Public Health in Canada: Considerations on the History of Neglect

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The growing concern over the state of public health in Canada has risen exponentially as numerous tragedies suggest that the system is failing. Examples include the transmission of the hepatitis C virus and the human immunodeficiency virus in contaminated blood products, which led to the Commission of Inquiry on the Blood System in Canada in 1997, and the *E. coli* 0157:H7 contaminated water sources in Walkerton, Ontario in 2000, which left 2300 people ill and seven dead.1 Most recently, during the SARS outbreak in 2003, Canada was witness to 438 probable and suspect cases, which included 44 deaths.2

During times such as these, when many are reflecting upon Canada’s health care system, it becomes important to ask the questions: How it is possible for these public health tragedies to have occurred, is Canada not a world leader in health and healthcare policy? Is health not one of Canada’s most prized national values? Where does the blame lie for the current public health system? And, how can we address the underlying issues that have ultimately led to this state of neglect?

The answers to these questions are not simple. Consideration of Canada’s public health system requires consideration of the priorities upon which our healthcare system is based, as well as an understanding of population health in addition to the responsibilities of various levels of government. The interaction of these factors has contributed to the state of neglect in which we find our public health system. The lack of progress in the public health system needs to be addressed; however, until we are able to look into the past and understand from where we have emerged, we will never be able to shed light on how the decisions we make today will affect tomorrow.

DEVELOPMENT OF THE HEALTH CARE SYSTEM

Examining the priorities upon which our healthcare system is based, in addition to the division of responsibilities between the federal and provincial governments at that time, are the first steps in understanding our past.

At the time of Confederation, the federal government was minimally involved in the health of the people. Under the *British North America Act* (now known as the *Constitution Act*, 1867), provincial governments were responsible for social welfare, education, civil law and agriculture, whereas the federal government was given jurisdiction over aboriginal peoples, the armed forces, the RCMP, immigrants and refugees, and those living in the territories; health was formally declared a provincial responsibility in 1937 by the Supreme Court of Canada.1 Today’s structure, consisting of ten distinct provincial, and three territorial health systems, stems from the division of powers that occurred at Confederation. Over time, however, it became increasingly evident that provincial governments alone were unable to cover the rising costs of healthcare. As time progressed, the federal government began sharing in the costs of health care services.1

Enacted in 1957, the *Hospital Insurance and Diagnostic Services Act* was the first national agreement in which all patients requiring acute hospital services would be covered by a publicly funded insurance plan; following this, the *Medical Care Act* in 1968 ensured the coverage of all physician services.1 The combination of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act* formed the basis of the *Canada Health Act* of 1984, which is still Canada’s federal legislation for publicly funded health care insurance. Under the *Canada Health Act*, federal cash contributions for “medically necessary hospital, physician and surgical-dental services” would be given to the provinces provided the insurance was comprehensive, universal, portable between provinces, publicly administered, and accessible to citizens of all provinces or territories regardless of socio-economic status.3 The Act also made provisions regarding extra-billing and user charges.3,4 Canada’s publicly funded health care system was founded on the basis of physician and medical services, and promoted health by placing the emphasis on the diagnosis and treatment of disease in the individual. This perspective is radically different from that which emerged in the middle of the 20th century.

THE POPULATION HEALTH MODEL

The population health, or health promotion model, recognizes that in addition to an effective health care system, there are non-medical determinants such as social and economic factors that play a critical role on the health of individuals and communities. The Constitution of the *World Health Organization*, recognized in 1945, stated “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and, “Governments have a responsibility for the health of their peoples which can
be fulfilled only by the provision of adequate health and social measures.” 5 Beginning with the publication of A New Perspective on the Health of Canadians in 1974 by then-Minister of Health Marc Lalonde, Canada has been a world leader in developing policies reflecting the population health model. The Lalonde report was influential in recognizing that in addition to an adequate healthcare system, factors such as human biology, lifestyle, and physical, social, and economic environments, play a crucial role in determining the health of individuals and populations. 1

In 1986, Ottawa hosted the first International Conference on Health Promotion. The Ottawa Charter (Achieving Health for All) was subsequently developed to suggest specific actions needed to reach the 1978 Alma Ata Declaration goal of health for all by the year 2000. 6 Salient points of this document include the recognition that “Health promotion is the process of enabling people to control over, and to improve their health. Health is... a resource for everyday life, not the object of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.” 6

With this innovative understanding of health, it became clear that nations needed to look beyond hospital doors and physician services to both attain and maintain the health of their citizens. In Canada, governmental and non-governmental organizations adopted this perspective on health to develop policies and programs that help to create an environment conducive to attaining good health. In 1994, federal, provincial and territorial ministers of health officially endorsed this population approach to health in a report entitled Strategies for Population Health: Investing in the Health of Canadians. 7 The documents cited above attest to the fact that Canada as a nation does recognize the importance of health promotion; however, the dubious success of these programs leaves much to be desired.

PUBLIC HEALTH AT THE FEDERAL LEVEL

If Canada is a world leader in healthcare and healthcare policy, how then is it possible for the public health system to have fallen into the current state of neglect? According to the National Advisory Committee on SARS and Public Health, total health spending in 2002 was $112.2 billion, whereas total public health expenditures in Canada from 2002 to 2003 ranged from only $2.0 to $2.8 billion. 3 According to these figures, only 1.8% to 2.5% of total health expenditures was spent on public health. This seems counterintuitive when one considers the scope of public health practice itself.

By nature, the goals of public health - health promotion, health protection, in addition to illness and injury prevention - are incredibly broad. The expansive scope of public health practice leads to a lack of clear accountability by various levels of government. According to the Ottawa Charter:

The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. 6

Therefore, while the Constitution designates “health” as a provincial responsibility, many of the non-medical determinants of health, particularly political, economic and environmental factors, are under federal jurisdiction. Indeed, the federal government’s involvement in the nation’s health has increased since the time of Confederation. In 1993, Health Canada was born out of the reorganization of what was previously known as Health and Welfare Canada. 1 Responsible for developing health policy, enforcing health regulations, promoting disease prevention and enhancing healthy living, Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. 8 ParticipAction, the Dialogue on Drinking, the Canada Food Guide, the National Strategy to Decrease Tobacco Use in Canada and the Canadian Task Force on Preventive Health Care are some of the federal initiatives intended to promote the health of Canadians. While these programs have targeted specific areas of health in Canada as a whole, the structures of public health systems remain under provincial jurisdiction nationwide, thus each province has its own structure for fulfilling its public health mandate. While this allows local regions to identify their needs and determine their priorities, it also potentiates a fragmented infrastructure and lack of accountability.

In 2002, the Kirby report on The Health of Canadians called on the federal government for strong leadership to improve the state of public health systems in the various provinces and territories. “Fragmentation has resulted in a poorly coordinated or integrated health promotion infrastructure. More important, no health goals have been set nationally for health promotion...” 7 In studying Ontario as an example, we can see more clearly some of the difficulties of the current public health system.

PUBLIC HEALTH AT THE PROVINCIAL LEVEL: A LOOK AT ONTARIO

Established by urban and rural municipalities, Ontario has 37 public health units that represent the official agencies for administration of community health programs. In keeping with the population health model, these health units have a broad range of responsibilities including water, food and environmental safety; communicable disease control and surveillance; immunizations; maternal and child health; dental health for underprivileged groups; and, health promotion and population health assessment. While each municipality is able to determine its own priorities based on local needs, the provincial government mandates these fundamental responsibilities through a document called the Mandatory Health Programs and Services Guidelines. 9, 10

In early 2004, the funding formula for these public health programs was 50:50, meaning that a municipality would pay 50 per cent of the costs and the other 50 per cent would be covered by the province. Municipal governments made the decision as to which programs would be funded and how much funding each would be allocated. 11 Once the municipal government determined a budget, the provincial government would then match the dollar amount. Money for community public health...
programs is therefore in competition with other municipal services such as garbage and snow-removal. This arrangement clearly contributes to the deteriorated state of Ontario’s public health system, especially when many municipal governments find themselves in financial crisis. Furthermore, with local issues as their primary concern, municipal governments are less likely to make budget decisions based on what is happening elsewhere in the province. Therefore, a co-ordinated public health system is contingent on close communication between the Ministry of Health and Long-Term Care and each of the 37 public health units in the province of Ontario.

Tragedies such as Walkerton and SARS highlight the degree to which public health has been neglected; indeed, the Interim Report on SARS and Public Health in Ontario, released by the Campbell Commission, identifies Ontario’s central public health system as “broken”, “woefully inadequate”, “unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate.” Support for the public health system is long overdue and, regrettably, the impetus for change has come from the tragic loss of human lives.

CONCLUSION: CHALLENGES FOR THE FUTURE

Understanding the history of neglect of Canada’s public health system requires an understanding of the priorities upon which our healthcare system is based, the evolution of the definition of health to include social determinants, and the complex nature of federal-provincial and provincial-municipal relationships. Early in Canada’s history, health was determined to be a provincial responsibility, which created a structural division in duties. As health care costs have soared well beyond the ranges affordable solely by provincial governments, the federal government initiated involvement through Medicare. Higher financial burdens and complex health care related issues have led to a blurring of federal and provincial health care roles. Also, the recognition in recent years that social determinants of health, including the global environment, affect health, has increased the need for federal leadership in public health practices. Recently, commitments have been made at the federal level for new public health funding for the establishment of a new Public Health Agency of Canada, and for the appointment of a Chief Public Health Officer for Canada. The challenge for the future will be in creating a new model for public health which encourages co-operation and communication between different governments, i.e., a model that is efficient enough to co-ordinate the efforts of the ten provincial and three territorial health systems yet allows enough flexibility for local needs to also be met.

Canada’s health care system was built upon a now outdated perspective that viewed health solely as the absence of disease; as such, health expenditures were, and will continue to be, focused on the treatment of acute diseases through physician and hospital services. As the federal 2002 Romanow report states:

For too long, Canada’s health care system has been overly focused on treatment rather than prevention. A central focus of primary health care must be on preventing illness and injury and helping Canadians stay healthy. There is evidence that current programs are dated. We also need to take steps to ensure that Canada is well prepared to face new and emerging problems resulting from globalization and the evolution of infectious diseases.

It is important to recognize that governments alone do not determine healthcare priorities. This emphasis on diagnosis and treatment, and the subsequent lack of focus on non-medical determinants of health, is perhaps an attitude held by the wider medical community. Implementation of health care policies cannot be accomplished without the partnership of medical professionals at large. How supportive are physicians of public health initiatives? How effective is health promotion education in medical schools? The challenge for the future is to develop a generation of physicians who will share in the pursuit of injury and illness prevention.

Finally, poor funding arrangements by provincial governments, as exemplified in Ontario, can lead to cuts in public health programs. Successful public health programs are not readily visible, and too easily are municipal funds allotted to other priorities when public health programs become undervalued. As exemplified by the tragic Walkerton case, cutting budgets for routine public health protection can be devastating when a public health emergencies occur. Fortunately, changes to public health funding are forthcoming. In Ontario, the Ministry of Health and Long-Term Care has committed to increasing the provincial share of public health costs from 50 per cent to 75 per cent by 2007. The challenge for the future will be to protect and advocate for public health programs through increased public awareness.

The underlying factors that have led to the state of neglect in Canada’s public health system are complex. Canada is indeed a world leader in health and health care policy, yet Canada’s state of public health can be blamed on our failure to recognize just how essential a strong public health system is to the functioning of our everyday lives. Federal, provincial and municipal levels of governments, the medical community and the general public all have a role to play in improving the public health system. By working toward a common vision of the future, one in which the health of the public is better protected and health tragedies prevented, it is hoped that the history of neglect may remain in the past.

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