

Chapter 4

ENHANCING THE PUBLIC HEALTH INFRASTRUCTURE: A Prescription for Renewal

Chapters 2 and 3 have shown how and why the infrastructure that supports the delivery of public health services in Canada is fragile and uneven. Canadians must be able to rely upon public health to protect them from hazards to health, known and as-yet-unknown, while providing the full range of public health services. Some phenomena are predictable (e.g., “flu season”), but most public health threats are unpredictable in their timing and location. As the SARS episode has demonstrated, they can also be unpredictable in their nature. The structures and processes required to enable core public health functions constitute the public health infrastructure [PHI]. This infrastructure is analogous to personal health services, where clinical interventions such as surgery and drug therapy require an infrastructure of hospitals, doctors, nurses, equipment, medical schools, a pharmaceutical industry and so on. Hence, in this chapter, we consider the nature of the PHI and recommend strategies for renewing it at the federal, provincial/territorial, and municipal levels.

4A. Core Elements of the Public Health Infrastructure

The PHI schema set out below is similar to that used by the CDC. The first three categories apply across the system at the local, P/T and national levels.

a. Organizational Capacity

- Agreed strategies to maintain the capacity of the public health system, to effect improvement in major health issues, to set priorities and make strategic investments.
- Modern legislation, harmonized across jurisdictions.
- Defined essential functions, programs and services.

- An effective governance structure to ensure clear decision making authority and public accountability, that ensures clarity of roles and responsibilities within a systems-wide perspective, and maximizes resources to achieve public health objectives.
- Visibility for, and leadership of, the public health community and effective communication with the public.
- Mechanisms to consult and undertake collaborative planning to develop national strategies for important public health issues.
- Mechanisms to support non-governmental organizations and to consult with them.

b. The Public Health Workforce

- Appropriate number of staff.
- Standards for qualifications and competencies.
- Health human resource planning for public health.
- Accessible and effective training programs in a number of formats.
- Lifelong learning and career-development opportunities.

c. Optimal Business Processes and Information and Knowledge Systems

- Defined, optimized and agreed programs and business processes, including a streamlined and enhanced capacity to assist with the management of outbreaks of disease and threats to health, including linkages to clinical systems.
- Standards and best practices.
- Research related to population and public health.

- A central resource for knowledge translation and evidence-based decision-making, including the identification of research needs.
- Evaluation of population and public health programs.
- An information infrastructure, including information architecture, models and standards, technology transfer, privacy and information management, development of data sources, and system development.

To these three categories one can add a fourth category of functions that fall naturally to the national level. These include highly technical or scarce expertise, facilities or equipment that constitute a specialized reserve or surge capacity that is best provided or organized nationally, and formal international liaison activities. The federal public health function is a participant in the first three categories, and the provider of the fourth.

d. National Strategic Capacity

- Continuing national resources
 - technical assistance
 - development of technical protocols and practice guidelines
 - reference laboratories
- Specialized surge capacity
 - personnel
 - materiel
 - logistics assistance
 - management and/or coordination of outbreaks and emergencies
- International
 - liaison with, and reporting to/from foreign countries and international organizations

This schema illustrates first and foremost that there are no great mysteries in the organization of an effective public health system. Most of these functions are self-explanatory. Rather than elaborate on all of them here, we shall focus on a few general and critical functions. Additional detail on outbreak management, disease surveillance, laboratories, and health human resources follows in the next chapters.

4B. A New National Public Health Focus

4B.1 General Considerations

Many submissions from health stakeholders have called for a revitalization of the public health organization at the national level and the creation of a professionalized extra-governmental centre of expertise. For example, the Canadian Medical Association has recommended the “creation of a Canadian Office for Disease Surveillance and Control as the lead Canadian agency in public health, operating at arm’s length from government.” The Canadian Public Health Association reported on consultations showing “that the critical first step must be to increase current front-line public health capacity and to establish a National Public Health Agency.” The Canadian Infectious Disease Society also favoured a “CDC North” with a specific mandate for infectious disease prevention and control.

We have seen above that a national agency for public health is a common pattern in other countries of the Organisation for Economic Co-operation and Development [OECD]. The Population and Public Health Branch [PPHB] of Health Canada currently operates many of the core federal public health functions for Canada. Its organization chart (see Appendix 4.1) includes multiple centres, some headquartered outside of Ottawa. In suggesting a major restructuring of Branch activities, the Committee intends no disrespect to the culture or accomplishments of Health Canada or the federal public service in general. However, the current placement of public health functions within a department of government puts public health professionals inside a very large organization and a highly process-oriented culture with a particular orientation to the political issues of the day. One advantage highlighted by many commentators has been the transparency and enhanced credibility arising from a clearer distinction between scientific advice on the one hand, and policy-making within Health Canada and Parliament on the other. A new agency could also provide expert advice to regulators in areas such as food safety, environmental hazards, and therapeutic products.

The processes by which policy is developed and communicated may be suboptimal for the provision of specialized public health services or even advice on regulatory matters. Whereas the scientific process demands a relatively free flow of information, governments tend to seek control of communications and aim for a somewhat hierarchical policy function leading towards the ultimate democratic authority—Parliamentary debate and decision making.

Some observers believe that one organization cannot discharge both functions concurrently; rather, these streams should be brought together by building stronger bridges between the distillers of evidence and the framers of policy. Moreover, a service orientation and collaborative culture are essential if the new national agency is to fulfill the mandate that Canadians rightly expect of it. These attributes are at least partially distinct from other policy-making functions.

The Committee believes scientists and professionals would find an arm's-length public health agency more attractive as a place of employment. An agency would enjoy greater flexibility in developing cooperative or contractual arrangements with academic institutions and other private partners, thus facilitating research and enhancing access to first-class talent. Agency status might also provide for a longer time horizon and greater stability of funding, with less risk of diversion of funds to other purposes.

The creation of an agency cannot depoliticize traffic among jurisdictions, but it could reduce the chances that the health of Canadians would inadvertently be held hostage in a jurisdictional disagreement among levels of government. An agency standing outside government and led by a public health professional could find new ways to engage public health professionals in the provinces and territories, and re-energize the public health workforce. Creation of an agency would also bring the delivery of public health services in line with public health in many other countries.

By analogy, personal health services themselves are generally not delivered directly by federal or provincial governments. They are devolved to a vast number of individuals, institutions, and agencies. We see potential for better partnership with personal health service providers through a new public health agency, particularly given the sometimes acrimonious interactions around health care at F/P/T tables in recent years. An agency would also provide some continuity of leadership and insulate public health functions from the lamentably short terms in office of senior F/P/T health officials and health ministers during the last decade.

4B.2 What Does 'National' Mean?

The lexicon of Canadian F/P/T politics, and the need to reinforce public health infrastructure at all levels of government lead logically to consideration of two options for a national agency. One is an F/P/T agency, accountable to federal, provincial, and territorial representatives. This is the model endorsed by the Council of Chief Medical Officers of Health. The other is a federal agency, more closely resembling the USA's CDC.

We begin with F/P/T agency options. One current example is the Canadian Institute for Health Information [CIHI]; it has blended F/P/T funding and governance. Albeit structured as a non-profit corporation, the Canadian Blood Services [CBS] is another distinct variant. It is P/T-governed and-funded, with the federal government acting as the national regulator for the agency. Creating any such agencies would involve difficult and time-consuming negotiations that could exacerbate existing tensions at F/P/T tables. CIHI has a more limited service mandate and much smaller budget than would be encompassed by the existing public health functions. The F/P/T agency option would also blur lines of accountability. As Prof. Kumanan Wilson¹ advised the Committee, the CBS model has other drawbacks. It has been criticized by provinces for importing the US problem of unfunded federal mandates to Canada, because it couples national regulation to provincial supply and payment. Even assuming new federal funds to cost-share the operation of a P/T-governed national agency, and federal regulations to create consistency of operations across provinces, this variant seems wholly impractical. In general, the F/P/T agency option is not compatible with calls for clarity of roles along with renewed federal and provincial strength in public health.

SARS has nonetheless underscored for Canadians the need for coordination of functions in areas such as disease surveillance, outbreak management, and emergency response. These areas inescapably involve a roll up of activities from the municipal or regional to the provincial, interprovincial, and federal levels. We shall return to these points in Chapter 5. For now, the Committee will simply highlight the logical appeal of an F/P/T network structured to reinforce and help coordinate disease surveillance and outbreak management on a truly pan-Canadian basis, linked to the work of the successful F/P/T network that is already operating in the realm of emergency preparedness and response. A new infectious diseases network would need earmarked funding that

1 Interested readers can find more information on Wilson's work on federalism at <http://www.iigr.ca/publication/detail.php?publication=301> (accessed on August 21, 2003).

could flow from a federal agency to provincial centres and agencies on an equitable, transparent, and strictly mission-oriented basis. It could become a bulwark against new threats such as SARS. Such a network, however, requires a strong federal node that can pull its weight in disease surveillance, outbreak management, and emergency response. And, for reasons given in Chapter 3, the federal government must be positioned to work more generally in support of provincial and municipal public health programs. To these ends, the Committee endorses the creation of a new federal public health entity which, for ease of reference, we shall term the *Canadian Agency for Public Health*.

4B.3 The Structure of a New Federal Agency for Public Health

The Committee considered some options available in the current machinery of government.

A **Crown Corporation** offers substantial independence from the financial and personnel controls that accompany departmental administration. The enabling legislation for each Crown corporation sets out the corporation's mandate, powers and objectives. Crown corporations are accountable to Parliament through assigned responsible ministers. The federal government retains power and influence over Crown corporations through: i) the appointment and remuneration of directors and chief executive officers; ii) directives and regulations; and iii) approval of corporate plans and budgets. The Committee concludes that a Crown Corporation removes the new agency too far from Parliament and government—a point of concern given the need to ensure integration of public health activity with a wide variety of departments, not least Health Canada itself.

Special Operating Agencies [SOA] are designed to balance controls (and risk avoidance) with encouragement of innovation and initiative. SOAs support a set of values—including innovation, enhanced authority at the front line, client-centred operation, self-regulation, better management of people and accountability for results—which will lead to greater efficiency of operation and improved service quality. SOA examples include Technology Partnerships Canada, Training and Development Canada and the Canadian Heritage Information Network. SOAs are not independent legal entities, and are established on the basis of Treasury Board approval. We reject this option on the grounds that SOAs remain part of, and accountable to, their home departmental organization, with preservation of all existing labour relations.

Departmental Service Organizations are operational units or clusters of units within a department. They are organized to deliver services to the department's clients. Like SOAs, they operate within a management framework approved by the deputy minister and the Treasury Board, but may represent a larger share of the department's overall activity than a typical SOA. No separate legislation is required. Environment Canada's Meteorological Service is the only such organization in existence. Again, this option does not provide the required independence or opportunity to integrate activity from multiple departments.

Separate (statutory) agencies, also known as **Legislated Service Agencies** [LSA] or Departmental Corporations, provide a fourth option. Included in this category are the Canadian Food Inspection Agency, the Canadian Institutes of Health Research, Statistics Canada and the Canada Customs and Revenue Agency. These are mission-driven organizations established by specific legislation to manage the organization and delivery of services within the federal government. They typically perform administrative, research, supervisory, advisory and/or regulatory services of a governmental nature. Legislation sets out the framework under which each agency will operate including its mandate, governance regime, powers and authorities, and accountability requirements.

Separate agencies differ only slightly from each other. They have the following common characteristics:

- headed by a chief executive officer [CEO] reporting directly to the Minister;
- supported by a "Board" with members appointed by the Governor in Council;
- subject to Ministerial direction;
- separate employer under the *Public Service Staff Relations Act* (e.g., increases staffing authority/flexibility);
- managed on the basis of a corporate business plan;
- focus on performance and accounting for results;
- greater financial and administrative authorities than traditional departments, e.g., ability to enter into partnering/licensing arrangements and can obtain non-lapsing spending/revenue retention/re-spending authority; and
- oversight by the Auditor General and subject to the *Official Languages Act*, *Privacy Act* and *Access to Information Act* and Federal Identity Program requirements.

As one example, the Canadian Food Inspection Agency [CFIA] has some powers/authorities that distinguish it from a “typical” department. These are listed for reference:

1. Separate employer (e.g., authority to appoint from outside of the public service, full control over classification, collective bargaining, pay and compensation);
2. Can set its own fees and sell assets/services, e.g., training, accreditation, intellectual property, and retain revenue;
3. Funded through parliamentary appropriations but can spend/carryover for two years at a time;
4. Enhanced F/P/T collaboration mechanisms, in that the Agency can
 - a. delegate inspection/quarantine powers to P/T public servants and private sector specialists;
 - b. enter into agreements with one or more P/T governments for the provision of services; and
 - c. create F/P/T corporations to carry out joint activities in a more “integrated” fashion;
5. Choice of service providers, e.g., legal, property management services; and
6. Increased contracting authority.

Even a cursory review of these characteristics underscores the rationale for the Committee’s recommendation that the new federal public health agency be structured as a legislated service agency.

The relevant legislation could be relatively skeletal with a view to timely passage. It would presumably include appropriate and consolidated authorities to address public health matters where the federal government is expected to provide leadership and action, such as national disease outbreaks and emergencies, with or without additional authorities regarding national disease surveillance capacity. Spending authorities, however, would need to be determined and specified, especially given the need for the Agency to use financial transfers as a means of strengthening infrastructure and collaboration on a truly national basis.

On the human resources side, it seems desirable for the organization to have the authorities of a separate employer under the *Public Service Staff Relations Act* to allow it to address unique recruitment and retention challenges in an environment of global competition for scarce scientific and public health expertise. Two other desirable features of agency status are the ability to use a 24-month financial

horizon, thereby escaping the perverse cycle of year-end spending that persists in Ottawa, and enhanced flexibility in selecting providers in areas such as information technology, legal services, and property management.

The new **Canadian Agency for Public Health** would report through its director to the Minister of Health. The Minister would be ultimately responsible for the agency, as occurs with the US CDC. The legislation would provide appropriate powers for delegation of ministerial authorities to officials. The Minister would continue to give policy direction to the agency and obtain any information required to provide appropriate ministerial oversight, direction and accountability. However, we envisage that the agency would have a strong internal priority-setting process and a clear strategic focus in its own right. In other words, the new agency would have meaningful autonomy as contrasted with, say, the relationship between Finance Canada and the Canada Customs and Revenue Agency today.

The constituting legislation might also include legal authorities to access and use sensitive data sourced from public and private sectors for public health purposes, creating a data enclave as exists for Statistics Canada. Indeed, the public health data enclave might be a ‘Swiss bank’ within Statistics Canada itself. Absent such authority, and given problems with extant privacy legislation as will be outlined later, the agency may have difficulties balancing the appropriate protection of privacy with its performance expectations.

As the agency would be part of the Health portfolio, the Government would need to clarify and establish the appropriate roles and responsibilities of Health Canada, as a department, in relation to the agency. We return to the specific question of agency scope below.

The agency would receive an annual appropriation from Parliament, and be subject to Parliamentary scrutiny in the same manner as for departments. That is, the Auditor General of Canada would provide oversight of the agency’s financial statements and performance, including an assessment of the fairness and reliability of the performance information contained in the performance report to Parliament. The Institute would also be subject to all legislation governing departments, such as the *Official Languages Act*, *Canadian Human Rights Act*, *Access to Information Act* and the *Privacy Act*.

4C. A Chief Public Health Officer for Canada

The Committee received a number of recommendations for the creation of a professionally-qualified leadership role in public health at the national level. This is variously described as a Surgeon General, National Public Health Commissioner, Federal Chief Medical Officer of Health, or Chief Public Health Officer of Canada. Among the many stakeholder groups endorsing variations on this theme were: the Council of Chief Medical Officers of Health, the Canadian Medical Association, the Canadian Federation of Nurses Unions, the Canadian Association of Emergency Physicians, the Canadian Public Health Association, and the Association of Canadian Academic Healthcare Organizations.

Other countries have established similar positions. In the UK, there are Chief Medical Officers for England, Scotland, Wales and Northern Ireland; and the UK's Health Protection Agency is headed by a public health physician. In the USA, the Surgeon General and Director of the Centers for Disease Control and Prevention are both health professionals.

The Committee has considered different options regarding this position. One would be to create a Surgeon General or 'auditor-general for health' who is arm's length and apolitical. This public health watchdog could report directly to the Minister as in the UK. A second and related option would be to establish the position as an officer of Parliament. Officers of Parliament are generally those who have cross-cutting functions related broadly to government and governance. This does not square fully with the public health role. In either case, the problem is that such an office would have moral authority but little else. An alternative option would be to create the role, but nest it within an existing or new structure. For example, in a new agency, a senior professional could be the Chief Public Health Officer, analogous to the Chief Veterinary Officer of Canada who reports to the director of the CFIA. This is feasible, but again could leave the Chief Public Health Officer in a rather awkward position as regards independently raising issues of broad concern for public health.

If the Chief Public Health Officer were also to be the chief executive of the new federal agency for public health, then he/she has a logical position of advocacy and leadership, and the tools to advance an agenda of change. We acknowledge potential conflicts of interest in the dual role: i.e., the Chief Public Health Officer has an interest in ensuring that the agency is perceived to be

discharging its responsibilities effectively. However, given the visibility of the agency, appropriate ministerial oversight, and—as described below—the creation of a National Public Health Advisory Board, this conflict can be mitigated.

Protections for the independence of the Chief Public Health Officer can be devised that are analogous to those in various provinces or territories. In urgent situations where the health of their respective public is threatened, a P/T health officer often has independent authority to notify the public and advise on measures necessary for public protection. Specific provincial examples exist for protection of the independence of chief health officers. In British Columbia, the Provincial Health Officer has the power to report directly to the legislature:

If the Provincial health officer considers that the interests of the people of British Columbia are best served by making a report to the public on health issues in British Columbia, or on the need for legislation or a change of policy or practice respecting health in British Columbia, the Provincial health officer must make that report in the manner the Provincial health officer considers most appropriate... Each year the Provincial health officer must give the minister a report on the health of the people of British Columbia including, if appropriate, information about the health of the people as measured against population health targets, and the minister must lay the report before the Legislative Assembly as soon as practical. (Health Act, ch 179, 2.3 (3) & (4))

In Manitoba, as a result of a review by the Ombudsman of events surrounding a delay in notification of the public, the employment agreement between the province and the Chief Medical Officer of Health states:

While accountable to the Department, the Chief Medical Officer of Health may function autonomously when necessary in the interests of the health of the public. Under these circumstances, the Chief Medical Officer of Health has the authority to issue public health advisories and bulletins, or take other actions. The Chief Medical Officer of Health will inform the Deputy Minister and/or the Minister prior to such actions or as soon as practically possible, in accordance with established protocols. (Schedule "I", (12))

In short, appropriate safeguards for the independence of the **Chief Public Health Officer of Canada** can be set in place without compromising her/his accountability as an agency director.

The Chief Public Health Officer of Canada would be a leading national voice for public health, particularly in outbreaks and other health emergencies, and a highly visible symbol of a federal commitment to protecting and improving Canadians' health. She or he should obviously be trained and adept in crisis communications. The Chief Public Health Officer of Canada should be required to report to Parliament on an annual basis on the state of public health, and given authority to make a special report to a special parliamentary committee on any matter of pressing importance or urgency that should not be deferred.

Additional duties of the Chief Public Health Officer of Canada could include:

- to protect and advance the health of Canadians by advocating for effective disease prevention and health promotion programs and activities;
- to articulate scientifically-based health policy analysis and advice to the federal minister of health and, as requested, provincial and territorial ministers of health, on the full range of critical public health and public health system issues;
- to provide leadership in promoting special health initiatives, (e.g., relating to health inequalities, childhood injuries, Aboriginal health) with governmental and non-governmental entities, both domestically and internationally; and
- to elevate the quality of public health practice in the professional disciplines through the advancement of appropriate standards and research priorities.

4D. Scope of the Canadian Agency for Public Health

Public health agencies, centres, and institutes around the world vary greatly in their scope. It is premature for the Committee to recommend exactly which activities and programs should be included at this point, beyond indicating our support for a strong and integrative organization. Instead, a systematic review of the scope of the new agency is needed. While there is also an option to have two, or more, agencies, as in the UK, we endorse a unitary structure. A list of areas for inclusion follows, together with a table indicating which activities fall within the scope of particular centres or agencies in different jurisdictions.

1. infectious disease, prevention & control
2. microbiology reference laboratories
3. emergency preparedness & response
4. chemical exposures
5. poison control
6. environmental health
7. chronic disease prevention & control
8. injury prevention & control
9. perinatal & child health/human development (programs)
10. health promotion grants
11. tobacco control
12. drug control
13. screening
14. occupational health
15. food protection
16. radiation protection
17. knowledge translation
18. research
19. infostructure
20. international collaboration



Agencies	Components
BC CDC	1, 2, 4, 5, 6, 12, 15, 16, 18, 20
Quebec's National Institute of Public Health	1, 2, 4, 5, 6, 7, 8, 9, 11, 13, 14, 18 20
New Zealand Institute for Environmental Science Research	1, 2, 4, 6, 18, 19
U.K. Health Protection Agency	1, 2, 3, 4, 5, 18
U.K. Health Development Agency	9, 17
European Centre for Disease Prevention & Control	1, 3
Finland: National Public Health Institute	1, 2, 6, 11, 18
Sweden: Institute for Infectious Disease Control	1, 2, 18
Norwegian Institute of Public Health (Folkehelseinstituttet)	1, 2, 18
U.S. Centers for Disease Control and Prevention	1, 2, 3, 7, 8, 9, 11, 12, 13, 17, 18, 19, 20
Canadian Food Inspection Agency	15

In Canada, a range of government departments and agencies engage in public health activities, including the Canadian Food Inspection Agency, Canadian Customs and Revenue Agency, Citizenship and Immigration Canada, Indian and Northern Affairs, and Environment Canada. In each of these cases, a working relationship exists with Health Canada. This division of roles may not be uniformly optimal. As one example, the area of environmental impacts on health has been seriously neglected in Canada and requires urgent investment; we envisage this as a program of activity that must be supported by the new agency.

Specific programs within Health Canada also deal with non-regulatory aspects of tobacco and nutrition. One view is that these functions should stay linked to the corresponding regulatory activities; another would argue that they should be rolled into the new agency. The Committee believes that regulation of food, pharmaceuticals, therapeutic products, pesticides, or consumer products should remain outside the mandate of the agency. While its work should inform the regulation of environmental hazards, and occasionally generate expert advice for federal regulatory functions as listed, the agency would not be expected to deal with the mechanics of regulation. For reasons that will be outlined in the next chapter, the Committee envisages that the Centre for Emergency Preparedness and Response would be sited in the new agency, albeit with continued cross-linkages to other departments throughout the federal government. The new agency should create opportunities to engage in activities that currently receive less attention in Health Canada than might be deemed ideal, such as injury prevention and control and mental health.

Zoonoses are of special interest to the Committee, for obvious reasons. The SARS coronavirus is simply the latest in a growing number of viruses that are believed to have moved from animals to humans with devastating effects in recent decades. Currently, the Chief Veterinary Officer of Canada works within the CFIA, serving as Executive Director of the Agency's Animal Products Division, with responsibility for administration of the *Health of Animals Act*. More specific responsibilities include surveillance systems, certifying that Canada is free of the International Organization for Epizootics (usually known by the French acronym, OIE) "A" list diseases, representing Canada internationally, and helping to manage veterinary epidemics of notifiable and reportable diseases.

At risk of oversimplification, one can say that the CFIA would consider an animal disease part of its mandate if it led to a food safety or food trade concern, or if it were legislated to be responsible for a disease. This leads to the odd situation whereby rabies and equine encephalitis (which are human health risks, but of little food safety concern) are considered part of the CFIA mandate because of legislation, whereas West Nile virus (a human and animal health concern but not a food safety issue) is outside of its mandate. As outlined in a submission from the Canadian Veterinary Medical Association [CVMA], veterinarians collaborate across federal, provincial, and territorial governments, and extensive lists of notifiable and reportable animal diseases are maintained and updated. The CVMA states, "Despite the extensive animal disease surveillance programs, there is no direct link with public health care programs; not at the national level, the provincial level, or at the local level...There is a much clearer role for veterinarians defined in federal statutes for animal disease control, and particularly for Reportable diseases, than seems to be the case for human health."



Zoonotics do have coverage within existing Health Canada structures. These include the Food Safety and Zoonotics Division within the Centre for Infectious Disease Prevention and Control, the Laboratory for Zoonotics and Special Pathogens at the National Microbiology Laboratory and the Laboratory for Foodborne Zoonoses in Guelph. Nonetheless, the new agency will clearly need to develop strong partnerships with academic veterinary medicine and the veterinary practice community in Canada. In this respect, the Committee notes that the 1994 Lac Tremblant report recommended that the government of the day should “[a]ddress zoonoses, such that an effective means of information sharing be established between all the interested groups (i.e., veterinary medicine, Agriculture Canada, regulatory bodies, Canadian Cooperative Wildlife Health Centre, public health).” Progress has been made, but more is needed.

As noted above, another function that should be strengthened and vested at least partly with a new agency is the production of an annual report on the health status of Canadians, as well as other reports focused on specific aspects of population health from time to time. Currently CIHI produces an annual report on the health of Canadians. This information and the related analytical capacity are essential for the new agency in setting targets and working towards them collaboratively with the provinces and territories.

We have deliberately left an issue of great importance for final comment in this section. The health status indicators for Canada’s First Nations and Inuit peoples are dramatically worse than those for the majority populations. These health status disparities are a national disgrace. They exist for a variety of infectious diseases as well as non-communicable illnesses. Addressing them requires a wide-angle approach to health determinants and community development that must clearly be integrally supported and guided by the affected Aboriginal communities. A continuing challenge in mounting appropriate responses is a recurring tension between the right and aspirations of Aboriginal peoples to greater self-determination within the Canadian federation, and the uncertain effectiveness and efficiency of reinforcing the extant pattern of separate health systems for First Nations and Inuit communities. Early in its deliberations, the Committee made a strategic decision not to move into this difficult terrain, believing that a superficial verdict would do more harm than good, and that the field was best left to general assessments with a longer timeline such as the one now underway by the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby. At this point, we shall say only that the scoping exercise for the new agency must be informed by a careful review of public health service provision and health promotion for First Nations and Inuit Canadians.

4E. A Federal Agency with a Pan-Canadian Orientation

Jurisdictional ambiguities and tensions have long bedevilled public health activities and programs as well as personal health services in Canada. Chapter 9 reviews how the federal government might work with the provinces to clarify some of these jurisdictional ambiguities and strengthen its legislative role in public health as part of the omnibus review of health legislation that is underway. However, attempts at unilateral centralization of authority in a fragile federation with a complex division of powers and responsibilities are generally a prescription for conflict, not progress. Measures to create collegiality, consensus, and commonality of purpose can lead to collaborative work that overcomes jurisdictional tensions. Indeed, as already stated, part of the rationale for a new agency is to remove it some distance from F/P/T fault lines. We accordingly review here some of the features of the agency that would give it a national rather than federal flavour and orientation. Three salient features are the distribution of the functions of the new agency, creation of what we term, after the Australian precedent, the Public Health Partnerships Program to flow funds to provinces, territories and municipalities in support of front-line public health functions, and the appointment of a National Public Health Advisory Board drawing on an F/P/T nomination process.

4E.1 One Agency, Many Locations

Health Canada currently operates a system of regional offices, with the headquarters of the Department in Ottawa at Tunney’s Pasture. Few of the core functions of PPHB are sited in these regional offices, and their connections to provincial and municipal health agencies vary from one office to the next. We see little merit in spreading agency staff through these offices. On the other hand, PPHB does have major foci outside of Ottawa. Particularly pertinent given the Committee’s mandate are the National Microbiology Laboratory in Winnipeg, Manitoba, and the Laboratory on Foodborne Zoonoses in Guelph, Ontario.

The Committee does not believe that the agency should be centralized in a single new location. This would involve a transition from the current arrangement, be disruptive for staff, and fail to capitalize on the full range of opportunities for partnership in P/T and municipal jurisdictions. We assume, moreover, that there will be some expansion of core functions in Ottawa, aligned

with the funding recommendations and national public health strategy (see below). But the agency must be seen to reach across Canada in tangible and visible ways.

There accordingly exist two logical options. One is to concentrate on specific locations for establishing or expanding agency functions that reflect the current geographical siting of PPHB. The other is to expand judiciously some of the existing sites and deliberately devolve some existing or new functions to new locations across Canada. In this latter vision, which the Committee endorses, an explicit effort would be made to delineate regional hubs (for example, in Vancouver, Edmonton, Winnipeg, Toronto, Quebec City and Halifax) that could each offer a specialized national resource, differentiated in support of the entire system (such as exists in Winnipeg with the National Microbiology Laboratory).

In the next chapter, we outline our recommendation for a national network of centres for infectious disease control, predicated on a provincial/regional hub system as recommended by the Canadian Public Health Association, and building on strengths by involving P/T, academic, and possibly other partners. Even without details about the network concept, one can imagine a fully developed system in which each regional centre has two components, both bolstered by partnerships with local academic centres, the relevant municipal health agency, and other stakeholders:

1. A regional centre focused on infectious disease surveillance and outbreak management, with F/P/T funding, networked into a national steering committee, and reporting to a director appointed under specific P/T authority (either on a single jurisdictional or multi-jurisdictional/regional basis). Federally-funded personnel could work in the P/T regional centre (or elsewhere in municipal or provincial public health agencies) as part of a system of strategic secondments within a national public health service.
2. A specialized federally-funded and administered centre, serving as a national resource, led by a director within the new federal agency, and reporting to the Chief Public Health Officer of Canada.

In the best of all worlds, activity in these regional hubs would become mutually reinforcing, with the emergence of a common culture dedicated to protecting the health of Canadians. Regional specialty centres within the new agency might supplement some of the technical support functions of P/T ministries. For example, public health laboratory functions could logically be rolled into a P/T

regional centre for infectious disease control. If a federal laboratory were to be developed as a specialized resource and co-located, sharing of infrastructure and supplies would make sense. These hubs would be ideal settings for applied research, with both practitioners and academics involved in joint research programs. They would also be excellent settings for various types of training programs.

Last, some specialized federal resource centres may in themselves operate on a networked basis. While this reduces critical mass for regional hubs and F/P/T synergy, the network approach may have other advantages.

The key, in all cases, is to avoid building an empire at Tunney's Pasture and create a new culture of outreach, partnership, and excellence. As regards partnerships, any new agency must consult widely with stakeholders in the broader health community, including the voluntary sector and service provider associations and unions, to ensure that the energy and creativity of non-governmental organizations [NGOs] is usefully harnessed.

4E.2 A National Public Health Advisory Board

The Committee also envisages the prompt creation of a **National Public Health Advisory Board**. This Board would advise the Chief Public Health Officer of Canada on the most effective means to create and implement a national public health strategy that reinforces pan-Canadian collaboration so as to protect and enhance the health of Canadians. The Board would be chaired by a distinguished Canadian prominent in the health sphere; its membership must reflect Canada's geographic, cultural and linguistic diversity, as well as the range of disciplines and stakeholders in public health. International representatives prominent in public health would be included on the Board.

To maintain appropriate and clear lines of authority, the agency and its chief executive must report to the Minister; the Board is therefore not a board of directors in the usual sense of corporate governance, but rather has an advisory and strategic role. Nominations could be solicited from existing F/P/T networks and advisory committees, as well as key stakeholders in the health sphere. In order to facilitate pan-Canadian collaboration and integration of public health functions with the broader health agenda, one option would be to stipulate that Board nominees must be vetted by the F/P/T Conference of Deputy Ministers of Health. In any case, members would be appointed to limited terms by the federal Minister of Health, and the Minister could ask the Board for input on the performance of the Chief Public Health Officer of Canada.

4E.3 A National Public Health Strategy

As noted in Chapter 3, many countries have coherent strategies with nationally-agreed health goals. These nations link legislation, programs, monitoring, standards, funding and accountability to a national strategy and objectives.

Canada currently lacks an overall strategic approach to the health field; this includes both public health and health care. Several stakeholder groups, including the Canadian Nurses Association and the Canadian Public Health Association, called for the creation of a national health strategy. This theme also emerged strongly from focus groups with front-line hospital staff and their unions.

Some provinces do have specific health goals. Sector strategies at the federal level also exist with varying degrees of collaboration for foci such as healthy living, cardiovascular disease, cancer and immunization. Further, provinces drawing on federal transfers and their own revenue bases will want to set their own public health priorities. However, the Committee sees overwhelming merit in a collaborative process to integrate existing strategies and forge an F/P/T consensus on goals. Canadian citizens deserve a national health strategy that includes specific health targets, benchmarks for progress towards them, and collaborative mechanisms to maximize the pace of progress. The Committee envisages a process whereby public health professionals from different levels of government and from major stakeholder groups should confer with a view to developing priorities, goals and strategies. Public health professionals from Ottawa, the provinces, the territories, and various non-governmental partners must also pursue strategies to address the surveillance info- and infrastructure, and human resources, topics reviewed in more detail in Chapters 5 and 7. New federal funding for public health should be explicitly tied to these strategies and plans, with process and outcome reporting as in the Australian model, and be structured as contributions that are subject to audit (see below).

The national strategy should include provisions for a coherent response across jurisdictions to outbreaks of communicable disease. Infectious disease/public health emergency plans should be coordinated one with another and tested in simulation. However, the strategy must not be limited to infectious diseases: the application of increased resources and new structures should facilitate the development and implementation of a broader national strategy to address causes of chronic diseases and injuries. More research, more research synthesis and better evaluation of health promotion and other programs are all necessary as part of any effort to enhance the

effectiveness and efficiency of public health. And these strategies, in turn, would integrate the efforts of federal, P/T, and other stakeholders.

The Committee views communications as an integral part of a public health strategy, not a separate, stand-alone item. The scope for public education is substantial in many areas of disease and health promotion. For example, a national campaign—developed in partnership with a number of stakeholders—could be launched to enhance public awareness of the risks of various infectious diseases and encourage sensible new norms in behaviour, e.g., more frequent hand washing, avoidance of work while in the contagious phase of a respiratory illness, use of surgical masks to prevent droplet transmission of viruses, and care during illness with a respiratory or enteric virus to prevent potential contamination of fomites (an inanimate object that can carry disease-causing organisms) in the work or home environment. Increased engagement of key stakeholders in communicating with the public, before and during infectious disease outbreaks offers new opportunities to inform the public through additional, innovative communications channels (i.e., employers, unions, and industry sectors directly implicated).

4F. Funding to Strengthen Canadian Public Health Capacity

4F.1 General Considerations

Post-SARS, a rare consensus has emerged that more must be spent on public health by the federal, provincial, and territorial governments. Submissions and observers have provided suggested figures: all represent significant increases over current levels of funding. Given the many billions of dollars of extra funding per annum flowing to the acute care system as a result of two Health Accords, we have no hesitation in suggesting that it is time to redress the balance and invest an additional several hundred million dollars per annum in public health.

Although Health Canada's own operations require strengthening, this is not the only priority. New federal money must find its way to the front lines and to those activities which serve to strengthen the generic capacity of local and regional public health agencies to protect and promote the health of Canadians. The Committee's expectation is that provinces and territories recognize—indeed, will assert—their primary responsibility for those same services, and also generously augment their support.

The health human resource shortfalls and urgent need to bolster public health agencies in some municipalities and provinces make it essential that there be serious efforts in good faith at F/P/T coordination. The worst-case scenario would be one in which new funding served more to prompt bidding wars across jurisdictions and the movement of skilled public health personnel rather than building new capacity.

Obvious targets for early investment are surge capacity to deal with infectious outbreaks and other emergencies, a major program to build human resources in public health, reinforcement of the public health laboratory network (see Chapter 6), and creation of business process agreements to facilitate coordinated F/P/T responses to outbreaks. Immunizations, discussed in more detail below, are another target where money can be used quickly and well. The list could doubtless be extended in different directions by different parties. Regardless, appropriate prudence in ramping-up federal funding is warranted to ensure that investments meet strategic goals and that new federal monies do not simply displace existing public health commitments without much net gain.

4F.2 Funding the Core Agency Functions

As we saw in Chapter 3, the FY 2003 appropriation for the US CDC was C\$10.8 billion (US\$7.2 billion). Use of this US benchmark presupposes both a strengthened core function in a new federal agency and enhanced flow of funds to support P/T programs, given CDC's role in making diverse contributions to other levels of government. A direct comparison with federal spending in Canada is difficult given the fact that state and municipal public health infrastructure in the USA is arguably more uneven and the per capita expenditures at the local and regional level generally lower than in Canada after one discounts spending on personal health services for recipients of social assistance. Federal expenditures on public health in Canada in any case would need to increase several-fold to reach 1/10th of US expenditures suggested by the ratio of populations.

Another approach is to estimate the costs of strengthening and supporting public health infrastructure in Canada and focus on core functions already in existence or those functions such as disease surveillance where a new agency might reasonably be expected to take on a leading role. We have reviewed line-item estimates aimed at building a moderate level of infrastructure in the core agency over the long term, but these are rough estimates and the balance between lines would change over the years. These estimates did not include amounts necessary to galvanize capacity at the P/T level, and deliberately focused only on "narrow-definition public health" as outlined in Chapter 3, i.e., excluding the type of activities supported

by the program of grants and contributions to NGOs, universities, and other partners that is currently operated by PPHB. (Enhancement of core activities would naturally involve such partnerships; the issue here is the function and its incremental cost, not the mechanism.) How do these estimates roll up?

A proper national surveillance system alone could add \$40 million a year, assuming that costs are borne primarily by the federal government. However, as outlined in the next chapter, we are assuming that surveillance of infectious diseases will be largely financed by the agency through a separate allocation. This estimate can thus be reduced substantially as regards core functions, assuming synergy in infectious and non-infectious disease surveillance. Let us peg this new cost crudely at \$15 million per year on the grounds that infectious disease surveillance systems are a top priority in the present circumstances, and the P/T jurisdictions will themselves be co-investing in infectious disease surveillance. Development of the national health strategy, creation of performance standards, and preparation of a report card to measure progress towards health goals could easily run \$5 million a year. Enhancing health emergency preparedness and response, outlined in more detail in Chapter 5, adds at least \$10 million per annum, rising by another \$10 million if one considers the urgent need to create epidemic response teams and other health emergency response teams to provide public health and health services surge capacity. Defensible increases in spending to enhance infectious disease capacity within the agency could run \$50 million if the federal nodes in a new network for communicable disease control (see Chapter 5) are to be credible and supportive partners. This includes costs of creating or improving business processes for surveillance and outbreak management, enhancement of federal laboratories, and some urgent capacity-building partnerships with provincial laboratories until new F/P/T investments come on line. Investments in health human resources are urgently needed. The agency must play a lead role in building human resources for public health, including primary training programs in partnership with colleges and universities, scholarships and bursaries, secondments, continuing education programs, and a greatly expanded field epidemiology service. This has been projected at \$25 million per annum. Health Canada's internal investment in public health research and evaluation is seriously inadequate, particularly if the new agency is to be a leader in evidence-based public health practice or to partner effectively with the Canadian Institutes of Health Research [CIHR] and other research agencies provincially and in the non-profit sector. Another \$25 million could be spent on R&D effectively in steady-state, particularly if the same monies go towards knowledge synthesis and

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guideline development. The coverage of areas such as environmental health, mental health, and injury prevention is clearly suboptimal and taken together, could draw an extra \$30 million per annum.

Not all funding needs to be new. We see opportunities for public health to participate in programs already announced, such as the massive investment in the Canada Health Infoway, and perhaps even the 5-year \$90 million fund for health human resources planning. But the tally above has already taken us to \$170 million per annum in new spending. Furthermore, this list assumes that there are no new costs from institutional redesign, or new costs imposed by legislative and regulatory reforms. It assumes that Health Canada has already invested adequately in the existing programs that address healthy human development or chronic disease prevention and control. Both deal with exceedingly important areas in the public health portfolio—nothing less than, respectively, healthy beginnings to the lives of future generations of Canadians, and the great non-communicable scourges of our time such as cardiovascular disease and cancer. The list also assumes that if the scope of the new agency expands, the activities that are transferred in require no increases in budgets.

In the circumstances, we are recommending that the federal government budget for increases in core functions of a new federal agency for public health that will rise, over the next 3 to 5 years, to a target of \$200 million per annum in incremental funding beyond that already spent in the “narrow” conceptualization of federal public health functions set out in Chapter 3.

How does this figure align with current spending? Recall from Chapter 3 that the core functions within PPHB currently amount to \$187 million per annum (2002 budget). Allocating a portion of extant grants and contributions to this number, we reached \$225 million as a rough estimate of core function costs in the Branch currently. We estimated, again crudely, that about \$75 million of the costs of operations in other branches of Health Canada could be deemed to fall within this “narrow” range of public health activities. If the agency were simply to roll these functions together, exclusive of vaccine costs, then it would spend about \$300 million per annum based on the 2002 budget. Thus, the proposed growth is about 60% over time to \$500 million per annum for core functions. The growth becomes smaller in relative terms if one assumes that the scope of the agency broadens meaningfully.

We make this recommendation in light of an urgent need to enhance federal public health capacity, recognizing that it will go only a limited distance to narrowing the major per capita spending gap when aligning similar functions for Health Canada and USA's CDC. We also take note of the billions of dollars recently invested in personal health services, the staggering costs of the SARS outbreak, and the fact that \$200 million per annum is about equal to the annual operating budget of a single large community hospital. In the circumstances, it seems minimally prudent to increase spending on core functions over 3 to 5 years, reaching a target of an additional \$200 million per annum to ensure that Canada has an effective federal agency for public health protection and promotion.

4G. A New Public Health Partnership Program for Provinces and Territories

4G.1 Level of Funding

We have emphasized the need for funds to flow to the front lines where most outbreaks are contained and where public health does most of its good daily work in preventing disease and protecting the health of Canadians. Ideally, to determine the necessary funding, analysts would establish a reference level for required local and P/T programs and services based on a combination of expert consensus, established efficacy and cost-effectiveness/cost-benefit, and comparisons with other countries. They would then establish the gap between current reality and the reference level, and estimate the cost of closing that gap over a reasonable period of time. Such a process would be extremely time-consuming and is beyond the mandate of the Committee.

As noted in Chapter 3, incremental funding to bring all provinces up to the spending level in British Columbia would require an additional \$408 million annually. However, the level of service in British Columbia cannot be assumed to represent the ‘gold standard’ for public health service delivery. As is evident internationally with personal health services, the boundaries for justifiable spending on public health are highly elastic given different community or societal tolerances for health risks and disparities. A crude \$400 million figure also does not consider the potential differences in delivery costs due to geographically-dispersed populations or differing proportions of higher needs populations (e.g., health status, poverty, language, education, etc.), as well as the fixed systems costs independent of population size.

A second approach is to consider federal support for personal health care. The 2003 Health Accord provides \$34.8 billion in additional funds for health care over a five-year period (2003-4 to 2007-8). If public health spending were pegged at not less than 3% of the personal health services spending through public channels, at least \$1 billion in new public health spending should have been earmarked for public health over 5 years to keep pace with new personal services spending. And since the goal is to redress the balance in some measure and build greater F/P/T capacity, the new benchmark would need to be well above \$200 million per annum for P/T transfers.

Other estimates of necessary spending are similarly approximate. We saw in Chapter 3 that the total spending on public health ranges from \$2.0 billion to \$2.7 billion, depending on whether the definition is narrow or broad. The provincial spending, based on rough estimates and projections, is \$1.72 billion, inclusive of vaccine costs. If one assumed that over several years, there should on average be a 50% increase in P/T/Municipal core activities, the increased spending would amount to about \$850 million per annum. One arbitrary point of reference is that the federal government should cover at least 50% of the increased P/T spending in its role as the primary revenue collector for Canada. This leaves half of \$850 million or about \$425 million as new and earmarked federal support. Provinces vary sharply in their ability to finance additional public health spending; and the proportion of federal funding in the extant \$1.72 billion fell between 1977 and 2000 until the first Health Accord began reversing a trend to downloading of health costs onto P/T governments. Certainly it cannot be said that Ottawa is paying 50% of the existing P/T public health expenses. That said, the Committee again takes note of more than \$30 billion in new federal monies to support provincial health spending vested in the second Health Accord.

We have therefore agreed that the total new federal contribution to P/T (and therefore local/municipal) public health funding can defensibly be set at \$500 million per annum. This assumes that P/T governments themselves will make a greater allocation to public health over the next several years with the result that a much stronger F/P/T system will steadily emerge.

In the next chapter we shall outline how \$100 million per annum of these new federal monies should be invested in infectious disease surveillance and outbreak management through P/T or regional structures. We also recommend that \$100 million per annum be used to reinvigorate the National Immunization Strategy (see below). However, not less than \$300 million per annum

should be earmarked for a new Public Health Partnerships Program to strengthen general P/T public health infrastructure. The logical question then becomes: How should the funds flow?

4G.2 Programmatic Funding: Some Constitutional and Legal Considerations

The frustration with some of the jurisdictional issues in public health spurred a small chorus of informants suggesting that the federal government should enact new public health legislation to create national standards in areas such as disease surveillance and notification. Others called for the acceptance of tough new rules in exchange for new federal monies. The Committee supports the need to modernize the extant public health norms and legislation, and impose conditions on funding as occurs in both the USA and Australia. However, federal spending power has both advantages and limitations.

The federal government can transfer funds to individuals, institutions (e.g., hospitals), and other levels of government (provinces, municipalities). All are legally free to accept or decline the grant or contribution. Federal funds can be unconditional or conditional. It is well-established that conditional transfers have had the effect of influencing provinces to alter their policy priorities (e.g., by making health insurance universal). A strengthened infrastructure could therefore be created through the use of transfers that make provincial compliance with national public health norms or rules a prerequisite for federal funding. However, the provinces must agree to the conditions. In theory, if federal spending conditions were seen as disguised attempts to regulate provincial areas of jurisdiction, the courts might look favourably on a constitutional challenge. Moreover, the remedy in the event of provincial non-compliance with federal conditions is political and financial, not legal.

The Committee also heard suggestions from some informants that if the provinces did not cooperate with the development of a national infrastructure, the federal government should deal directly with municipalities and local health units, flowing federal funds to them in exchange for complying with federal standards on reportable diseases, timetables for reporting, etc. However, contractual obligations cannot bind third parties. A contract between the federal government and a municipality would not bind providers who report information to local public health officials, and municipalities generally do not have the power to impose data standards on providers outside the authority of the provincial public health branch. Furthermore, federal-municipal contracts

could not bind provincial public health officials and institutions, and local public health officials are regulated by provincial statutes, which integrate them into provincial public health systems.

A more useful tool that is better suited to the nature of Canadian federalism, and the culture of collaboration that we believe must exist in public health, is the *Intergovernmental Agreement*. These agreements are often structured as memoranda of understanding and are “soft” policy instruments. Although they are sometimes drafted in legal language, they lack formal legal status. Memoranda of understanding [MOUs] between governments are a form of intergovernmental agreement. Intergovernmental agreements are a central feature of Canadian cooperative federalism. These documents range from the very general (e.g., the Social Union Framework Agreement [SUFA]) to the very detailed (which resemble contracts). The incentive to enter into these agreements is that they help to formalize and regularize relations between levels of government. Should a dispute arise, the terms of the agreement can be reviewed and conduct assessed against them. At the extreme, intergovernmental agreements could even require that certain provisions be entrenched in provincial legislation, to make them legally binding on provincial officials. The Supreme Court has nonetheless stated that intergovernmental agreements do not bind provincial or federal legislatures, which remain free to legislate in breach of intergovernmental agreements or to roll back legislation passed to operationalize an intergovernmental understanding. A number of federal-provincial MOUs are already in use in the public health sector. Consistent with practice in Australia and the USA, we see numerous areas in public health where MOUs could be concluded among F/P/T governments as a precondition to the flow of federal funds.

4G.3 Funding Instruments

Currently, the Government of Canada transfers funds to provinces and territories as a contribution towards the provision of insured health services on condition that they are provided according to the five principles laid out in the *Canada Health Act*. Provinces and territories fund the provision of these insured health services, as well as other health services, including public health. In Ontario, municipal governments are also responsible for contributing 50% to the cost of most public health services. Federal programs include the provision of advice and in-kind service for the prevention and control of infectious and non-communicable diseases, support for emergency response, public health services for select First Nations communities, and grants and contributions to NGOs as outlined earlier.

In thinking about how new funds might flow, one sees at once that the *Canada Health Act* cannot practically be revised to include public health as an insured service. The types of service are distinct, and the five current principles of the Act are not germane to public health with its population focus.

New public health funding for P/T functions might be separately transferred to provinces and territories on an otherwise unconditional basis for general public health purposes. Even if there were somehow a set of indicators to support the broad requirement that the money be demonstrably directed to public health, this approach would do little to reduce disparities, augment coordination, initiate a national public health strategy, create national surge capacity, or promote more uniform approaches to disease surveillance. It would also undermine Canada's position with international agencies such as the World Health Organization that are increasingly looking to nation-states for disease prevention or control in this era of globalization.

Another option would see tax points transferred to the provinces and territories so that they gain greater fiscal capacity to meet their public health needs. This has all the disadvantages of the previous option, and because of differential P/T ability to generate tax revenues, also augments disparities in per capita spending, as occurred with post-1977 personal health services spending.

Grants and contributions to local public health agencies, universities, professional associations, NGOs and other stakeholders might be provided to promote activities that strengthen public health services. This will occur as part of the roll-out of many aspects of a new national strategy. It may be particularly important for the federal government to consider more direct liaison with public health agencies in major municipalities such as Vancouver, Edmonton, Calgary, Winnipeg, Toronto, or Montreal. However, the first line of interaction should logically be with the level of government that, constitutionally, has primary responsibility for overseeing public health services. In short, transfers to non-P/T stakeholders make sense for specific activities (e.g., aspects of health human resource development), ideally with the full knowledge and support of P/T jurisdictions. (Because contributions are subject to full audit while grants are not, the Committee urges use of contribution agreements for transfers wherever possible.)

Another option suggested by some was general cost-sharing, e.g., the federal government would implement a specific formula for sharing the cost of public health services with the provinces and territories. This option requires a clear definition of the services and programs to be cost-shared, and runs the risk of displacing, rather than augmenting, spending. It would not address disparities, coordination or surge capacity.

Two other related options are the public health capacity foundation or a public health capacity fund. The first involves transferring a lump sum to an arm's-length corporation which would disperse funds to public health stakeholders. This would provide financial stability and allow for non-partisan solutions to specific challenges that are not policy issues. However, this option, similar to Infoway or the Canada Foundation for Innovation, has been criticized for a lack of accountability to Parliament, and has the disadvantage of failing to put public health on a continuing and stable footing. A public health capacity fund, similar to the Primary Health Care Transition Fund, would hinge on an F/P/T process to define public health programs to be funded. It would provide allocations to each P/T, and each jurisdiction would then use the funds to develop/maintain chosen activities within the overall program direction. This approach is more applicable to developmental projects, especially for information infrastructure and human resources, than to continuous funding of infrastructure. Furthermore, it requires advance agreement with all provinces and territories, yet the program needs of different P/T jurisdictions are highly variable.

Program funding, in contrast to all the foregoing approaches, has one massive advantage. It avoids creating another focal point for F/P/T tensions with a visible sum of money. Program funding is unabashedly targeted to the diverse needs of specific jurisdictions, but can simultaneously reinforce an agreed national strategy. In essence, the Committee envisages an explicitly depoliticizing strategy. We recommend placing the \$300 million in the hands of the Canadian Agency for Public Health, and allowing a series of programmatic and *ad hoc* negotiations to unfold among F/P/T public health professionals who have the health of Canadians, rather than the vicissitudes of re-election, as their immediate and ongoing priority. The transfers would be structured as contributions and therefore open to audit. As noted in Chapter 3, we also recommend that the funds be allocated according to SUFA to avoid perverse incentives and penalties for early investments by P/Ts. A logical strategy would be to manage the entire \$500M in new public health transfers as a single sum on this basis, providing greater flexibility to both the federal agency and P/T public health leaders in setting priorities. The earmarking of funds for an

immunization strategy and an infectious diseases network would therefore not constrain province-specific flexibility. A province might balance out greater per capita participation for front-line public health in the new program with a lesser degree of participation in the federal funding for provincial infectious disease control. The majoritarian provisions of SUFA also preclude blocking of necessary national norms by one or two provinces that have a smaller stake in one or the other funding stream.

This option is used by the USA and Australia to improve public health infrastructure. Its critical characteristic is the ability to use funding as an instrument to direct activities according to an agreed plan. Funding for programs can be directed at, for example, information systems, laboratory capacity, training, recruitment and retention, emergency response capacity, developing P/T and local strategies and plans, among others. The programmatic option might also be combined in part with cost-sharing: some programs would offer a percentage of the cost, up to a maximum with the province or territory finding the balance. This option most closely aligns funding and policy direction, and reduces the risk of displacing existing spending.

We are therefore recommending the creation of a new \$300 million Public Health Partnerships Program, modelled on precedents set by the Commonwealth Government in Australia and the US CDC. The Canadian Agency for Public Health would flow these funds largely through agreements with P/T public health officials, aimed at reinforcing core public health functions, collaborative arrangements, and local capacity for the full range of contemporary public health activity.

4G.4 Current Program of Grants and Contributions

Currently, more than half of PPHB's budget is for grants and contributions [G&C], flowing mainly to NGOs across Canada. Inside this \$200 million G&C envelope are well-established programs covering a range of issues from communicable and non-communicable diseases to wellness and healthy living/aging. For example, among the programs is one to support a joint Health Canada/CIHR research initiative on Hepatitis C—a condition for which there is still no vaccine. Hepatitis C has infected an estimated 240,000 to 300,000 Canadians. Thousands of those infected develop chronic disease that could lead to death from cirrhosis or liver cancer. According to Prof. Mel Krajden, prior to the joint initiative there were only three funded hepatitis C researchers and very limited research occurring in Canada. The joint research

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initiative has catalyzed a substantial expansion in Hepatitis C research across Canada, much of it internationally competitive and already yielding results that can translate from bench to bedside. There is obvious value in investments of this nature and in a great many other G&C-supported activities.

Nonetheless, the Committee has heard mixed reviews of the existing G&C program, in part, we surmise, because spending on core functions has lagged and led to a sense of non-proportionality in the magnitude of transfers to NGOs. Concerns about politicization of grants and contributions were also raised, but we have no way of testing the validity of this innuendo. We recognize that many communities and community groups have benefited from this investment, and that it has multiplier effects through the NGO sector that are meaningful.

In her September 2001 report, the Auditor General comments on the management of these programs. Her team examined a sample of 38 projects from across Canada under three programs. The sample was selected because these projects covered the life course, were administered nationally and regionally, used sizable amounts of funds, and involved both grants and contribution agreements. Her report stated: "We are concerned about the significant number of our project reviews that identified problems in the project management process. In particular, we noted that the Branch did not subject high-value projects to a rigorous selection process, nor did it monitor those projects adequately..." In one of the program portfolios, the Auditor General noted that the Branch had identified problems with two of the projects, "but had failed to take timely action to resolve them... In the eight national and regional files on projects under \$2 million, we found five cases that were not subjected to an adequate selection process and yet the Branch recommended them for approval..." In another program, the Auditor General found that six of the national projects were not eligible for funding based on the program's own guidelines: "Further, there was no evidence of communication with interested parties to invite project proposals; nor was there evidence of internal or external review or consultation with advisors. Yet all six of these projects were recommended and approved for funding" (totalling \$15 million). Amendments to agreements are a further problem in that they are not subject to the same selection process as new agreements, and can be used to bypass selection and approval processes.

The Committee believes that the grants and contributions programs directed at various NGOs are valuable policy tools. The above-referenced concerns have more to do with management of the funds than the intrinsic worth of the investment. However, these expenditures should be reviewed to ensure that they reinforce and complement the Public Health Partnerships Program, and re-allocated if there are any issues about value-added in relation to a new national health strategy.

4G.5 *Reinvigorating a National Immunization Strategy*

The Committee's assessment of the status of the National Immunization Strategy offers another example of sound proposals to invest in public health that have received uneven and inadequate support by various levels of government. The Committee reviewed a series of documents dating back to the 1990s that show substantial diversity in the publicly-funded program and legislation pertaining to immunization and vaccination. As one example, not all children in Canada have received two doses of measles vaccine because some P/Ts could not afford to institute 'catch-up' programs in 1996-1997. Although the benefits of adolescent hepatitis B immunization were recognized a decade ago, Canada took seven years to reach national coverage because of variable uptake across P/T jurisdictions.

A proposal to strengthen collaboration on immunization was first presented to the F/P/T Conference of Deputy Ministers of Health in June, 1999. It was based on various concerns related to immunization in Canada, including escalating vaccine prices, concerns about security of supply, safety issues with some vaccines, evidence for growing inequity in access to newer vaccines, and uneven electronic recording of immunizations. Thereafter, a highly collaborative F/P/T process led to a proposal for a National Immunization Strategy. Those involved have not been able to achieve support for the vision of a fully-funded strategy, in which resources to purchase vaccines and secure their delivery would be guaranteed from coast to coast.

At present, provinces and territories remain responsible for finding the money to buy vaccines and deliver programs. This system continues to be criticized by expert informants and stakeholders alike. We understand that some suppliers offer provinces a package deal including various perquisites for health promotion. The current system compromises purchasing power, limits the security of vaccine supply, and puts providers in the untenable position of having to recommend vaccines to persons/families who often cannot afford them.

New vaccines are adding to the problem. Four new vaccines are currently unfunded in most P/Ts—conjugate pneumococcal vaccine, conjugate meningococcal vaccine, varicella vaccine and acellular pertussis vaccine. The estimated bill for Canada was expected to mount fairly rapidly to a steady-state of about \$200 million per year for these new vaccines alone. Immunization experts from federal, provincial, and territorial jurisdictions proposed that the federal government pay for the new vaccines while P/Ts cover the costs of administration. To support their case, those involved produced documentation showing meaningful health and economic benefits from more complete coverage and upgrading of vaccination strategies. However, the F/P/T focus was instead on adding money to personal health services through the Health Accord.

The 2003 federal Budget acknowledged that immunization has been a remarkably effective preventive health measure. However, it provided only \$45 million over five years (\$5 million in year one, and \$10 million a year thereafter) “to assist in the pursuit of a national immunization strategy.” The Budget document claimed that the “objective of the strategy will be to ensure equitable and timely access to recommended vaccines for all Canadians in order to reduce the incidence of specific vaccine-preventable diseases.” It further claimed that the national strategy would result in: “improved safety and effectiveness of vaccines; enhanced coordination and efficiency of immunization procurement; and better information on immunization coverage rates within Canada.” In fact, notwithstanding this lofty objective and these anticipated results, the financial support in the 2003 Budget is nowhere near sufficient to catalyze a national immunization strategy.

The Committee believes that not less than \$100 million per annum should be earmarked for a major reinvigoration of the National Immunization Strategy under the auspices of the new Canadian Agency for Public Health. Earmarked funds could be transferred to a purchasing body, e.g., Public Works and Government Services Canada, to purchase vaccines as agreed under the renewed strategy, so as to meet provincial and territorial needs. This would ensure that the funds go only for the agreed-upon vaccines, consolidates purchasing power and facilitates price reductions, and sets annual and national target volumes to ensure that industry can meet the needs of the nation. Furthermore, other branches of Government, such as Industry Canada, could use the vaccine investment to leverage private sector investment in vaccine research and development, as well as production in Canada. Working from an F/P/T consensus enhances inter-jurisdictional equity, by creating a “minimum agreed upon standard”

for the introduction of new vaccines. Absent such consolidation, P/Ts have actually ended up competing with each other for available supply and on price as occurred with meningococcal vaccine shortages during outbreaks.

Also, in the absence of immunization registries in most jurisdictions, Canada is not in a position to provide reliable and accurate information on coverage levels. Our best information is that coverage with older vaccines, fortunately, is adequate. Thus, the focus of \$100 million in incremental federal funding can be on new vaccines as well as improving the information systems to ensure that Canada meets an articulated health goal (and international norms) as regards vaccination coverage.

4H. Recommendations

The Committee recommends that:

- 4.1 The Government of Canada should move promptly to establish a Canadian Agency for Public Health, a legislated service agency, and give it the appropriate and consolidated authorities necessary to provide leadership and action on public health matters, such as national disease outbreaks and emergencies, with or without additional authorities regarding national disease surveillance capacity.**
- 4.2 The Government of Canada should ensure that the scope of the Agency’s mandate covers public health broadly with appropriate linkages to other government departments and agencies engaged in public health activities. The Government’s scoping exercise for the new Agency must be informed by a careful review of public health service provision and health promotion for First Nations and Inuit Canadians.**
- 4.3 The Government of Canada should budget for increases in core functions of the new Canadian Agency for Public Health that will rise, over the next 3 to 5 years, to a target of \$200 million per annum in incremental funding beyond that already spent on core federal public health functions.**
- 4.4 The architects of the new Canadian Agency for Public Health should ensure that its structure follows a hub and spoke model whereby links are made to existing regional centres with particular strengths in public health specializations while some other functions and new**

- ones are devolved to other regions of the country, with a vision that these parts support the entire system.
- 4.5 The Government of Canada should create the position of Chief Public Health Officer of Canada. The Canadian Agency for Public Health should be headed by the Chief Public Health Officer of Canada who would report directly to the federal Minister of Health and serve as the leading national voice for public health, particularly in outbreaks and other health emergencies.**
- 4.6 The Government of Canada should create the National Public Health Advisory Board, and ensure that nominations of board members come forward through provincial and territorial as well as federal channels. The mandate of the Board will be to advise the Chief Public Health Officer of Canada on the development and implementation of a truly pan-Canadian public health strategy.**
- 4.7 The Canadian Agency for Public Health should play a catalytic role in developing a National Public Health Strategy in collaboration with provincial and territorial governments and in consultation with a full range of non-governmental stakeholders. The new Strategy should delineate priorities and goals for key categories of public health activity along with provisions for public reporting across jurisdictions of progress towards achieving goals.**
- 4.8 The Government of Canada should fund a new Public Health Partnerships Program under the auspices of the Canadian Agency for Public Health. The Agency would thereby provide program funding to provinces and territories to strengthen their public health programming in agreed areas and in support of the National Public Health Strategy. The funding for the Public Health Partnerships Program should rise over 2-3 years to \$300 million/annum.**
- 4.9 The Government of Canada should incorporate into the new Agency the current grants and contributions programs of the Population and Public Health Branch of Health Canada. These grants and contributions should be reviewed and their uses aligned with the National Public Health Strategy and made complementary to the Public Health Partnerships Program.**
- 4.10 Through the Canadian Agency for Public Health, the Government of Canada should invest \$100 million/annum within 12 to 18 months to realize the National Immunization Strategy whereby the federal government would purchase agreed-upon new vaccines to meet provincial and territorial needs and support a consolidated information system to track vaccinations and immunization coverage.**

Appendix 4.1

***Population and Public Health Branch:
Current Organization Chart***

