Positioning Public Health for Future Success in Canada

Cordell (Cory) Neudorf, BSc, MD, MHSc, FRCPC

It is a unique opportunity to be Chair of the Canadian Public Health Association (CPHA) at a time when the Association is in transition from reflecting on its first 100 years to envisioning its future and that of the public health system in Canada. I confess that this made me wax somewhat philosophical as I pondered what to pen for this article. In other forward-looking invited commentaries published this year,¹⁻⁴ we have heard about various current trends, challenges and opportunities facing public health in Canada. We have been challenged to consider the need for public health to take action on the social determinants of health in the next century. We have also been told about the need to be prepared for emerging infectious and chronic diseases, once again with approaches that build health equity.¹⁻⁴ These statements resonate with me in my capacity as a regional Medical Officer of Health (MOH), seeing local research and reports on the health status of the population focus on the impacts of health inequity and what can be done to mitigate these impacts through program and policy changes. I concur with the analysis that the public health workforce should be far more active in advocating for changes that lead to a more equitable distribution of wealth, employment, education and housing, improved social and family supports, promotion of healthy and vibrant communities, and empowerment of the disenfranchised, as well as a more integrated approach to chronic disease prevention and management. So why have we not made more progress on these fronts as a public health system? In this paper, I focus on what I consider to be two prerequisites for success that have not yet been covered but are essential if public health hopes to make the next leap forward in health status over the next few decades in Canada:

- the composition of the public health workforce;
- the organization and positioning of the public health system.

Composition of the public health workforce

In its definition of the public health workforce, the Pan-Canadian Framework for Public Health Human Resources Planning, produced by the Joint Task Group on Public Health Human Resources (HHR) in 2005, lists 12 regulated and 14 non-regulated providers, most requiring specialized training.⁵ This same document states that in addition to this complex workforce, other unique HHR planning challenges facing public health include the highly interprofessional nature of practice and the fact that a number of public health functions can be performed by a variety of practitioners. The report goes on to give a blueprint for improving training requirements and continuing education, and increasing the number of highly qualified public health workers in Canada. It should be pointed out that these suggested improvements were formulated in the wake of the SARS (severe acute respiratory syndrome) crisis in Ontario, partly in response to recommendations from multiple reviews of the capacity of public health systems at the national and provincial level, beginning with the 2003 Naylor report, "Learning from SARS:

Renewal of Public Health in Canada."⁶ These reports emphasized that the SARS crisis was only the latest in a sequence of outbreaks and emerging disease threats (continuing to the present day with H1N1 pandemic influenza as the most recent example) that had been occurring over the previous decade, all outlining the need for enhancing public health capacity. Public health tends to manage individual crises relatively well but has no surge capacity to handle multiple crises at once. These reports suggest that the best way to guarantee public health capacity in these types of crises is to ensure that the public health system has a strong baseline capacity – a highly qualified workforce with transferable skills or competencies that can be called upon in times of need.

While I agree with these recommendations, I am also aware that they have cost implications for the health system. It can certainly be argued that a greater proportion of the health care dollar should be spent on the prevention end of the spectrum in our health system. However, while we need to ensure that the health professionals who choose public health as a career are paid comparably with their counterparts in the rest of the health system, we also need to re-examine the staff mix of our workforce to ensure that we are using professional staff appropriately and to their full scope of practice, achieving the right balance of effectiveness and efficiency for choosing which staff deliver what aspects of our programming to specific populations.

For example, an analysis of the Saskatoon Public Health Department budget and workforce shows that although our total budget has increased substantially in the past decade along with that of the rest of the health system, it remains at just under 2% of the total health budget for the region. Most of this increase has been used to meet increased costs for existing staff, and only a few new positions have been created, mostly by targeted funding in a few professional areas. The proportion of the budget required to pay for staff wages and benefits has increased from 87% to 93% in the last few years; despite a concerted effort, only 1% of our staff would be considered "lay" staff or entry-level positions at a peer level in the more vulnerable neighbourhoods. The net result is that despite the appearance of increased capacity in public health locally, net capacity increase has been marginal at best, despite the presence of a senior executive at the local level who understands and supports prioritizing disease prevention and health promotion (Saskatoon Health Region, Public Health Services: personal communication).

While public health needs to continue to advocate for resource increases to allow for program growth, we also need to look to internal reallocation, using creativity and best practice to allow us to be more effective within existing resource limitations. In our efforts to secure a highly professional workforce with specialized compe-

Author Affiliations

Chief Medical Health Officer, Saskatoon Health Region; Chair, CPHA

tencies, we have paid little attention to some of the unique skill sets needed to achieve good outcomes in our most vulnerable populations, often available without extensive training. For example, even in the best circumstances, where programs have been designed with strong input from the targeted population, too few of the front-line staff come from the same backgrounds or live in the same communities as those clients in greatest need (Saskatoon Health Region, Public Health Services: personal communication), whereas research has shown that these factors are important in gaining acceptance from clients and having the intended outcomes.^{7,8} Using a social determinants of health approach to our own program delivery, we should be working with our provider unions in searching for ways to make it easier to hire staff from the neighbourhoods in which we want them to work. We should encourage students in the most vulnerable neighbourhoods to consider careers in public health, creating entry-level positions at a living wage with on-the-job training, so that they can act as technicians, educators and community health workers to help translate our public health messages for the local community in a way that is understood and trusted. At the same time, we should be increasing the opportunities for individuals to upgrade their training on the job if they so desire, making it easier for our staff to advance through the system while earning an income. In this way we would create more of a balanced workforce, with each worker utilizing more of their unique competencies toward common goals but in a more cost-efficient and effective manner. Early efforts in these directions have shown promise in Saskatoon Health Region, but as a large employer we still have a long way to go to truly lead by example and do our part to improve the social determinants of health.

Organization and positioning of the public health system

Increasing the staff mix of the public health workforce and becoming a more representative workforce are necessary steps for public health in the coming decades, but alone they are not sufficient to effect maximum impact in improving health status. We also need to optimize the positioning of public health within the larger health system and improve the way in which public health is organized within our Canadian context. While most provinces have incorporated public health into regional health authorities in their various forms across the country, they have fared differently from place to place in this transition. In some cases, whole public health programs (e.g., Healthy Mother Healthy Baby in Saskatoon) or disciplines (e.g., public health nursing in parts of British Columbia) have been moved to the oversight of another part of the system, while in other cases they have seen growth and have increased their role and profile (e.g., by adding a physical activity promotion program, becoming responsible for population health reporting and planning for the entire health system, and making the Medical Health Officer a member of the senior leadership team in Saskatoon).

One common initial reaction by public health to the prospect of being made part of a regionalized health system has been resistance and fear. In our efforts to promote best practice in disease prevention and health promotion approaches and services, we have tended to be perceived as elitist by other parts of the health system, thereby making us seem insular. Further, in our fear of being subsumed by the larger acute care system in the various health reform experiments underway across Canada, we have tended to

take a protectionist approach, resisting efforts to fully integrate public health into the health system. In so doing, we risk losing the opportunity to influence and shape the overall health system.

Although true that it is difficult for a relatively small service such as public health to substantially influence change at the system level, history shows that well-placed comments, briefs and advocacy have guaranteed a prominent place for the concepts of health promotion, disease prevention and health protection within most health reform movements in Canada's recent past. In most health reform documentation at health region, provincial or national levels, a holistic definition of health has been adopted incorporating both the health of individuals as well as the health of communities, and there is an effort to encourage interventions across the continuum of care, from prevention through to treatment, rehabilitation and palliation. If public health staff and programs have been lost or marginalized during health reform in some cases, it may be because we have failed to consistently make the case that public health is greater than simply the sum of its parts – more than just a collection of specific disciplines providing a prescribed set of services within a geographic region.

I contend that public and population health is an ethos or common set of worldviews and perspectives shared by a diverse group that strives to work together despite members' differences and backgrounds toward the common goal of improving the health status of their community at the population level. To the extent that this group of staff can work together, plan and strategize together, get ideas from one another and continue to reinforce this common purpose, the collection of programs and services will work in synergy to produce more than they could ever hope to achieve in isolation. However, when an individual program or discipline is taken away from the rest of the public health workforce and forced to function on its own, this common worldview or perspective can be gradually lost or diluted, and the programs and services become more individual oriented, focused on short-term outputs. Examples include nurses who are asked to do primary care nursing with public health duties on the side and report that over time the primary care duties take up an increasing proportion of their day; or the diversion of whole departments, such as public health nursing, to be placed with other nursing staff, resulting in a loss of connection to the rest of their coworkers who share the same worldview.

Even in an optimally structured environment where shared perspectives are reinforced regularly, where best practice is reviewed and incorporated systematically, and diversity in training, discipline and background is nurtured and encouraged, the tendency to gravitate toward individual-oriented, short-term programs and services seems irresistible at times. People like to see the immediate results of their labours by serving the individual in front of them rather than acting at the more nebulous population level through advocacy, committee work and community development, which may lead to changes in policy or societal attitudes and empower communities, albeit over long periods of time. Those staff working at this population level need to work closely together to continually reinforce these ideas and shared principles with one another as they shape program planning and delivery. However, given that health service delivery is seen to be the mandate of provincial governments in Canada, there has been limited success in articulating and enforcing a core set of mandatory programs, services and staffing levels for public health with consistency across the coun-

try, let alone an authoritative statement about the need for these services to be kept together as a unified department.

If you accept that public and population health is more than just the sum of its services and staff but is also a conceptual approach or worldview, then there are implications for not only how public health is structured but also its positioning and role within the health system.⁹ In the Ottawa Charter for Health Promotion,¹⁰ we are told that a key element in health promotion is reorienting the health system. It seems that within Canada, most public health workers have narrowly interpreted this to mean “try to get a larger proportion of the health budget for public health programs”. It is my contention that a much broader interpretation is required. Front-line workers, managers, supervisors and leaders need to balance the provision of population-based programs (our service provider role) with a support service role that involves advocacy and empowerment, influencing or even co-opting a wide variety of partners inside the health system, in the broader human service sector, and beyond. Functioning well in this dual role may be more difficult if public health is not positioned optimally within the health system, with a seat at the senior leadership table and representation on key decision-making bodies and committees, but this is not the fault of health reform alone. There is an inconsistent level of competence or even level of interest shown by public health workers in functioning at this broader level. While some individuals have natural skills and abilities and others have gained competence through unique training backgrounds, such as Masters in Business Administration or health administration training, most public health workers are insufficiently prepared to function in this role. If we are to take on this broader role consistently across the country, this will need to be corrected by continuing education opportunities for existing staff and enhancements in the training programs for public health workers.

It should be recognized that this broader role for public health workers is not a new concept but, rather, is merely being rediscovered as we look to our roots.¹¹ The formal public health service was established in most jurisdictions in Canada largely in response to the health concerns being faced as a result of factors such as urbanization and the European colonization model.¹² This model brought with it the same challenges being faced in cities and settlements elsewhere (e.g., outbreaks of enteric and respiratory diseases, and nutritional deficiencies), compounded by immature social and physical infrastructures. The greatest gains in the health of most Canadians occurred in the early part of the last century as a result of improvements in areas such as sanitation; urban planning; agriculture and food distribution; improved labour laws, including prohibitions against child labour; occupational health and safety improvements; and publicly funded education. Vaccination programs and the introduction of antibiotics followed, bringing further improvements to the health status of the population, particularly children. Our publicly funded Medicare system was a relative latecomer to the list of societal improvements with health impacts, and while it has certainly contributed substantially, in relative terms it has made far less of an impact at a much greater cost when compared with those interventions that came earlier.⁹

A common thread through many of these past interventions is what we now come to recognize as the public and population health approach. Although most of the people who worked to make these improvements possible were not employed by the fledg-

ling public health system, it was this perspective or worldview, often catalyzed or at least strongly supported by public health, that drove this slow but steady progression of programs and policies and led to the gains in health status most of us enjoy today. I contend that these very successes have made many of us working in public health somewhat complacent and content to play our small part in discrete service delivery rather than continue in our role as catalysts and advocates for continual improvement in societal conditions that improve health status, particularly for those being left behind today. We need to rediscover and redevelop the atrophied skills needed to move the twin policy levers of shaping public opinion and creating political will.¹³ This is what will be required if we wish to reorient the health system, reduce health inequities and see continued improvements in the health of our society in the century ahead.

Across the country, we see glimmers of what reorienting the system could look like. Using Saskatoon as an example, health status reports are used as key planning documents for the entire health system, not just the local public health department, and they are allowed to contain recommendations for change, from the MOH, that are discussed and adapted or adopted by the senior leadership team. Decision-making tools are adopted that have population health and disease prevention elements among the criteria against which health system change requests are judged. Health boards receive education on the population health model and hold senior management accountable for taking a balanced approach to strategic planning, setting corporate goals and objectives, and monitoring progress. Disease prevention and health promotion perspectives become adopted by programs in many departments of the health system, not only those programs delivered by public health. All health programs begin to look at the equity of their access and outcomes through approaches such as “health equity audits”, which emphasize the concept of “equal service for equal need” (see www.saskatoonhealthregion.ca). The net result is a slow but steady reorienting of the health system toward one that has more balance between treatment and prevention and leads to better health status for the population over time. Unfortunately, inconsistency in the role and positioning of the public health system, and varying capacity and training of the public health workforce, have not made this type of participation by public health in the reorientation of the health system equally prevalent across Canada.

In addition, the rules of engagement between the federal, provincial/territorial and regional levels of the public health system itself make it difficult to share innovation and develop consistency in programs and supports. Formal communication or organization between public health units at the local level from different provinces, or between the local and federal levels, generates political sensitivities unless the communication flows through the provincial level. However, many local public health units have found that they have more in common with other units of the same size or geographic features. Many program areas and public health professionals find they need to share information and best practice across these boundaries. Given Canada's political system, these needs are increasingly being filled by the emergence of networks, not to circumvent the FPT process but, rather, to augment it. Examples include (to name only a few with which I am most familiar) the Pan-Canadian Public Health Network (see www.phn-rsp.ca), which creates a new way for different levels of government

and experts to work together to improve public health in Canada; the Urban Public Health Network (see www.uphn.ca), which facilitates the sharing of innovations in programming, common practice problems and solutions among the MOHs of Canada's largest cities; the Public Health Observatory Network (www.saskatoon-healthregion.ca/your_health/ps_public_health_pho_about.htm), which links the applied research, surveillance and best practice work emerging in some health regions, cities and universities; and the National Specialty Society for Community Medicine (see www.nsscm.ca), which provides for continuing education and a common voice for public health physicians in Canada.

At the risk of inducing a Hawthorne effect on this organic process, I would propose that pan-Canadian public health leadership (both at the government and non-government organization level) needs to formally nurture and support these nascent networks by helping them link together to avoid unnecessary duplication, enhance each other's work and allow them to grow faster. Given the realities of our Canadian public health system's structure, this network of networks could represent a key ingredient in catalyzing increased public health capacity. These networks have the ability to accelerate the diffusion of innovation and best practice, and to share common problems and solutions at the local level unencumbered by the politics often at play between the federal and provincial levels. The networks also have the potential to counteract the natural tendency of large public health units with more resources within individual provinces to "go it alone", developing one-off programs, information technology solutions or workforce strategies rather than using the generic solutions developed by the provincial level. Facilitating networks of networks in a matrix of geography, population size, discipline and program area creates an environment that encourages sharing these innovations and solutions to similar problems, thereby reducing the waste, inefficiency and lack of connectivity that result from solving the same problem multiple times in different ways across the country.

We often hear that Canada is a nation where innovative ideas for public and population health are developed, but that we leave implementation to other nations. If public health in Canada is to

make the next great leap forward in improving health status, we will need to challenge this reputation. We need to learn from our past, adapt global best practice to our context through networks and strategically use a more balanced, diverse workforce to both deliver services and participate in advocacy. We need to reorient the health system to take action on the social determinants of health, using its own resources and by influencing societal change. This is our challenge and our mandate for the next century.

REFERENCES

1. Brunham RC. Infectious disease prevention and control: Remembering 1908 and imagining 2108. *Can J Public Health* 2009;100(1):5-6.
2. Frank J. Thoughts from Scotland on the challenge of equitable health improvement. *Can J Public Health* 2009;100(2):89-90.
3. Butler-Jones D. A reflection on public health in Canada: Applying lessons learned for the next century of public health practitioners. *Can J Public Health* 2009;100(3):165-66.
4. Lessard R, Raynaud M-F. La santé publique et la pauvreté. *Can J Public Health* 2009;100(4):245-46.
5. The Joint Task Group on Public Health Human Resources. Advisory Committee on Health Delivery and Human Resources. Advisory Committee on Population Health and Health Security. Building the Public Health Workforce for the 21st Century. A Pan-Canadian Framework for Public Health Human Resources Planning. Ottawa, ON: Public Health Agency of Canada, 2005;1.
6. Learning From SARS: Renewal of Public Health in Canada. A Report of the National Advisory Committee on SARS and Public Health. Ottawa, ON: Health Canada, 2003.
7. Beal AC. Policies to reduce racial and ethnic disparities in child health and health care: Eliminating racial and ethnic disparities will require multiple interventions throughout the health care system. *Health Affairs* 2004;23(5):171-79.
8. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med* 1999;159:997-1004.
9. Canadian Public Health Association Board of Directors. Focus on Health: Public Health in Health Services Restructuring. Issue Paper. Ottawa, ON: CPHA, February 1996.
10. Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986. Available online at: http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (Accessed September 9, 2009).
11. Awofeso N. What's new about the "new public health"? *Am J Public Health* 2004;94(5):705-9.
12. Saul JR. *A Fair Country: Telling Truths about Canada*. Penguin, 2008;230-43.
13. WHO. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Commission on Social Determinants of Health Final Report. Geneva: World Health Organization, 2008.