# Public Health in the Public Interest

**A Contribution from the Canadian Public Health Association**

**to the National Advisory Committee on SARS and Public Health**

**July 4, 2003**

## CPHA Mission Statement

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 which 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.



For more information, contact:
Canadian Public Health Association
400-1565 Carling Avenue, Ottawa, Ontario, K1Z 8R1
Telephone: 613-725-3769
Fax: 613-725-9826
E-mail: info@cpha.ca
www.cpha.ca

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## RECOMMENDATIONS

**Recommendation 1: A New Paradigm**

Canada requires a new paradigm for governance, financing, policy and practice in public health based on the following themes:

1. Preparation in advance of need (Be Prepared).
2. Recognition that public health is a national responsibility and that all levels of government and sectors must cooperate to protect the health of Canadians.
3. Build on existing assets.

**Recommendation 2: Funding**

$1 billion immediate investment in front-line public health. Establish a National Public Health Agency, with a Chief Medical Officer. Double current public health spending to at least $4 billion for the mid-term. Establish a new, comprehensive funding regime for the long-term based on the principles of adequacy, transparency and accountability. The components of this regime would include:

- Cost-sharing for on-going funding e.g. like Canada Assistance Plan AND
- Federal flexibility to innovate through Grants and Contributions, including those directed to national and provincial / territorial voluntary organizations such as CPHA and its provincial / territorial counterparts among others, to municipalities AND
- Infrastructure Fund for bricks and mortar and connectivity – the technology, data collection and sharing infostructure required for ready and rapid surveillance, planning and administration AND
- Stand-alone fund for development of health human resources.

**Recommendation 3: Health Human Resources**

Funds to encourage public health professionals to stay in Canada and stay in public health, such as what has been done to encourage M.D.s to locate outside urban areas. Funds to increase salaries. Funds and policy changes to increase nursing jobs to full-time.

Funds to encourage specialties in community medicine, public health, and public health administration. Enhance the prestige of public health work through the establishment of chairs in community medicine, public health in schools of medicine and nursing, and in public health administration in schools of public administration.

**Recommendation 4: Information Architecture**

Invest in upgrading of current information technology capacity of front-line public health and of linkages with related care facilities and provincial and national public health entities.

Invest in a "National 'Architecture' for data collection, information sharing and knowledge development.

**Recommendation 5: Partnerships**

Funding is needed to strengthen the already extensive role of stakeholders, including the voluntary sector and NGOs in strategic planning processes, in bridging diverse perspectives and disciplines, and in delivery of appropriate public health functions.

**Recommendation 6: Response Capacity**

Funds are required for the following:

- Rapid deployment of human resources
- Surveillance capacity
- Annual readiness exercises
- Communication systems (clinical, public, media relations)
- One public health professional in each hospital.
- Training of current staff, including immediate 'on-site' and community-based training.
- Specialized training in public health management

**Recommendation 7: Laboratories**

Funding is required for:

- Incentives to attract and retain skilled scientists who can carry out the required work.
- Upgrading equipment

Improvement in laboratory systems will be accomplished by the following:

- Establishing national standards for all laboratories
- Strengthening the regulatory authority
- Strengthening connectivity among all laboratory-related sectors (public health and health care)

**Recommendation 8: Communications**

- Conduct Canadian research into conditions facilitating compliance with public health directives.

- Re-introduce public health education in the school systems.

- Develop a national 'communication architecture', built on the strengths of current and potential actors including a comprehensive communication plan for public health emergencies, with agreed-upon and tested lines of authority.

**Recommendation 9: Comprehensive Review of Public Health**

CPHA supports the proposal by Senator Kirby for a comprehensive review of public health that results in a **National Public Health System** and encourages Dr. Naylor to encourage Senator Kirby to build upon work already done, and to involve the wide range of public health actors in his study.

**Recommendation 10: National Public Health Strategy**

Develop A National Public Health Strategy, building on the a National Public Health Agency and a Canadian Medical Officer of Health role recommended above. Additional components would include a financing role; educational capacity such as a 'public health institute' and a staff college; an Accountability Program; new 'information architecture'; new 'communication architecture', and a partnership strategy, as well as a research agenda, and a surveillance strategy that is the best in the world. The National Public Health Strategy must be founded in a comprehensive review of current and necessary legislation, including all dealing with public health, in all government departments, and implementation of a 'health emergency' legislation superseding jurisdictional consideration.

# Introduction

Thank you for the opportunity to contribute to your deliberations on these vital issues.
In our brief we will provide you with specific recommendations regarding your questions, and we will also present a 'larger view' of solving issues arising from SARS.

The Canadian Public Health Association (CPHA) has been Canada's primary voice for public health for nearly one hundred years. This brief reflects a long-term view, looking back to the successes of the past, and forward to the challenges of the future.

### Public Health is More Than the Health Care System

Our presentation is based on the recognition that public health approaches are required to address issues such as SARS that affect entire groups and populations, and that personal health approaches can not do so.

Public health is more than health care which usually focuses on diagnoses and treatment for individual patients. Instead, public health focuses on communities and populations for the prevention of disease, promotion of health and protection of the public.

It is also more than the programs we often associate with Public Health Services. It is certainly that, but it is also a science and perspective on the diagnosis of health problems and their mitigation or solution that looks beyond the individual and current events to underlying causes.

The public health approach is based on the conviction that improved health is linked both to the health of the individual and the community at large.

Strengthening of the public health system[1] in Canada should be guided by the following three principles, and all decisions about that system should be based upon these principles:

1. Preparation in advance of need (Be Prepared)
2. Recognition that public health is a national responsibility and that all levels of government and sectors must cooperate to protect the health of Canadians
3. Build on existing assets

Our conclusion is simple – Only a strengthened public health system can confidently serve the public interest and protect the Canadian population and prevent infectious, communicable and chronic disease.

### Principles

**1. Preparation in advance of need (Be Prepared)**

In order to meet emerging and urgent public health concerns such as SARS, BSE or bioterrorism, Canada must invest in full-scale public health capacity at the community level, in health care facilities, and in the systems required to provide world-class health protection for all Canadians. Investing in public health functions[2] will result in improved health of all Canadians and for the international

community, as infectious, communicable and chronic diseases are addressed through population health approaches.

As we invest immediately to strengthen local public health capacity, Canada must move from a "Just in Time"[3] approach to one built on the established motto of "Be Prepared" so that our public health capacity is adequate for tomorrow's challenges as well as today's tasks. In our view, the efficiency and economy principles that underlie a "Just in Time" approach have proven to be inadequate in dealing with health crises such as SARS, and water- and food- borne diseases, much less purposeful attacks on large groups of people such as this continent is now experiencing.

Furthermore, 'surge capacity' is impossible without a strong base capacity. For example: The current health system can be likened to a community or village where the underground systems that support it, representative of public health, are unstable and breaking apart, no longer able to sustain and support the health infrastructure above ground, representative of the acute care and personal care system. Immediate substantial attention to the foundation as a whole is required to prevent total break down of that foundation and collapse of the system as a whole.

**2. Recognition that public health is a national responsibility and that all levels of government and sectors must cooperate to protect the health of Canadians**

Canada's international renown in sharing costs of hospital and medical care arose because Saskatchewan's population recognized that catastrophic illness could bankrupt individuals and family resources through no fault of their own. In the face of that collective danger, some people thought 'outside the box', beyond individual risk and responsibility. Medicare was the result.

The SARS outbreak reminds us that Canadian's vulnerability to infectious disease is also a shared risk, one that is beyond individual ability to resolve. Thinking 'outside the box' of our recently engrained personal health care approaches can remind Canada of other past successes in health – those brought about during the last century through public health.

Canada's national success in eradicating disease, preventing illness and promoting health has been transferred across jurisdictions around the globe. This success came about because people, organizations, governments and businesses worked together to deal with issues they knew were larger than themselves. They recognized that polio could not be eradicated by dealing with one child at a time – immunization for the population was required, and the public, private and NGO sectors worked together to make that a reality.

We recognize that public and political focus on costs of insured personal health care have drawn attention away from public health approaches which are not only non-insured by Medicare, but largely invisible because of their successes. But SARS reminds us that public health is a national responsibility, transcending government jurisdictions, disciplines, and sectors of society and the policy and program silos that result. Canada must also recognize that while the source of a public health emergency may differ, the approaches and outcomes are often similar. For example, a purposeful

spread of SARS, smallpox or anthrax would have the same result as an unintentional one and policies and programs that bridge existing silos of personal care, emergency preparedness and public health are in the best interests of Canadians.

By working together across industry, government, the health and environmental NGOs, and international boundaries, progress has been made before, and will be made again as public health approaches are applied to infectious disease, and to the pressures of chronic illness that burdens the personal health care system.

**3. Build on existing assets**

Across the country there are concentrations of experience, expertise, knowledge, equipment, systems, information. However, linkages between and among levels of government; private and public sectors, and disciplines are often lacking, as was demonstrated by the SARS outbreak and by Walkerton. It also appears that when the linkages do exist, they are sometimes ill-used. As well, the fact that responsibility for 'protection of health' is spread across eight departments and agencies within the federal government alone provides opportunity for building on strengths, and improved coordination and collaboration.

We see real value in the establishment of a National Public Health Agency with a Chief Medical Officer, building in such elements of the Centre for Disease Control and Prevention as appropriate to our context and current situation and built on existing strengths. Implementation of such a National Agency would complement the separate $1 billion in local capacity support.

Canada's model of public health reflects our unique history, cultural diversity, government and governance. To have a public health system that can deal effectively and on a timely basis with current, emerging and urgent issues, when and where they arise, we must build the future on a threefold foundation of the strengths of the past, the learnings of the present, and the experience of others.

# Specific Naylor Committee Issues

CPHA's response to The National Advisory Committee on SARS and Public Health's suggested topics for inquiry are addressed below, following a paraphrase of the issues. Each recommendation is based in the new paradigm proposed above.

**1. Infectious Disease Control and Prevention Models**

*The National Advisory Committee asks about enhancements to national infectious disease prevention and control capacity, and about seamless linkages with the broader public health and clinical systems.*

The first issue is capacity. Over the past several decades, the public health infrastructure in Canada has been progressively weakened, and public health functions dispersed across departments, jurisdictions, geographic areas, and sectors. The essential human resources, equipment, knowledge,

experience, supplies such as vaccines that can protect people and prevent disease and injury through population health approaches have been weakened, if not set aside, by an emphasis on personal health, and the associated costs.

Expenditures on public health cannot be determined with accuracy; the need for improved data collection has been recognized by the Canadian Institute on Health Information (CIHI), which currently carries out that task. However, we observe that decisions about amount and direction of the money that has been spent has led us to the situations where public health tragedies like SARS, Walkerton, and the Battlefords can bring municipalities to a near stand-still, with immeasurable human costs and economic consequences.

In the **short-term**, an immediate investment of $1billion is required at the local level to enable public health departments to meet current needs. That is where public health begins. The $1B would enhance all public health functions, as well as begin to make linkages among all existing systems and jurisdictions providing public health services and collecting and analyzing information. NGOs that contribute to these efforts should also be supported in their essential advice, advocacy, analysis, and linking roles, as well as in their service provision in health promotion. As well, we see real value in establishment of a National Public Health Agency with a Chief Medical Officer to provide expertise and facilitation coordination of Public Health.

In the **mid-term**, current public health funding should continue to increase so that at the end of five years the base has increased to at least $4billion. In the absence of good financial data, and with the current status of public health, proposing a 100% increase is as reasonable an approach to amounts as is available at the current time. These funds should top-up local capacity needs, and to begin implementation of the National Public Health Strategy which is recommended later on in this brief.

As a **longer-term** measure, CPHA puts forward for discussion a new funding regime for public health, on which we will consult further in the coming months.

CPHA notes that the public's trust in government continues to decline. Calls for increased accountability mount, and transparency in government spending has become a mantra. The public has been shocked to find that money directed toward health care by the federal government, was spent on lawnmowers by some provincial governments.[4] If citizens are to be full participants in public health, as they must, increased trust in government can be aided by fuller accountability for their tax dollars. CPHA believes that a more reliable and transparent funding regime that is targeted to public health will serve Canadians best in the current climate. In order to 'Be Prepared', adequate, predictable funding is required.

The new funding mechanisms should be based on the principles of adequacy, transparency and accountability and be comprehensive. They should reflect the belief that public health is a national responsibility. The formula and mechanisms must be developed jointly with all who share

responsibility for public health, including municipalities, provinces, territories and the federal government.

CPHA is developing concepts of a suite of four funding mechanisms based on those principles to ensure a strong foundation for public health. The mechanisms would complement each other, and as a package would address both the current public health capacity crisis, and the desire to build for the future. They would be developed as the Canada Health and Social Transfer (CHST) is renegotiated during the next year, and implemented by 2005. The amounts of funding required would be determined as better information on current public health spending becomes available, and as a National Public Health Strategy is developed, as will be discussed in the last section of this brief.

**New Funding Regime**

1. Cost-sharing for on-going funding e.g. like Canada Assistance Plan[5] AND
2. Federal flexibility to innovate through Grants and Contributions, including those directed to national and provincial / territorial voluntary organizations such as CPHA and its provincial / territorial counterparts among others,[6] to municipalities AND
3. Infrastructure Fund for bricks and mortar[7] and connectivity – the technology, data collection and sharing infostructure required for ready and rapid surveillance, planning and administration AND
4. Stand-alone fund for development of health human resources.

**What Is The Short-Term Money For?**

Funds to build capacity for public health should be targeted to the following areas:

**a) National Public Health Agency**

The development of a National Public Health Agency would provide expertise and facilitate coordination of Public Health and a network of centres across Canada.

**b) Health Human Resources**

Health human resources are integral to public health; the shortages and limitations of the current workforce are many. The shortage of public health professionals including doctors, nurses and managers, in epidemiology, public health, infectious disease control and surveillance is problematic. Retention of current professionals in all areas, and recruitment of new professionals is key to the success of the public health approach. (The spread of SARS may have been fed by the efficiency approach underlying policy shifts that forced nurses to seek multiple employers). Funding and policy changes are required to deal with this critical human resource challenge. Short-term investments should not preclude the development of a national Public Health Human Resource Strategy.

**c) Information Architecture**

The absence of coordinated and collaborative information sharing systems horizontally and vertically across jurisdictions and sectors hampers timely and effective application of public health principles to SARS and other infectious, communicable and chronic diseases. SARS highlighted the

need for funding for equipment and information technology, technical support, and for linkages. While 1950's efficiency experts would be thrilled at public health departments' reliance on the use of three-part carbon forms for hand-written contact tracing reports, more contemporary technology is available now, which will dramatically increase efficiency.

Canada requires a virtual public health information network, based on the latest technology available, with various levels of access to increase utility. The concept is an 'all-hazards' approach that includes infectious and chronic disease (indicating vulnerable populations), as well as information relevant to counter-terrorism. The principles of data collection, analysis and information sharing are the same, regardless of the content and should be applied across jurisdictions and sectors.

This 'architecture' is not one database, but a series of them, with vertical and horizontal connectivity. Linking the information systems already in place is where to start in the design and implementation of the new architecture. It must include tested rapid response measures that link clinicians and researchers during emergencies; actions and investments for data management to track information for surveillance and decision support.

**d) Stakeholder Partnerships**

Organizations such as CPHA and its eleven provincial and territorial associations (PTBAs) are important representatives of broad public health interests, providing views from a multi-disciplinary, multi-sectoral perspective. CPHA and the public health associations in the provinces and territories build networks, coalitions and partnerships among and between disciplines and sectors that cultivate public understanding and bridge professional interests. Voluntary organizations such as the Heart and Stroke Foundation of Canada and the Canadian Cancer Society already provide extensive health promotion activities, often in partnership with public health units.

The voluntary sector and notably the voluntary health sector is a critical national resource in responding to on-going, emerging and urgent health concerns. In the aftermath of 9/11 it was found that the functioning of public and private organizations was affected by the mental health status of employees, including those directly involved in response. SARS has had some of the same impact. The effectiveness of the newly emerging Mental Health Support Network of Canada comprised of voluntary and professional associations can lead to enhanced functioning of individuals in all settings, which would increase public confidence at home and internationally. It is essential that governments at all levels increase support to the voluntary sector as we chart a course to enhance the response of our health system to new and emerging health concerns. The development of a national Partnership Strategy that ensures public health advocacy through intersectoral collaboration and public engagement is key to future relationships that strengthen public health.

## 2. Response Capacity for Outbreaks

*The National Advisory Committee asks about surge capacity, jurisdictional consideration, linkages between primary care and public health units, and institutional infection control.*

The concept of 'surge capacity' is founded on the belief of adequacy, from which resources can be re-allocated in time of need. Governments and businesses have focused considerable attention on the concept of 'redundancy' and have opted for an 'efficiency-based' approach to public services. As a governing principle, efficiency contradicts public health effectiveness. As one observer recently quipped "One man's redundancy is another's surge capacity".

When Canada's current public health units are adequately resourced for every-day work, Canada will have a stronger foundation to deal with current expectations for chronic disease, and will be better prepared to deal with the emerging and urgent health concerns, such as SARS or terrorist threats.

The absence or limited presence of public health in health care facilities contributed to a continuation of personal health approaches to SARS. As well, current care facility staff often lacks up-to-date training, information and equipment for infectious and communicable diseases. Containment of SARS was hampered because public health units have an insufficient number of trained staff to do contact tracing. Overall management of the containment effort was hindered by the lack of public health managers with experience in outbreak control.

Rapid response measures such as health emergency legislation, rapid deployment of human resources, surveillance capacity (include rapid response measures and routine surveillance), annual readiness exercises and communications systems are essential and should include clinical, public, media relations.

## 3. Laboratories

*The National Advisory Committee asks about the ideal laboratory network, and improvements to the current network.*

The application of the principles of 'national responsibility' and 'building on existing strengths' through adequate financial investment will address the public health staffing and connectivity and capacity issues specifically as they relate to laboratories and the laboratory network. Funding is required to provide incentives to attract and retain skilled laboratory scientists. Current inabilities or unwillingness to share information within the laboratory network are aggravated by the fact that three sectors—the public, private and voluntary sectors at three levels—the municipal, provincial and federal levels—provide laboratory services. The fact that at least one province has privatized laboratory services implies the need for stronger regulatory functions, with consideration given to establishing national standards for all laboratories.

Communication among laboratories at various levels; as well as among laboratories, clinical services, public health, and government regulators must be strengthened. Improved connectivity can ensure

that a problematic result is quickly communicated and immediate action can be taken to restrict the cause and plan for and implement appropriate responses. As well, strong penalties for lack of adherence to national standards should be implemented and applied to all laboratories.

The time frame for processing diagnostic tests is hampered by inadequate capacity at all levels; and consideration should be given to establishing a capital fund to upgrade equipment.

### 4. Communication to the Public

*The National Advisory Committee asks about enhancing communication to the public.*

Communication to the public must be based on the recognition that the heroic efforts of governments and professionals cannot succeed without every person's faithful observance to good public health practice. A single employee who side-steps quarantine directives can bring an entire electronics plant to a halt, for example, and further widen the reach of quarantine orders.

Trust is at the heart of communication. Canadians generally act in accordance with directions provided by a trusted authority; but are less willing to adhere to orders from an unknown figure seen to be acting from self-interest, or from a need to hide or downplay institutional inadequacy. The United States has had unfortunate experience generating compliance in some geographic areas, because some population groups fear targeting because of racial, ethnic or 'criminal' status.

Public authorities and organizations whose twin mantras are efficiency and cost-cutting are part of the reason Canadians trust government less than in the past, and trust politicians less than most other professions. As well, the initial refusal of governments to recognize the lack of an income cushion for Torontonians obeying quarantine orders clearly contributed to reluctance of some to stay away from work, further spreading SARS. Canada has some research regarding reluctance to obtain immunizations for disease, and this could be built upon to inform planning for current and future events.

As well, teaching of basic public health practices such as hand-washing seem to have fallen by the wayside in Canadian schools. Public health nurses are rarely present in schools, and individual responsibilities for public health no longer emphasized.

The SARS outbreak provides a case study for communications, with many voices, multiple spokespeople, and delayed and often-conflicting messages contributing to public uncertainty and international consequences. Clear, consistent, legitimate and timely information would have enhanced professional response, policy and practices, engaged effective public responses, and lessened fear. Improved communication, coordination and collaboration are needed to eliminate inter-agency and inter-jurisdictional breakdown such as resulted in the WHO travel advisory.[8]

An improved infrastructure for information dissemination based in tested and agreed upon authority and practice, and which includes international / national / provincial / local authorities and NGOs

will result in clear, consistent and timely exchange of information on disease outbreaks and provision of clear guidance on how to respond to a public health emergency.

As with the information architecture, the communication architecture should be multi-layered, building on existing communication and education capacity, and linked to counter-terrorism needs. As mentioned earlier, the cause of a public health emergency is less important than the outcomes, which are often similar.

As with the earlier recommendation on a national 'Information Architecture', Canada requires a communication system to ensure effective engagement of the public and enhance practitioner responses. Federal/ provincial/territorial and local government officials and relevant NGOs such as CPHA, their provincial and territorial counterparts, and the professional associations should inventory their current communications capacities, including systems as the beginning step. A communication strategy should include a research agenda (public health and communications researchers) to develop an evidence base of media / communication influences on health knowledge and behaviour; and, a targeted communication strategy with an evaluation component.

As well as establishing the 'architecture', the content and effectiveness of the plan must be regularly tested. Its content should provide clarity on the disease in question and options for preventive practice. The content would be multi-focused, with consistent messages but a level of detail appropriate to the audience – for example, new practice / research findings in detail to practitioners, but at a more general level for the public.

## 5. Other Considerations in Building Capacity for the Future

*The National Advisory Committee invites views on research, barriers, the relationship between public health and response capacity, and any other issues the respondents would like to provide.*

### Comprehensive Review of Public Health in Canada

The status quo is not 'good enough' to guarantee Canadian leadership in planning, preparing and responding to public health issues in our continuously changing and globalizing world. CPHA concludes that the time is right for a comprehensive review of public health – its capacity, financing, legislative structure, jurisdictional issues, functions and research. A comprehensive review is required to implement the new paradigm for public health. The recent announcement by Senator Kirby that the Senate Standing Committee on Social Affairs, Science and Technology plans to study the public health system is a good start.

The process Senator Kirby engages in is key to success. The review must reflect multi-jurisdictional, multi-disciplinary, multi-sectoral responsibilities and activities. Key stakeholders such as CPHA, and its provincial / territorial counterparts, the Federation of Canadian Municipalities, voluntary associations, and professional associations must have opportunities for input. Senator Kirby can build on existing knowledge such as the several papers produced recently by the 2001 "Survey of Public Health Capacity in Canada" and reports from the Canadian Institutes of Health Research as well as the

recommendations from public health experts set out in the Lac Tremblant Declaration in 1994.[9]

Such a review should result in a common understanding of public health, its functions, roles and responsibilities, and strengths and gaps; and, practical actions and investments for strengthening public health over the next five years in the areas of governance, policy, financing, human resources, information management, research and surveillance, and accountability.

While Senator Kirby's proposal for a comprehensive review of public health is a good step, we recognize that the work will not be completed within four months. It can however set the stage, and through attentive listening, perhaps can propose an agenda for next steps toward development of a public health system for the new millennium.

As the Kirby Committee is at work, public health is growing and becoming more integrated as a field. We recognize the need to explore more broadly what is needed, and to develop the best solutions to Canadian concerns. Public health sector actors will work together to move toward the future; and CPHA will continue to play a leadership role.

CPHA believes that Canadians must pull together to develop and implement a coordinated, cooperated, clear consistent collective ability to address urgent infectious outbreaks which threaten the well-being of Canadians and the Canadian economy; and to plan for and take preventive action for chronic disease and the other functions of public health.

**A National Public Health Strategy**

The development of a National Public Health Strategy is a mid-term goal that must be done to ensure effective preparation for the future. CPHA'S discussions to date tell us that **the critical first step must be to increase current front-line public health capacity and to establish a National Public Health Agency.** CPHA believes that other early actions must be crafted in ways that complement the indispensable first step. Any actions that would take funding away from those two priorities in the short term will slow Canada's preparations for the next inevitable public health crisis.

A National Public Health Strategy should comprise a comprehensive and integrated set of policies, leadership and other activities that work together to protect the health of Canadians. Our previously recommended National Public Health Agency with the Medical Officer of Health would form the nucleus of a larger strategy. At least some of the elements would include a national presence of expertise in public health – containing some elements of the U.S. Centers for Disease Control and Prevention.[10] A second element would be a national leadership role – perhaps a Canadian Medical Officer of Health modeled on the U.K. role[11] Responsibilities might include the implementation of an intergovernmental public health strategy; the implementation of an intergovernmental governance model for collaboration and cooperation' and an annual report on the state of Canada's public health system and its capacity to provide essential service. A third element might be financing of public health activities. A fourth element should be an Accountability Program that annually reports to the public and parliaments on high level outcomes from the recommended actions and investments, and

on the state of Canada's public health system and its capacity to provide essential services. The launch of a national Public Health Human Resource Strategy is key.

The National Public Health Strategy should include integrated models of teaching and practice (e.g., cross-jurisdictional rapid response, intersectoral intervention impact a determinant of health) and dissemination of best practices to close the public health gaps and retain public health professionals. As well the Information Architecture, and Communications Architecture referred to earlier must be included in the overarching National Public Health Strategy. The Agency would work collaboratively with federal / provincial / territorial jurisdictions and processes, and would have capacity to support national surveillance, and analysis of disease trends, population health issues and emerging public health problems. It would have resources to fund positions to work in provincial / territorial and large municipal health departments to facilitate an epidemiological and public health network. As well, it would provide visibility and ongoing credibility on public health issues, and have the capacity and expertise to assist in controlling disease outbreaks.

Actions like those cited above increase the visibility of public health and help sustain public and political attention to public health into the future, and ensure a central place for public health perspectives in the broader view of health systems.

As well, the need for on-going training and upgrading of public health professionals, and for closer linkage between academia, professions, research and practice could be built through a 'Public Health Institute', or a 'Staff College' such as exists for the United States Public Health Service. A research agenda led by CIHR that invests in intersectoral research on all aspects of public health is essential. All of these elements should be grounded in a comprehensive review of current legislation dealing with public health, including those of all governments, and all departments that have some degree of responsibility for public health. As well, CPHA believes that 'health emergency' legislation that can supersede jurisdictional considerations must be implemented as part of overall legislative reforms.

# Conclusion

The Canadian Public Health Association is calling for a 'paradigm shift', a change in the way Canada thinks of, plans for, and responds to health concerns such as SARS. We must move from a just-in-time, efficiency-based, personal health model to a public health approach that is grounded in adequate capacity to meet Canada's expectations for the health of the whole population.

Only through such a momentous shift can Canada be prepared for whatever comes next on the health front. As Canada led at Alma Ata, when the new population health approach was developed for the World Health Organization, as Canada led in the development of insulin, as Canada leads in tobacco control, this country can again lead the way in public health. Now is the time for courageous leadership, outspoken risk-taking based on both evidence and on hope for the future.

Canada's time in public health is now.

## References


1. Characteristics of a properly functioning public health system: Fundamental philosophy is to prevent disease and improve health by all means possible (identify core functions here); Clearly defined roles and responsibilities at all levels of society; Intersectoral collaboration; Rapid response; Surge capacity; Instant communication everywhere; Corporate memory lasting decades; Self-repairing; Self-renewing–adaptable, evolving, learning, teaching, researching; Superb coordination ability; Independent of short-term political or fiscal pressures; Always evaluating effectiveness of its actions; Transparent–honest, open; Accountable to the Canadian public.

2. Public health functions include: Population health assessment; health surveillance; health promotion; disease and injury prevention and health protection.

3. 'Just in Time' is a business philosophy - resources are not stored up against certain necessities, much less against uncertain possibilities. The basic idea is to have available only the supplies and human resources for what is needed for a certain level of operation and putting in place a number of management functions that will trigger the provisioning of capacity as need expands.

4. "Ms. Mclellan: I've got to say. There wasn't that much abuse in the last one. I mean things like lawnmowers get a lot of attention, right? You know, I'd like people to understand that there may have been one lawnmower bought in New Brunswick, or an ice machine here or there. But I think, overall, based on the reports I have seen, from the provinces, the money was overwhelming spent on high-end diagnostic equipment. " Hill Times March 24, 2003. accessed at http://www.thehilltimes.ca/2003/march/24/mclellan/ July 2, 2003

5. Though the CAP is long gone, and most federal transfers are 'unconditional', Health Canada continues cost-sharing arrangements with provinces for alcohol and drug treatment programs.

6. Health Canada already provides more than $100M in contribution funding to several thousand voluntary sector organizations to deliver on departmental priorities such as Pre-natal nutrition and Heart health, Canadian Diabetes Initiative, Tobacco control, and Aboriginal Head Start among others. Solicitor General provides sustaining grants to 14 national and provincial NGOs to enable the NGOs to do their work.

7. Federal Infrastructure programs provides direct grants to municipalities for water / sewer upgrades among other purposes.

8. WHO criticized Canada for lack of cooperation between feds/provinces during SARS. And, the public made clear during Romanow that they are 'fed up' with federal / provincial bickering on responsibility for health.

9. "Proceedings and Recommendations of the Expert Working Group on Emerging Infectious Disease Issues" Canadian Communicable Disease Report, vol. 20S2, December 1994.

10. CDC model includes chronic and infectious, HHR, data collection and dissemination, research etc. About 48% of its nearly $8billion budget goes to Infectious and communicable disease control including HIV/AIDS and immunizations including vaccines for some Americans. Some portion of this $8billion goes in the form of grants to individual states. CDC is dispersed across US with 25% of its staff outside Atlanta.

11. The Chief Medical Officer of the U.K. is the U.K. government's chief medical advisor and England's Chief Medical Officer. (There are other Chief Medical Officers for Scotland, Wales and Northern Ireland.) The appointment is within the civil service. The CMO has two Deputy Chief Medical Officers and leads a team of nine Regional Directors of Public Health. He also provides leadership to all public health staff in the country, including those employed by local National Health Service bodies.