Public Health in Canada: A Comparative Study of Six Provinces

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Public health in Canada, like medical care, is constitutionally a responsibility of the provinces. Unlike medical care, however, overarching principles, as laid out in the Canada Health Act, do not exist for public health,1 and the scope of practice and target populations are broadly and variously defined.2,6

Studies designed to answer the perennial question “What is public health?” have been conducted for several countries.7-12 In Canada in 1979, Le Riche described 70 years of Canadian public health practice,13 and others have examined the training requirements for Canadian public health practitioners.14 Canada has a remarkable history as an international leader in public health, having produced the 1974 Lalonde Report,15 the 1986 Ottawa Charter for Health Promotion,16 and the 1980s healthy communities movement.17 However, we are not aware of any recently published studies that comparatively describe the current state of public health in Canada. Additionally, there have been two recent developments in the health system in Canada whose impact on public health needs to be examined.

The first of these developments is the emerging discourse on population health and broad determinants of health. Population health strategies address the “entire range of factors that determine health”, and include social, economic, environmental, and behavioural factors in addition to traditional medical care and biological factors.18 The work of Canadian academic and front line population health proponents19-24 has been adopted at the political level by all provinces.18 Like that of the healthy communities movement of the 1980s,17 this perspective has the potential to stretch the limits of public health practice or to shift activities to alternative players. The public health implications for the current broadly endorsed, broadly focused population health discourse need to be examined.

The second development is the cross country trend toward regionalization of the health care system. Health care reform and, in particular, regionalization and devolution of decision making has occurred or is occurring in most provinces.2,25,26 As Lomas et al noted, “These changes arguably constitute the most radical restructuring of medicare since its inception, with far-reaching implications for governments, citizens, physicians, hospitals and other interest groups.”26 Public health has been swept up in health care reform to varying degrees in different jurisdictions, and the implications of the structural and governance changes for public health practice need to be analyzed.

Deber has categorized health care by a public–private mix along the two dimensions of financing and delivery.27 Table I depicts the resulting quadrants into which services may fall, and clearly public health services may be categorized in the same way. For those provinces in which private physicians provide immunizations, for example, services fall under the public

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financing/private delivery quadrant. The “wellness industry” is an example of both privately financed and privately delivered public health services. Traditionally, however, most provincial public health activities occur though a defined organizational structure (e.g., a public health unit) found in the publicly financed, publicly delivered category. This study focuses on this public–public quadrant and addresses the following three questions: 1) What are the content, structure and future of public health in Canada? 2) What are the implications for public health of the emerging discourse on population health and broad determinants of health? and 3) What are the implications for public health of the trend toward regionalization of health care in Canada?

METHODS

A literature review was conducted using computer-based Medline searches for the subjects "public health trends" and "public health and health care reform", and core public health texts were identified. Published works describing public health in Canada, the United States and the United Kingdom were reviewed to determine core public health functions and strategies. A data collection tool was developed from this review.

Six provinces were selected for study: Newfoundland, New Brunswick, Ontario, Manitoba, Saskatchewan, and Alberta. This combination was chosen to reflect a variety of regions and a number of types and stages of health care reform.

Telephone interviews were conducted and documents were reviewed for the six provinces. These activities were all completed by one person with the use of the same data collection tool. The documents examined were those selected by key informants in each of the provinces and included formal and informal material about provincial public health expectations, program descriptions and organization charts. In all provinces the chief medical officer of health was interviewed, in five of six provinces a medical officer of health was interviewed, and in three of six the provincial public health association president was also interviewed.

Table I summarizes the core content areas and core strategies of each of the six provincial public health systems. Items were categorized as mandatory (or expected/highly recommended), discretionary, or alternative public provider with public health liaison.

Table II summarizes the core content areas and core strategies of each of the six provincial public health systems. Items were categorized as mandatory (or expected/highly recommended), discretionary, or alternative public provider with public health liaison.

RESULTS

Content

Table II summarizes the core content areas and core strategies of each of the six provincial public health systems. Items were categorized as mandatory (or expected/highly recommended), discretionary, or alternative public provider with public health liaison.

The content areas that consistently fell into the “expected” category for all six provinces clustered in communicable disease control and health protection programming. Examples included outbreak management, sanitation health inspection activities and ongoing disease surveillance. For those provinces without mandated responsibilities in any one of these areas, there was evidence of a closely connected alternative public provider.

Many provinces had no evidence of mandated programs that were explicitly health focused, that addressed broader determinants of health or that used multiple strategies approaches. Programs to address noncommunicable diseases, for example, were not mandatory in many provinces. Health promotion strategies that provided opportunities for commu-
ty involvement were discretionary or absent in most provinces. Environmental health programs and community health status reporting fell under the mandate of public health only in Ontario.

Structure

New Brunswick, Newfoundland, Manitoba, Saskatchewan and Alberta have regionalized their health care systems. Regionalization is a term whose meaning may vary with the purpose of the user. Here, it is applied to reflect the common characteristics of regionalization: decentralization, geographic orientation, and rationalization of services. Ontario had not regionalized its health care system but had a longstanding history of providing public health services on a regional basis.

In so far as governance provides for an integrated health system, three of the provinces either have (Saskatchewan and Alberta) or are evolving toward (Manitoba) this end. The boards of health in these instances are responsible for the continuum of care: from public health to acute and long term care. For the remaining three provinces, Ontario has boards governing only public health, Newfoundland has boards governing community health, and New Brunswick has no board structure but has a reporting structure between the regional medical health officers and the chief public health officer.

The degree of devolution of public health decision-making authority varies between the provinces. This function was clearly centralized only for New Brunswick and clearly devolved for Alberta and Saskatchewan. Manitoba, Ontario and Newfoundland fell between these two ends of the continuum. (Between the time of data collection and of writing, Ontario announced a proposed change in funding from the current cost-shared arrangements for boards of health to a requirement that boards of health be 100% municipally funded as of January 1, 1998.6 The extent to which provincial standards will still apply if this plan is implemented is as yet unknown.)

Future

Nearly all key informants recognized the broader determinants of health and identified the need for increased community involvement and for coordinated strategies to address these determinants. There was a recognition that such strategies were not currently being emphasized: “There is lots of rhetoric about health promotion in the provincial government and in institutions, but the real concern is about providing care in the community.” Many respondents expressed hopes that the future of public health in their province would see the incorporation of a broader base of programs and strategies. Most cited financial constraint as the reason for not moving forward in these areas; however, low morale among staff who need “time to heal” and “lack of political will” were also identified.

Several informants reported concerns about the potential impact on public health identity and funding of integration with other health care sectors: “Currently people still identify health with the number of hospitals and doctors. . . . public health is still on the back burner and institutional medicine is continuing to drive the agenda.” There was concern that opportunities for reinvestments in public health were being forfeited and that provincial public health issues were being overshadowed by preoccupations with the acute and long term care sectors. This was expressed succinctly by one respondent whose first comment was: “I am not sure if we have a public health system.” In the fight for resources, it was feared that long term prevention activities would receive lower priority than short term acute care activities.

DISCUSSION

This study was subject to certain limitations. Provincial public health systems are complex and are the result of many factors, including structures, policies and personalities. To make meaningful comparisons, generalizations must be made that result in loss of detail. There was great diversity in the availability of written documentation. Where gaps in information existed, attempts were made to obtain this information during telephone interviews. The terms used to describe certain content and practices may be variably defined, and although definitions were provided during interviews it is possible that misinterpretations occurred.

In the context of the population health discourse, this study found that most key informants identified a need to address broad determinants. Population health concepts have permeated public health. Despite “talking the talk”, however, “walking the talk” is less evident, as there has not been a parallel commitment of resources. Perhaps, as identified by some respondents, it is not the lack of dollars that impedes the path forward but the lack of political will to support public health practice outside of the traditional core. For the six provinces under study, the reality is a retrenchment of public health scope during a time that should have been considered conducive to public health expansion, with the recognition of the importance of determinants of health and longer term disease prevention and health promotion.

All provinces but one have regionalized their health care systems, and three are at various stages of development of integrated health systems. For the provinces that have reformed their health care systems, public health has been included in this reform and is becoming increasingly ”vertically” integrated within smaller geographic units. This phenomenon could enhance coordination within the health care system at the local level but could also cause fragmentation within specialties, including public health, and lead to a narrowed scope of public health programming.

This study provides observations that are useful when questions about the appropriate role and structure for public health are being considered. With regionalization and vertical integration, the optimistic forecast is that traditional silos of practice will be broken down and public health activities will be appropriately incorporated into everyone’s mandate. The pessimistic forecast is that public health will fall through the cracks because resource allocation is sensitive to needs for short term, acute care. In addition, fears were expressed that the resulting regional units are too small to support adequate local expertise and that this structure could be an obstacle to ensuring consistent provincial programs and standards for public health where they
might be appropriate. It is critical that informed discussions take place to determine which future will greet public health in Canada.

In asking the question “What is public health?”, this study provided insights into the answer for the Canadian context. The "core business" for the majority of provinces is communicable disease control and health protection. Are these activities the key contribution that public health can and should make? Canada has a remarkable international reputation in public health and has led the way in expanding the limits of public health practice, addressing broad determinants of health, and strengthening community involvement. However, this study described a current role for public health that is much more circumscribed. The study clarifies that current reform efforts present both opportunities and risks for public health activities. Our findings suggest that despite the rhetoric of determinants of health, reality represents some backtracking and risks to Canada’s reputation as a world leader. Careful scrutiny of appropriate mechanisms to ensure proper attention to the full array of core public health activities seems essential.

REFERENCES


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