A Reflection on Public Health in Canada: Applying Lessons Learned for the Next Century of Public Health Practitioners

David Butler-Jones, MD

As we look back over the last century, we can take pride in the advances we have made in improving the health of Canadians and in establishing an effective public health approach that to this day continues to be an influential and driving force in Canada and around the world.

Over the past 100 years, our discipline has evolved. We have progressed from a purely reactionary practice that confronted infectious diseases only in the face of outbreaks, to one that responds to crises while at the same time proactively promoting and protecting health. Today we look past poor health as a stand-alone problem and are moving toward a better understanding of how to address what Sir Michael Marmot would call the “causes of the causes”,¹ the social and economic factors that contribute to our community and individual well-being.

As public health practitioners, it is important that we be open to learning from our shared past. After all, some of our very earliest advances in public health remain relevant and applicable today.

Before the benefit of mass immunization, generations of Canadians lived with the threat of a range of frequent and debilitating diseases. The 1830s and 1840s saw waves of cholera and typhus kill large numbers of early settlers, while the Aboriginal population experienced epidemics of smallpox, tuberculosis, diphtheria, typhus, measles and syphilis.² The 1867 *British North America Act* creating the Dominion of Canada accorded the very first health powers to the federal government; in addition to responsibility for marine hospitals, Parliament would have jurisdiction over the establishment of quarantine, a fundamental element of public health to this day.³

Immunization against diseases like smallpox, polio, and diphtheria through the early days of the twentieth century changed the public health landscape in Canada, averted countless deaths, and allowed us to focus on other aspects of proactive health promotion. Measles continues to affect millions of people worldwide and is the leading global cause of vaccine-preventable death in children under five, according to the World Health Organization (WHO).⁴ However, after the introduction of the measles vaccines to Canada in the early 1960s, the average number of annual cases dropped from over 300,000 to just over 2,300.^{5,6} Canada has had tremendous success in reducing and eliminating vaccine-preventable diseases, and the case to maintain high vaccine coverage rates and to continue the effort to assure Canadians that vaccines are safe and effective remains strong.

The Great Depression and the Second World War dealt serious blows to the Canadian economy and society. Farmers went bankrupt, industries in towns and cities collapsed, people lost their homes and livelihoods. Those who had been uprooted and unemployed became migrants and sometimes vagrants – homeless, hungry and frequently ill.

These events, in addition to the high incidence of polio at the time, laid the groundwork for contemporary concepts of public health. Canada began to strengthen its social fabric and focused on social improvements such as construction of new housing and the provision of education to returning soldiers and their families. Canada's first Food Guide was born out of the need to reduce nutritional deficiencies resulting from war-time food rationing. Meanwhile, the notion of social and economic factors impacting health became more pervasive and influenced the development of many broad social programs from which we still benefit today, including the Canada Pension Plan and Old Age Security.

The post-war period also brought unique public health challenges. People were living longer which meant chronic diseases and injury became the more common causes of death. New trends emerged, including widespread smoking, drinking, recreational drug use and a resurgence of sexually transmitted infections. More automobiles led to decreased physical activity and more air pollution. However, public health experts explored the causes of these trends with a view to prevention. This important work identified associations between smoking and lung cancer; diet, physical exercise and heart disease; seatbelt use and road traffic injuries; and air pollution and worsening asthmatic conditions.

In the 1970s and 1980s, as the health care system saw improvements through the passing of the *Canada Health Act*, which ensured comprehensive, universal and accessible insured health coverage to all Canadians, the concept of health promotion was further developed. The 1974 landmark report, *New Perspectives on the Health of Canadians*, from then-Minister of Health Marc Lalonde got us thinking, as a country, about population health, and how “good public health” was so much more than just good health care. Just over a decade later, *Achieving Health for All: A Framework for Health Promotion* (1986) was tabled by then-Minister of Health Jake Epp. This report placed greater focus on the determinants of health and identified income-related health inequalities as an area for priority action. It also brought to the forefront the notion that health was not just a by-product of personal choices, but of environmental influences as well. These reports, as well as the Ottawa Charter for Health Promotion, resulted in important advances in the health and health promotion field – such as the establishment of breastfeeding as a cultural norm and new regulations on the manufacture, sale, labelling and promotion of tobacco – and helped to cement Canada's influence in changing the global paradigm on public health approaches.

In the late 1990s, the increasing burden of HIV infections and an outbreak of invasive meningococcal disease reminded Canada

Author Affiliation

Chief Public Health Officer of Canada, Public Health Agency of Canada

that infectious diseases remained a challenge and a threat. That threat took on a new dimension in 2003 with the arrival of Severe Acute Respiratory Syndrome (SARS) in Canada, which claimed the lives of 44 Canadians and significantly damaged segments of the Canadian economy. SARS was a reminder that the next infectious disease outbreak may be just a plane ride away and that, for all its strengths, Canada's health care system may not be enough, on its own and under its own merits, to protect us. The lessons of SARS and the recommendations that followed from the Naylor Report⁷ and the SARS Commission Final Report⁸ led to the creation of the Public Health Agency of Canada, whose responsibilities include population health assessment, surveillance, disease and injury prevention, health promotion, preparing for and responding to emergencies and strengthening our public health capacity.

Moving Forward – The Next 100 Years

Clearly, any reflection on the history of public health in Canada reveals some tremendous successes. Unfortunately, despite our advances, not all health trends are improving and not all Canadians are benefiting to the same degree.

Examples are not hard to find. Today we are seeing a growing prevalence of obesity and diabetes in our young which, if left unchecked, could see this generation of children become the first in Canada to have a shorter life expectancy than their parents. We link poverty to education, employment, and health status; as Canada navigates through a global economic crisis, the downturn can be expected to have ripple effects on health and social spending, affecting the most vulnerable of our citizens.

Our national history has taught us that it is a combination of programs, services and policies that protect and promote health. The necessity of clean water, reliable infrastructure and food safety was reinforced with the incidents of water contamination in Walkerton, Ontario and North Battleford, Saskatchewan, and with the listeriosis outbreak in 2008. Restaurant inspections, safety regulations, immunizations, physical activity and nutrition programs, education and literacy and social welfare programs all contribute to our overall community and individual health. The majority of Canadians are fortunate to have access to these programs and services and, as a result, enjoy good to excellent health.

Undoubtedly, the means and will exist to tackle the wide array of health inequalities which limit Canada's ability to achieve its full economic and social potential, but there are three key areas where we can focus time and resources: working collaboratively across sectors and jurisdictions; investment and collective effort focused on the early years of life; and strengthening community-level efforts.

By working across sectors and jurisdictions, health inequalities can be reduced and other social goals such as crime reduction and civic participation can be attained. Through collective will and leadership, and cultivating a whole-of-society response, we can build recognition of the importance of preventing disease and injury and of promoting health. Public health is about more than being able to respond in the event of an emergency – it is about keeping the population at large healthy so that the impact of health

emergencies can be mitigated. Through this level of collaboration, with all leaders at all levels and in all sectors, we can identify the appropriate indicators and create the tools required to measure and monitor progress, as well as address the information gaps that prevent effective measurement.

In terms of focusing on the early years, we know that some of the greatest returns on investments are those targeted at our youngest citizens. Investments made to help ensure a healthy start in the early years of a child's life have been proven to reduce the long-term costs associated with health care, addictions, crime, unemployment and welfare. These investments, including early learning and childhood development, and housing and infrastructure, help children become better educated, adjusted and more productive as adults.

Finally, it is clear that the community is a point of convergence for government, private and volunteer sectors and is the intersection where all players can come to the table to establish local priorities and develop shared strategies. Strong communities can help to mitigate the health impacts of factors such as low income and poor access to education and can play an important role in creating environments that support health choices for all citizens. Continuing to improve community access to skills and resources for local programs; sharing community-generated and national-level data for the benefit of community groups; and sharing research and knowledge to encourage the replication of successful initiatives across the country are all ways in which a focus on community-level efforts can further improve health.

The last century has brought tremendous advances in the public health field that have helped Canada to become one of the healthiest nations in the world. The next step is to aim to be the healthiest nation with the smallest gaps in health. Imagine the improvements in peoples' quality of life if, by addressing the social and economic factors that influence health, physical and social environments were created in which Canadians could easily make good choices to achieve and maintain good health. By paying attention to and addressing these underlying determinants of health, not only do we level the playing field for all Canadians, we effectively support the functioning of society and Canada's competitiveness as a nation for this century and for many years to come.

REFERENCES

1. Marmot M. Social determinants of health inequalities. *Lancet* 2005;365:1099-103.
2. Waldram JB, Herring DA, Young TK. Aboriginal health in Canada: Historical, cultural and epidemiological perspective. Toronto, ON: University of Toronto, 1995.
3. British North America Act, 1867, 30-31 Vict, c.3 (U.K.).
4. World Health Organization. *Vaccine-preventable Diseases: Measles*. Geneva, Switzerland: WHO, 2007.
5. Public Health Agency of Canada. *Vaccine-Preventable Diseases: Measles*. Ottawa, ON: PHAC, 2002.
6. King A, Varughese P, DeSerres G, Tipples GA. Measles elimination in Canada. *J Infect Dis* 2004;189 (suppl 1):S236-42.
7. National Advisory Committee on SARS and Public Health. *Learning from SARS: Renewal of Public Health in Canada*. Ottawa, ON: Author, 2003.
8. The SARS Commission. *Spring of Fear – Final Report*. 2006.