A collective voice for advancing public health: why public health associations matter today

The Canadian Network of Public Health Associations

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Abstract

We reflect on *why public health matters today* from the perspective of Canada's provincial, territorial, and national public health associations. As independent, non-profit organizations that transcend professional roles and sectors, public health associations are positioned to play an essential role in strengthening public health, broadly speaking, across Canada. We outline three reasons why public health associations matter today. First, public health associations are uniquely positioned to champion a public health perspective. Second, they represent and connect a diverse range of roles, professions, and stakeholders involved in public health. Finally, they are positioned for advocacy, providing a platform for participation to those who may not otherwise be able to engage but who understand the importance of a collective voice. These reasons why public health associations are important are not new, but arguably carry renewed importance in the context of a contemporary public health landscape characterized by, among other things, weakened formal public health infrastructure, neoliberal agendas and individualism, and public health imperatives such as growing economic and social inequity and ecological determinants of health that require intersectoral responses.

Résumé

En réponse à la question *Pourquoi la santé publique aujourd'hui?*, nous réfléchissons à l'importance de notre association nationale pour la santé publique et de ses pendants provinciaux et territoriaux. Comme ce sont des organismes indépendants et sans but lucratif qui transcendent les rôles et les secteurs professionnels, les associations pour la santé publique sont en position de jouer un rôle essentiel dans le renforcement de la santé publique au sens large partout au Canada. Nous présentons trois raisons pour lesquelles ces associations importent aujourd'hui. La première est qu'elles sont particulièrement bien placées pour faire valoir une perspective de santé publique. La deuxième est qu'elles représentent et rapprochent une grande diversité de rôles, de professions et d'acteurs de la santé publique. La troisième est qu'elles sont bien placées pour faire de la sensibilisation en offrant une plateforme de participation à des personnes qui sinon n'en auraient aucune, mais qui reconnaissent l'importance de parler d'une même voix. Ces raisons de l'importance des associations pour la santé publique ne sont pas nouvelles, mais elles ont sans doute gagné en importance depuis que le paysage de la santé publique se caractérise, entre autres, par l'affaiblissement des infrastructures officielles, par l'individualisme et les visées néolibérales et par des impératifs comme la croissance des inégalités sociales et économiques et les déterminants écologiques de la santé, qui exigent des interventions intersectorielles.

Keywords Public health · Public health association · Intersectoral · Advocacy · Partnerships

Mots-clés Santé publique · Association pour la santé publique · Intersectoriel · Défense des droits · Partenariats

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Introduction

Public health, “the science and art of preventing disease, prolonging life, and promoting health through the organized

efforts of society” (Acheson 1988), concerns multiple societal sectors, including government (public sector), industry (private sector), and civil society.¹ Members of public health associations (PHAs) are from all of these sectors. The associations represent an important (though under-realized) feature of the contemporary public health landscape and a unique vantage point for reflecting on the question of *why public health matters today*.

We reflect on *why public health matters today* from the perspective of Canada’s provincial, territorial, and national PHAs (the *Canadian Network of Public Health Associations*). Two questions guide our commentary: (1) do PHAs matter today and if so, (2) how and why do they matter, in light of the contemporary and constantly evolving public health landscape?

Overview of PHAs in Canada

PHAs in Canada (Table 1) are independent, not-for-profit, member-driven associations that exist to advance public health—broadly speaking—at the provincial/territorial and national level. Unlike formal professional licensing bodies, membership in Canada’s PHAs is not restricted to certain professions, or to those employed in public health in a professional capacity, but is open to anyone who identifies as involved or interested in public health.

PHAs engage in issues identified as important to the associations, such as mental health, chronic diseases, and food security (NTNUPHA)²; eliminating poverty, reducing inequities, addressing climate change and healthy environments, and preventing violence (PHABC)³; and literacy and gender equality (ASPQ) (ASPQ 2016). Particularly in the smaller provinces and territories, PHAs are able to connect with and act upon local public health issues, and often have a clear understanding of the issues that exist at a community level.

In addition to being attentive to unique local or regional issues, PHAs share common values, activities, and focus, as illustrated by the mission statements (Table 1). These shared attributes permit cross-association mobilization on issues of inter-provincial or national concern. Recent examples include the phase-out of coal-fired electricity (CAPE 2016) and public health system restructuring (CNPFA 2017).

The public health landscape has changed over time, and contemporary circumstances differ from those when

PHAs first formed (Table 2). Recent commentaries have highlighted a weakening of public health infrastructure across Canada, including downgrading the status of public health within governments or health authorities, eroding the independence of Medical Officers of Health, limiting public health scope, and decreasing funding (Guyon et al. 2017). Beyond the formal public health system, key contemporary challenges include social and economic inequity (Wilkinson and Pickett 2009), global ecological change (CPHA 2015; Whitmee et al. 2015) including climate change (Watts et al. 2015), and the global neoliberal agenda, which poses a formidable threat to health, well-being, and equity (ASPQ 2016; Schrecker 2016). These are “wicked problems”⁴ (Peters 2017) demanding a collective, multisectoral approach. Advocacy in these domains is PHAs’ territory.

Why PHAs matter today

PHAs are uniquely positioned to champion the public health perspective

Current public health issues are cross-sectoral and cross-ministerial, suiting the unique configurations of PHAs. Many issues confronting public health, such as the ecological determinants of health, and social forces driving poverty, are outside the scope of some health entities (e.g., health regions) and/or transcend levels of government and ministries. PHAs can advocate on such issues because they can work outside of these structures, and have the autonomy to partner with on-the-ground experts in community and service environments.

Furthermore, PHAs have an important role to play in terms of articulating what public health is and does. “Public health” is frequently misunderstood, conflated with publicly funded health care, and/or reduced to singular elements (e.g., immunization) (Valaitis et al. 2018). In contrast, public health is more accurately and holistically described as an approach to maintaining and improving (i.e., through promotion, protection, prevention, and monitoring) the health of populations and is based on principles of social justice and equity, attention to addressing the underlying determinants of health, and evidence-informed policy and practice (CPHA 2017). There is a need for community-engaged PHAs that can speak up for public health in the context of weakened formal public health infrastructure (Guyon et al. 2017), where public health’s identity and the public resources dedicated to it are overshadowed.

¹ Civil society refers to “the wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious, or philanthropic considerations.” They may include community groups, NGOs, labour unions, and other service agencies (<http://www.worldbank.org/en/about/partners/civil-society>).

² NTNUPHA website: <https://www.cpha.ca/northwest-territories-and-nunavut-public-health-association>

³ PHABC website: <https://phabc.org>

⁴ The notion of “wicked problems” was developed in the planning literature but has extended to public policy more generally to describe problems that, among other things, are difficult to define, have multiple explanations, have no clear solution, and may be a symptom of other problems.

Table 1 Public health associations in Canada and their year of establishment (ordered from earliest to most recent)

Public health associations	Year of establishment	Mission statement
Canadian Public Health Association	1910	“To enhance the health of people in Canada and to contribute to a healthier and more equitable world”
Alberta Public Health Association	1943	“To be an independent, credible and fearless advocate for public health and health equity in Alberta”
Association pour la santé publique du Québec	1943	“ASPQ is an association of citizens and partners working together to prioritise sustainable health / Regroupe citoyens et partenaires pour faire de la santé durable par la prévention, une priorité”
Ontario Public Health Association	1949	“To provide leadership on issues affecting the public’s health and to strengthen the impact of people who are active in public and community health throughout Ontario”
Manitoba Public Health Association	1952	“To work with many sectors to influence emerging and re-emerging health, social, environmental and economic policy decisions to improve the quality of life and well-being of Manitobans”
Saskatchewan Public Health Association	1952	“To promote the health of Saskatchewan people and their environment through education, advocacy, and empowerment”
Public Health Association of New Brunswick and Prince Edward Island	1952*	“To advocate for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection, and healthy public policy”
Public Health Association of British Columbia	1953	“Promotes health, wellbeing and equity for all British Columbians through leadership in public health”
Public Health Association of Nova Scotia	1955*	“Works towards a society that supports a broad vision of health for Nova Scotians by advocating for policy change. We hope to enhance the capacity of the public health workforce in Nova Scotia, by providing networking, education, and professional development opportunities to members”
Northwest Territories and Nunavut Public Health Association**	1977	“Committed to and passionate about providing leadership, sharing knowledge, and improving health equity for all”
Newfoundland & Labrador Public Health Association	1979	“To be an active voice to promote public health in Newfoundland and Labrador and to enhance and support public health capacity guided by the principles of disease prevention, health promotion and protection and healthy public policy”
Yukon Public Health Association***	In progress	N/A

*Approximate

**The Northwest Territories Public Health Association changed its name to The Northwest Territories and Nunavut Public Health Association after the Northwest Territories split into two Territories in 2009

***A Yukon Public Health Association was incorporated in 2001 and dissolved (last annual filing) in 2010. At the time of writing, discussions were taking place with the intention to reinstate a renewed YPHA, upon appropriate approvals

PHAs represent and connect a diverse range of roles, professions, and stakeholders involved in public health

PHAs welcome and represent a diverse range of roles and professions that bring together diverse knowledge and experiences. PHAs thus gain a perspective on public health problems and solutions that transcend professional silos. When many of the PHAs were initially established, they were served by people working in traditional public health professions, including nurses, physicians, and inspectors (Velez Mendoza et al. 2017). Since then, PHAs have dramatically expanded their scope (Horton et al. 2014) to engage a broad range of professionals⁵ and citizens, including those working in newer public health domains (e.g., health equity, climate change, mental health, health literacy).

Membership in PHAs is not limited to health professionals. Academic researchers, researchers in other settings, and trainees are now active members. By directly engaging knowledge generators with a scholarly stake in a population health

agenda, PHAs can have an evidence-informed approach to advocacy that is “built in” through membership. PHAs furthermore engage other relevant stakeholders, such as community leaders, private organizations, and media or political figures. These arrangements may take the powerful form of coalitions, where multiple groups work together around particular issues. Examples include British Columbia’s Poverty Reduction Coalition,⁶ the Alberta Policy Coalition for Chronic Disease Prevention,⁷ la Coalition Québécoise sur le contrôle du Tabac,⁸ and Coalition poids.⁹

The capacity of PHAs to represent and connect a diverse range of people reflects their voluntary membership. While voluntary membership can bring challenges, it is also a strength where the necessity of working across the boundaries of professions and sectors is imperative. With voluntary membership, members are those who want to engage and make a difference. PHAs often have memberships that are small but loyal, with many individuals retaining their membership for decades.

⁶ <http://bcpovertyreduction.ca/about/members/>

⁷ <http://abpolicycoalitionforprevention.ca/who-we-are/>

⁸ http://www.cqct.qc.ca/Documents_docs/DOCU_2011/DOCU_11_11_28_Flyer_CQCT.pdf

⁹ <http://www.cqpp.qc.ca/en/>

⁵ Examples include (but are not limited to) speech language pathologists, dental hygienists, audiologists, health information scientists, and community nutritionists.

Table 2 Brief and selective overview of key public health concerns and events in Canada, 1910–2010. Drawn from Rutty and Sullivan (2010)

Time period	Some key public health concerns and events
Pre-Confederation	<ul style="list-style-type: none"> • First peoples; European immigration to Canada
1867–1909: the sanitary idea	<ul style="list-style-type: none"> • Early temporary local efforts (quarantine, boards of health) → limited effects • BNA Act—est. federal jurisdiction over quarantine and marine hospitals • Bacteriological revolution → foundation for evolving public health • Waste management, drinking water demanded collective effort via government responsibility • Expansion of municipal public health
1910–1919: transformation and WWI	<ul style="list-style-type: none"> • Federal Census and Statistics Act passed in 1879 • Rabies, poliomyelitis, venereal disease • Medical inspections in schools
1920–1929: modernization and growth	<ul style="list-style-type: none"> • Growth of public health education (e.g., Swat the Fly! campaign) • Immigration → growth of rural health units • Changes to role of women (e.g., factory work during WWI) → concern about maternal and child health; connection with social welfare and social services
1930–1939: a period of decline	<ul style="list-style-type: none"> • Concern about adequate nutrition for families on relief • Emergence of accidents (including automobile) as important causes of death
1940–1949: World War II and expansion	<ul style="list-style-type: none"> • Increasing urbanization • Canada's first food guide ("Food Rules") • National Physical Fitness Act, stemming from large number of men unfit for service • Professionalization of public health (e.g., designated medical specialty) • WHO definition of health
1950–1959: growth in research, services and funding	<ul style="list-style-type: none"> • Postwar economic growth → development and expansion of welfare state, public health services, health research • Decline in infectious disease, immunization programs targeting children (e.g., Salk polio vaccine and antibiotics) • Chronic diseases, e.g., cancer and cardio-pulmonary diseases, became major causes of death among adults
1960–1969: social transformation and health services	<ul style="list-style-type: none"> • Period of rapid social change, social movements • Introduction of public medical insurance • Tobacco, alcohol, drug use, sexually transmitted diseases
1970–1986: a new perspective on PH	<ul style="list-style-type: none"> • Resistance to public health messages about vaccination, tobacco, fluoridation, automobile safety • Period of consolidation, rationalization, and reduced health care federal funding → a new perspective on public health • Health promotion (Lalonde Report; Ottawa Charter for Health Promotion)
1987–present	<ul style="list-style-type: none"> • Population health, health equity, social determinants of health • Ecosystem health and ecological determinants of health • Emerging public health issues (e.g., opioids; legalization of recreational cannabis)

Readers are directed to the excellent full volume by Rutty and Sullivan (2010), from which the information above was drawn, for more detail of the recent history of public health in Canada

PHAs are positioned for advocacy at the provincial/territorial, national, and international levels

Advocacy is a foundation, and core competency, of public health in Canada (PHAC 2008; Hancock 2015). Briefly defined as “speaking, writing or acting in favour of a particular cause, policy, or group of people” (PHAC 2008), advocacy’s long history in public health includes efforts to fight consequences of industrialization, harmful practices of various industries (e.g., mining, automobile, tobacco), and government policies that create or worsen social inequity. Public health advocacy is critical to working towards healthy public policy, but often involves opposing “powerful vested interests” (Hancock 2015).

PHAs offer a safe space for members to engage in advocacy. First, because PHAs are situated outside of formal health institutions or government ministries, they offer opportunity for those employed in those organizations, which may restrict advocacy, to participate.¹⁰ Second, and more broadly, PHAs present a credible platform for anyone (i.e., citizens) to mobilize as part of a collective.

The positioning of PHAs as platforms for advocacy is particularly relevant when considering the “wicked problems” facing public health today, which involve powerful interests and cross disciplinary, jurisdictional, and sectoral boundaries. One example is the negative health implications of the “40-year uncontrolled experiment in neoliberal economics,” which has led to calls for radical policy reforms that include re-regulating global finance, rejecting austerity, shifting away from policies that threaten environmental sustainability, and reforming employment and pay to be more fair (Labonté and Stuckler 2016). PHAs, by virtue of their structure and mandate, permit convening the diverse expertise and interests necessary to begin to address these wicked problems, by advocating for policy reforms, large or small. This work may start with local action but lead to awareness and efforts at a global level, including via collaborative inter-PHA efforts within Canada and the broader ecosystem of public health associations globally.

¹⁰ This benefit of PHAs may be particularly important in jurisdictions with small populations, where many members are employed by formal institutions such as government ministries.

By building a membership with the enduring skills and connections required for effective advocacy, PHAs carry potential for advocacy mentorship, whereby members can learn from each other as part of an advocacy collective. At the same time, they develop relationships and mechanisms for ongoing advocacy, even as individuals and governments change, thus contributing to a sustainable advocacy process.

Conclusions

As independent, not-for-profit, member-driven associations, PHAs are uniquely positioned to embody and defend what public health is and does, transcend professional and disciplinary boundaries, and offer a powerful opportunity for collective mobilization around public health concerns. Among others, British Columbia (PHABC),¹¹ Ontario (OPHA),¹² and Québec (ASPQ)¹³ present excellent examples of PHAs working in the ways described here to build public health infrastructure, address healthy public policy, and engage a wide range of partners, to address health challenges.

Maintaining and building capacity is an ongoing challenge for PHAs. Considering their unique positioning and potentially powerful role, it seems surprising that some PHAs struggle to retain and grow their membership and impact. Recalling some of the core values of public health (social justice and equity; improving the health of populations; addressing the underlying determinants of health) and the foundational role of advocacy, we enthusiastically support efforts to strengthen PHAs by inspiring and engaging the public health community, including professionals, students, and citizens.

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¹¹ PHABC website: <https://phabc.org>

¹² OPHA website: <http://opha.on.ca/Home.aspx>

¹³ ASPQ website: <http://www.aspq.org>

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