balance of health funding among all service components and particularly, ensure more and stable funding for public health which presently accounts for a mere 2-4% of total health care resources;
- the development of governance structures that promote and strengthen public participation in the decision-making processes associated with the planning, delivery and monitoring and evaluation of health care services.

## 7. Conclusions

Governments, and Canadians generally, need to capitalize on the significant work that has been undertaken within the provinces and territories and at the federal levels to bring informed and critically needed balance to health system reform. A lasting solution to the perceived funding crisis in health care is only possible if we reflect on what we know about what makes us healthy and the vision and framework this invites for the broad health system that is required for the 21<sup>st</sup> century.

This Issue Paper suggests that the building blocks for such a system must include:

- ▶ federal leadership and intergovernmental cooperation to create appropriate solutions to the immediate issues as well as the need to modernize the system and ensure its sustainability;
- ▶ a broad vision for health care for the 21<sup>st</sup> century that identifies an integrated continuum of services and is focused on population health and the full range of factors that affects it;
- ▶ enriched CHST funding and the development of an appropriate escalator to ensure ongoing, adequate financing of and stability for the health care system;
- ▶ federal financial participation in non-insured services including public health, primary care, and community and home care – all essential components of a comprehensive health system;
- ▶ strategies to strengthen the transparency and accountability of government health care funding including measures to strengthen information-sharing and best practices, services and system performance and public reporting on outcomes;
- ▶ measures to strengthen the development and delivery of public health within the broader health services continuum, including knowledge and skills development; human resources development and utilization strategies; alliance-building and intersectoral collaboration; performance and outcome indicators; and community-based governance systems;
- ▶ strategies for allocating more appropriate levels of public resources for public health and disease and injury prevention, health protection and promotion activities, from within global government budgets; and

- a moratorium on further privatization of Canada's health system until there has been a public analysis of the appropriate mix of public and private funding and delivery that is desirable and sustainable within a renewed health care system.

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