



*The Senate*

# **Reforming Health Protection and Promotion in Canada: *Time to Act***

Report of the Standing Senate Committee on  
Social Affairs, Science and Technology

Chair:

The Honourable Michael J.L. Kirby

Deputy Chair:

The Honourable Marjory LeBreton

November 2003



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The Standing Senate Committee on Social Affairs, Science and Technology

Reforming Health Protection and Promotion in Canada:  
Time to Act

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*Deputy Chair*

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NOVEMBER 2003



# TABLE OF CONTENTS

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<b>TABLE OF CONTENTS</b> .....	<b>i</b>
<b>MEMBERSHIP</b> .....	<b>ii</b>
<b>ORDER OF REFERENCE</b> .....	<b>iii</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>CHAPTER ONE:</b> .....	<b>7</b>
<b>SETTING THE CONTEXT</b> .....	<b>7</b>
1.1 The Committee’s Previous Study on Health and Health Care .....	7
1.2 Review of Selected Documents.....	9
1.3 The Naylor Report .....	10
1.4 Committee Commentary.....	12
<b>CHAPTER TWO:</b> .....	<b>17</b>
<b>CREATING A HEALTH PROTECTION AND PROMOTION AGENCY</b> .....	<b>17</b>
2.1 The Advantage of Having a National Arm’s Length Agency.....	17
2.2 What Model for the New Agency? .....	22
2.3 The mandate of the HPPA and the timetable for its creation.....	26
<b>CHAPTER THREE:</b> .....	<b>31</b>
<b>BUILDING DISEASE SURVEILLANCE AND EMERGENCY RESPONSE</b>	
<b>CAPACITY</b> .....	<b>31</b>
3.1 Disease Surveillance and Control.....	32
3.2 Building an Effective Health Emergency Response System.....	35
3.3 Human Resource Development.....	37
3.4 Laboratories .....	39
3.5 Information Technology and Communications Systems .....	40
3.6 Research.....	41
3.7 Globalization.....	42
<b>CHAPTER FOUR:</b> .....	<b>45</b>
<b>IMMUNIZATION AND CHRONIC DISEASE PREVENTION</b> .....	<b>45</b>
4.1 Chronic Disease Prevention .....	45
4.2 Immunization.....	47
<b>CHAPTER FIVE:</b> .....	<b>51</b>
<b>FINANCING REFORM: AN INCREMENTAL APPROACH</b> .....	<b>51</b>
5.1 Federal Government Spending Recommended in the Naylor Report.....	51
5.2 Federal Government Spending Recommended by the Committee.....	54
<b>CONCLUSION</b> .....	<b>57</b>
<b>APPENDIX A</b> .....	<b>59</b>
<b>LIST OF RECOMMENDATIONS BY CHAPTER</b> .....	<b>59</b>
<b>APPENDIX B</b> .....	<b>65</b>
<b>LIST OF WITNESSES</b> .....	<b>65</b>

## MEMBERSHIP

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Standing Senate Committee on Social Affairs, Science and Technology

The Honourable Michael J. L. Kirby, Chair  
The Honourable Marjory LeBreton, Deputy Chair

The Honourable Senators:

Catherine S. Callbeck  
Joan Cook  
Jane Marie Cordy  
Joyce Fairbairn, P.C.  
Wilbert Keon  
Viola Léger  
Yves Morin  
Brenda Robertson  
Douglas Roche  
Eileen Rossiter

\* Sharon Carstairs, P.C. (or Fernand Robichaud)

\* John Lynch-Staunton (or Noel A. Kinsella)

The Honourable Marilyn Trenholme Counsell also participated in this study.

\* *Ex Officio* members

## ORDER OF REFERENCE

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Extract from the *Journal of the Senate* of Tuesday June 19, 2003:

Resuming debate on the motion of the Honourable Senator Kirby seconded by the Honourable Senator P  pin:

That Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the infrastructure and governance of the public health system in Canada, as well as on Canada's ability to respond to public health emergencies arising from outbreaks of infectious disease. In particular, the Committee shall be authorized to examine and report on:

- the state and governance of the public health infrastructure in Canada;
- the roles and responsibilities of, and the coordination among, the various levels of government responsible for public health;
- the monitoring, surveillance and scientific testing capacity of existing agencies;
- the globalization of public health;
- the adequacy of funding and resources for public health infrastructure in Canada;
- the performance of public health infrastructure in selected countries;
- the feasibility of establishing a national public health legislation or agency as a means for better coordination and integration and improved emergency responsiveness;
- the Naylor Advisory Group Report and recommendations.

That the Committee submit its report no later than March 31, 2004.

After debate,

The question being put on the motion, it was adopted.

Paul B  lisle,

Clerk of the Senate





## INTRODUCTION

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*Canada must (...) move from a “Just in Time” approach to one built on the established principle of “Be Prepared”, so that our public health capacity is adequate not only for today’s tasks but also for tomorrow’s challenges.<sup>1</sup>*

On June 19, 2003, during the Second Session of the Thirty-Seventh Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the governance and infrastructure of health protection and promotion in Canada, as well as Canada’s ability to respond to health emergencies arising from outbreaks of infectious disease. The decision to undertake such a study came as a result of a combination of events including: the outbreak of Severe Acute Respiratory Syndrome (SARS) in the Greater Toronto Area and Vancouver earlier this year, the identification of a single cow diagnosed with Bovine Spongiform Encephalopathy (BSE) in Alberta, the confirmed cases of human infection with the West Nile Virus (WNV) in Ontario and Quebec, and threats of biological terrorism in the United States.

Globalization is a serious concern in this context. The rising speed and volume of travel and international food (and feed) trade markedly increase the risk of outbreaks of serious or emerging infectious diseases being spread rapidly throughout the world. In turn, this significantly increases the responsibility of the federal and provincial/territorial governments to put in place in Canada a structure which can rapidly meet these growing threats.

Interestingly, many of the new health risks – such as SARS, BSE and WNV – are zoonoses, that is, diseases that spread from animals to humans. As such, zoonotic diseases point to the need to alter the scope of health protection and promotion activity, in particular to the importance of closer collaboration between the human health field and the animal health sector.

The SARS outbreaks in two of Canada’s major cities, and especially the extent and duration of the outbreak in Toronto, have dramatically highlighted the critical issue of protecting the health of Canadians from infectious disease outbreaks as well as the dangers Canada faces, and the challenges it must meet in the near future, with respect to health protection and promotion issues.

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<sup>1</sup> Canadian Public Health Association, *Public Health – Serving the Public Interest*, Brief to the Committee, 1 October 2003, p. 7.

SARS had a tremendous impact on resources, health care personnel and hospitals. Above all, it was a human tragedy that claimed the lives of 44 Canadians, including two nurses and one physician. The Committee wishes to express its condolences to the families and friends of those who died from SARS, and hopes that this report, along with others recently completed or now underway, will help the country be better prepared to confront similar outbreaks in the future.

**The Committee wishes to express its condolences to the families and friends of those who died from SARS, and hopes that this report, along with others recently completed or now underway, will help the country be better prepared to confront similar outbreaks in the future.**

The terms of reference of this study read as follows:

*That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the infrastructure and governance of the public health system in Canada, as well as on Canada's ability to respond to public health emergencies arising from outbreaks of infectious disease. In particular, the Committee shall be authorized to examine and report on:*

- *the state and governance of the public health infrastructure in Canada;*
- *the roles and responsibilities of, and the coordination among, the various levels of government responsible for public health;*
- *the monitoring, surveillance and scientific testing capacity of existing agencies;*
- *the globalization of public health;*
- *the adequacy of funding and resources for public health infrastructure in Canada;*
- *the performance of public health infrastructure in selected countries;*
- *the feasibility of establishing a national public health legislation or agency as a means for better coordination and integration and improved emergency responsiveness;*
- *the Naylor Advisory Group report and recommendations.*<sup>2</sup>

In response to this broad mandate, the Committee initially reviewed background information prepared by the Parliamentary Research Branch of the Library of Parliament on the following issues: federal and provincial public health legislation; emergency preparedness in Canada as it relates to outbreaks of significant or emerging infectious diseases; Canada's capacity to monitor outbreaks threatening the health of Canadians; international examples of disease control and prevention infrastructure (Australia, United Kingdom, United States, as well as the proposed European Centre for Disease Prevention and Control); and the role of the World Health Organization with respect to health protection and promotion.

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<sup>2</sup> Debates of the Senate (Hansard), 2<sup>nd</sup> Session, 37<sup>th</sup> Parliament, Volume 140, Issue 72, 19 June 2003.

In addition, the Committee reviewed relevant reports and documents from the past few years that have raised critical issues with respect to Canadian health protection and promotion infrastructure. Among others, these reports and documents include:

- Auditor General of Canada, *Health Canada – National Health Surveillance*, Chapter 2, September 2002 Report.
- Canadian Institute for Health Information and Canadian Institutes of Health Research, *Charting the Course – A Pan-Canadian Consultation on Population and Public Health Priorities*, May 2002.
- Canadian Medical Association, *Submission to the House of Commons Standing Committee on Finance*, Pre-Budgetary Consultations, November 2001.
- Canadian Public Health Association (Board of Directors), *The Future of Public Health in Canada*, Discussion Paper, October 2001.
- Advisory Committee on Public Health, *Survey of Public Health Capacity in Canada – Technical Report*, prepared for the Federal/Provincial/Territorial Deputy Ministers of Health, March 2001 (unpublished).
- Auditor General of Canada, *Management of a Food-Borne Disease Outbreak*, Chapter 15, September 1999 Report.
- Auditor General of Canada, *National Health Surveillance – Diseases and Injuries*, Chapter 14, September 1999 Report.
- Expert Working Group on Emerging Infectious Disease Issues, *Lac Tremblant Declaration*, 1994.

Then, the Committee held a series of hearings at which it heard from a wide range of witnesses including: federal officials from the departments of Health Canada and Agriculture Canada; representatives from the Canadian Food Inspection Agency and the Office of Critical Infrastructure Protection and Emergency Preparedness; provincial public health officers (British Columbia, Ontario, Quebec, Saskatchewan); public health experts/researchers; national health organizations (Canadian Medical Association, Canadian Nurses Association, Canadian Public Health Association, Canadian Coalition for Public Health in the 21<sup>st</sup> Century); and representatives from the United States Centers for Disease Control and Prevention (US CDC). In addition, the Committee heard from Dr. David Naylor, Dean of Medicine at the University of Toronto, who chaired the National Advisory Committee on SARS and Public Health. The Naylor report, entitled *Learning From SARS – Renewal of Public Health in Canada*, is examined carefully in this report. In total, the Committee heard some 30 witnesses and received approximately 20 written submissions.

The Committee also wishes to acknowledge the contribution of Dr. Joseph Losos, Director of the Institute of Population Health (University of Ottawa). His expertise and very thorough knowledge provided us with sound advice throughout our study. We are most grateful for his valuable input.

The report consists of five different chapters. Chapter One summarizes the findings and recommendations of this Committee with respect to health protection, health promotion and population health. Chapter One also reviews the findings of relevant documents published over the past ten years, especially the Naylor report. In the last section

of Chapter One, the Committee comments on these reports and provides its overview of the steps that need to be taken to reform and renew health protection and promotion in Canada.

Based on the direction for reform described in the Committee's overview at the end of Chapter One, Chapter Two discusses the structural reform which is needed with respect to health protection and promotion and how such reform can be implemented. In particular, it addresses various issues related to the establishment of a new national agency for health protection and promotion.

Chapter Three provides the Committee's view on capacity enhancement for health protection and promotion, with a particular focus on surveillance systems, emergency preparedness and response, human resources, public health laboratories, information technology, communications and research.

In Chapter Four, the Committee repeats the call first contained in its October 2002 report (*Recommendations for Reform*) for the development of a national chronic disease prevention strategy. Chapter Four also addresses the need to establish a nationwide immunization program.

Chapter Five presents the Committee's recommendations on the level of federal funding that is required to initiate the reform and renewal of health protection and promotion in Canada and on the steps that must be taken in this respect in the near future.

Finally, in the concluding section, the Committee stresses the obligations on the federal government to act over the coming twelve months to begin to address the gaps in Canada's health protection and promotion system. The Committee sets out a timetable with precise objectives to be achieved within specified deadlines (3, 4, 6 and 12 months) and affirms its intention to closely monitor progress in this regard.

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Thus, this report reflects the Committee's response to recent health emergencies, and addresses only those issues that the Committee felt had to be examined in order for it to elaborate an action plan for improving Canada's ability to deal with such emergencies. The Committee, of course, recognizes that there are many additional questions that remain to be addressed with regard to health protection and promotion. In its October 2002 report, the Committee indicated its intention to continue to examine health related issues through a series of thematic studies. The Committee interrupted its ongoing study of mental health and mental illness in Canada (which it intends to complete by the spring of 2005) in order to prepare this study on health protection and promotion. Future projects include an examination of population health, which will allow the Committee to complete its study of the broad issues surrounding the protection and promotion of the health of Canadians.

In this report, whenever possible, the Committee deliberately avoids the use of the term “public health”. We find that this term is often confused with “publicly funded health care” (e.g. “public health can be interpreted as the opposite of “private health”). We have, instead, adopted the terminology “health protection and promotion”. We consider health protection and promotion to encompass the following activities: disease surveillance, disease and injury prevention, health protection, health emergency preparedness and response, health promotion, and relevant research undertakings.

**In this report, whenever possible, the Committee deliberately avoids the use of the term “public health”... We have, instead, adopted the terminology “health protection and promotion”.**



## CHAPTER ONE: SETTING THE CONTEXT

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*The National Advisory Committee on SARS and Public Health has found that there was much to learn from the outbreak of SARS in Canada – in large part because too many earlier lessons were ignored.<sup>3</sup>*

### 1.1 The Committee’s Previous Study on Health and Health Care

Throughout its multi-year and multi-faceted study on health and health care (1999-2002), the Committee addressed some of the issues surrounding health protection, health promotion, disease prevention and population health. *The Story So Far* (March 2001) provided detailed information on the health status of Canadians and explained the concepts of “health determinants” and “population health”.<sup>4</sup> *Current Trends and Future Challenges* (January 2002) examined trends in infectious disease, chronic disease, mental illness and injury and stressed the need to strengthen health protection and develop appropriate disease prevention and health promotion strategies.<sup>5</sup> In *Issues and Options* (September 2001), the Committee acknowledged that the federal government has an important role to play in the fields of health protection, disease prevention and health and wellness promotion. We stressed that the objectives of the federal government’s role in these areas should include the following:

- With respect to health protection: to strengthen our national capacity to identify and reduce risk factors which can cause injury, illness and disease, and to reduce the economic burden of disease in Canada;
- With respect to health promotion and disease prevention: to develop, implement and assess programs and policies whose specific objective is to encourage Canadians to live a healthier lifestyle;
- With respect to wellness: to encourage population health strategies by studying and discussing the health outcomes of the full range of determinants of health, encompassing social, environmental, cultural and economic factors.<sup>6</sup>

In *Recommendations for Reform* (October 2002), the Committee highlighted the fact that health protection often functions silently – through monitoring, testing, analyzing, intervening, informing, promoting and preventing – until something happens unexpectedly.

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<sup>3</sup> Naylor report, p. 12.

<sup>4</sup> Chapter Five, “Health Status and the Concept of Population Health”, Volume One, *The Story So Far*, March 2001.

<sup>5</sup> Chapter Four, “Disease Trends”, Volume Two, *Current Trends and Future Challenges*, January 2002.

<sup>6</sup> Chapter Four, “The Role of the Federal Government: Objectives and Constraints”, Volume Four, *Issues and Options*, September 2001.

In such instances, the crisis and profile of health protection quickly reaches major proportions. We also stressed that this often occurs at a considerable cost in human suffering, possibly including death, and financial expense for events which are often preventable.<sup>7</sup> The recent SARS outbreak is illustrative of this fact.

Also in *Recommendations for Reform*, the Committee was concerned with the low, often unstable and inconsistent, funding for health protection interventions. We also raised the issues of health protection system fragmentation; the multiple federal, provincial and territorial statutory responsibilities which result in complex negotiations among the various “players” and less than optimal coordinated activity with respect to health protection and promotion; and the lack of clear accountability and leadership. With respect to health promotion, the Committee was particularly concerned with the low level of government funding relative to its spending on health care.

In response to these concerns, the Committee recommended that the federal government ensure strong leadership in the area of health protection and promotion and provide additional funding to sustain, better coordinate and integrate health protection infrastructure in Canada as well as relevant health promotion efforts. We recommended that an amount of \$200 million in additional federal funding be devoted to this very important undertaking.

In *Recommendations for Reform*, the Committee also noted that chronic diseases are the leading cause of death and disability in Canada, that many chronic diseases are preventable to a very large extent, and that the federal government, in collaboration with the provinces and territories and in consultation with major stakeholders, should give high priority to the implementation of a National Chronic Disease Prevention Strategy. We recommended that the federal government contribute \$125 million annually to this strategy.

***In Volume Six: Recommendations for Reform the Committee recommended that the federal government ensure strong leadership in the area of health protection and promotion and provide additional funding to sustain, better coordinate and integrate health protection infrastructure in Canada as well as relevant health promotion efforts. We recommended that an amount of \$200 million in additional federal funding be devoted to this very important undertaking.***

We are pleased that the National Advisory Committee on SARS and Public Health acknowledges, throughout its report, the contribution of the work done by this Committee. Our knowledge of the issues surrounding health protection and promotion rests on the expertise of numerous individuals and organizations who provided information either as witnesses or through written submissions over the past three years. We were also made aware of health protection and promotion issues through a number of very important documents, which we summarize in the following section. The documents reviewed and testimony before the Committee strongly support the observations and conclusions of the Naylor report.

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<sup>7</sup> Chapter Thirteen, “Healthy Public Policy: Health Beyond Health Care”, Volume Six, *Recommendations for Reform*, October 2002.



## 1.2 Review of Selected Documents

Over the past ten years, and thus long before SARS, there have been numerous calls to strengthen health protection and promotion in Canada and to improve the country's capacity to detect, prevent and manage outbreaks of significant or emerging infectious diseases.

In 1994, the Expert Working Group on Emerging Infectious Disease Issues, a working group convened by Health Canada and made up of some 40 scientists, released the *Lac Tremblant Declaration*. The Declaration noted numerous problems including jurisdictional issues, a lack of coordination, incompatible computerized systems, limited surveillance capacity, shortage of epidemiologists, lack of timely analysis of data, lack of federal leadership, and need for increased federal funding.

The *Lac Tremblant Declaration* called for “a national strategy for surveillance and control of emerging and resurgent infections”, support and enhancement of “the public health infrastructure necessary for surveillance, rapid laboratory diagnosis and timely interventions for emerging and resurgent infections”, coordination and collaboration in “setting a national research agenda for emerging and resurgent infections”, “a national vaccine strategy”, “a centralized electronic laboratory reporting system to monitor human and nonhuman infections”, and strengthening “the capacity and flexibility to investigate outbreaks of potential emerging and resurgent infections in Canada”.<sup>8</sup>

In 1997, the Conference of Deputy Ministers of Health requested that the F/P/T Advisory Committee on Population Health undertake an examination of the health protection and promotion infrastructure in Canada. The Advisory Committee completed its report – *Survey of Public Health Capacity in Canada – Technical Report* – in 2001. This unpublished report outlined strengths and challenges and suggested improvements needed with respect to health protection capacity in Canada. Amongst its findings, we wish to note the following:

- There exist disparities and differences in the health protection capacity across the country.
- There is a lack of leadership and lack of commitment of resources for health protection at higher levels of government.
- Policy directions in the field of health protection are often seen as not “well thought-out”, that is, they are not always based on scientific evidence.
- Sustained prevention strategies are lacking at all levels of government and there is little long term investment in health promotion efforts and population health.
- There is a clear shortfall in human resource planning and development.
- With respect to surveillance, there are weaknesses in data quality, quantity and accessibility; there is a need for integrated data collection systems.
- There is also a lack of skills and knowledge to analyze and use data effectively.

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<sup>8</sup> Expert Working Group on Emerging Infectious Disease Issues, *Lac Tremblant Declaration*, 1994.

- Finally, and perhaps more importantly, “it would be difficult to manage more than one crisis at a time, and substantial crises would seriously compromise other programming”.<sup>9</sup>

In 1999, and again in 2002, the Auditor General of Canada raised critical questions about the F/P/T collaborative framework for infectious disease surveillance and outbreak management<sup>10</sup>:

- National surveillance is weak, and many systems lack timely, accurate and complete disease information. In the view of the Auditor General, this seriously impairs Canada’s ability to anticipate, prevent, identify, respond to, monitor and control diseases.
- There is no legislation that spells out roles and responsibilities of the various levels of government, or the terms of inter-jurisdictional cooperation. The lack of formal terms of cooperation impedes rapid responses to emergency situations.
- In particular, provinces and territories are under no obligation to report most communicable diseases to either the federal government or the other provinces/territories. This is a major impediment to surveillance and puts the health of Canadians at risk.
- Health Canada lacks the financial capacity to maintain its disease surveillance systems and has experienced in recent years an erosion of funding for the surveillance of infectious and chronic diseases. The Auditor General was also concerned about the way that Health Canada evaluated and accounted for its health surveillance activities.

### 1.3 The Naylor Report

In May 2003, following the outbreak of SARS, the federal Minister of Health established the National Advisory Committee on SARS and Public Health. The Advisory Committee, which was chaired by Dr. David Naylor, Dean of Medicine at University of Toronto, released its report in early October 2003. The Advisory Committee has outlined a comprehensive blueprint for urgent change in Canada’s approach to health protection and promotion. The analysis and recommendations in the Naylor report set out a clear plan for the reform and renewal of the country’s capacity to detect, prevent and manage outbreaks of significant or emerging infectious diseases.

The Naylor report builds strongly on the findings and recommendations of previous reports. As the members of the Advisory Committee themselves acknowledge: “A decade later, very similar recommendations are repeated in our report.”<sup>11</sup> A brief summary of key aspects of the report is provided below.

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<sup>9</sup> Advisory Committee on Public Health, *Survey of Public Health Capacity in Canada – Technical Report*, prepared for the Federal/Provincial/Territorial Deputy Ministers of Health, March 2001 (unpublished).

<sup>10</sup> Auditor General of Canada, *Health Canada – National Health Surveillance*, Chapter 2, September 2002 Report; *Management of a Food-Borne Disease Outbreak*, Chapter 15, September 1999 Report; *National Health Surveillance – Diseases and Injuries*, Chapter 14, September 1999 Report.

<sup>11</sup> Naylor report, p. 3.

The Naylor report identifies several systemic deficiencies at the institutional, local, provincial/territorial and federal levels, including multiple and serious inadequacies in the systems for disease control, surveillance and management. These shortcomings are the result of various factors, such as: resource constraints, shortfalls in the supply of skilled personnel, lack of preparedness and planning, failings in organizational structures, lack of integration of health protection with the health care sector, problems of political culture, and poor collaboration and communication across the various institutions, agencies and governments.

According to the Naylor report, many of these deficiencies could be mitigated or corrected by a stronger federal presence in the field through the creation of a national health protection and promotion agency, working at arm's length from government. This new agency, analogous in some respects to the US Centers for Disease Control and prevention, would enhance the federal government's ability to support local work in disease control and prevention. It would bring a professional and scientific focus and remove some difficulties of a political or bureaucratic nature. It would help bring a more collaborative culture among health protection and promotion professionals in different levels of government. Another advantage is that it would provide a clear focal point for Canada to manage health protection and promotion issues at its borders and to interact with its international partners.

**The Naylor report identifies several systemic deficiencies at the institutional, local, provincial/territorial and federal levels, including multiple and serious inadequacies in the systems for disease control, surveillance and management... According to the Naylor report, many of these deficiencies could be mitigated or corrected by a stronger federal presence in the field through the creation of a national health protection and promotion agency, working at arm's length from government.**

Although the Naylor Advisory Committee was not mandated to put forward specific funding recommendations, it did provide very careful "guesstimates" of the level of federal funding needed to renew health protection and promotion. According to the Naylor report, *existing* relevant funding from Health Canada amounting to some \$300 million should be immediately allocated to the new agency. An *additional* amount of \$200 million annually in federal funding is recommended for the new agency for expanded core functions. Another \$500 million in *additional* federal funding is also recommended in the Naylor report, including: earmarked federal funding to strengthen local and regional health protection and promotion capacity (\$300 million); flow through transfers to enhance communicable disease surveillance (\$100 million); and funding for a national immunization strategy (\$100 million).

**According to the Naylor report, *existing* relevant funding from Health Canada amounting to some \$300 million should be immediately allocated to the new agency. An *additional* amount of \$200 million annually in federal funding is recommended for the new agency for expanded core functions. Another \$500 million in *additional* federal funding is also recommended in the Naylor report.**

As the Naylor report clearly points out, some of this additional funding does not need to be new; it could be obtained from programs and initiatives that already exist

(such as some investment from Canada Health Infoway or from Human Resources Development Canada).

The Naylor report notes that F/P/T collaboration in the field of health emergency preparedness and response is more advanced than in health surveillance and outbreak management. This collaboration was triggered by the terrorist attacks in the United States on 11 September 2001. To accelerate collaborative activities in infectious disease surveillance and outbreak management, the Naylor report recommends the creation of a F/P/T Network for Communicable Disease Control. This network would draw together provincial and federal centres of excellence, including the British Columbia Centre for Disease Control, Quebec's National Institute of Public Health and the federal government's National Microbiology Laboratory based in Winnipeg.

The Naylor report also recommends a general inter-governmental review to harmonize F/P/T health emergency legislation. It further recommends that consideration be given to a federal health emergencies act to be activated in lockstep with provincial emergency plans in the event of a national health emergency. In the view of the Naylor Advisory Committee, this would greatly clarify the respective role of the F/P/T governments when a health threat affects multiple provinces. Nonetheless, the Naylor report repeatedly stresses that, although new legislation is necessary in the long run, all immediate reforms can be implemented before any new legislation is enacted, and in particular, the new arm's length agency could be established under current legislation.

#### 1.4 Committee Commentary

The Committee commends the Naylor Advisory Committee for its very thorough review and comprehensive report – probably the first of its kind in Canada. We strongly support the vision that inspires the Naylor report.<sup>12</sup> We consider the Naylor report as a *practical*, long term approach to improving the infrastructure and governance of health protection and promotion in Canada and we strongly support its recommendations. The Naylor report also identifies a number of initiatives that should be undertaken in the short term. This is critical if we are to restore the confidence of Canadians in the ability of their governments to protect their health, not only in the wake of the SARS outbreaks but also such devastating events as the tainted blood scandal and the Walkerton *E. coli* tragedy.

**The Committee commends the Naylor Advisory Committee for its very thorough review and comprehensive report... We consider the Naylor report as a *practical*, long term approach to improving the infrastructure and governance of health protection and promotion in Canada and we strongly support its recommendations.**

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<sup>12</sup> In this report, the Committee focuses on the recommendations of the Naylor Advisory Committee which address more particularly the role of the federal government. We have not reviewed the Naylor report's findings and recommendations related to matters of a provincial/territorial and local nature.

The Committee wholeheartedly agrees with the Naylor Advisory Committee that time is of the essence:

There is no time for complacency. SARS has been subdued, perhaps only temporarily, and the fall season of respiratory illnesses will soon be upon Canada. The work to improve the public health system and prepare the clinical services system must begin apace.<sup>13</sup>

Therefore, the primary focus of this Committee report is to identify the *initial* steps that must be undertaken to facilitate the renewal and reform of health protection and promotion in Canada. As such, the report focuses on the structure needed to enable health protection and promotion to be strengthened in the coming years and on the steps which should be taken over the next *twelve month period* in order to handle serious infectious disease outbreaks which, like national disaster emergencies, are issues of national importance which clearly require federal leadership. In the Committee's view, this includes the following areas: structural reform, capacity enhancement, immunization and chronic disease prevention, and funding.

**The primary focus of this Committee report is to identify the *initial* steps that must be undertaken to facilitate the renewal and reform of health protection and promotion in Canada.**

In terms of structural reform, we urge the creation of a Health Protection and Promotion Agency that is national in scope. We believe, along with numerous witnesses, that a single, credible national body will go a long way towards solving the problem of the current piecemeal approach to health protection and promotion. A single national authority will also enhance preparedness and facilitate response to health emergencies in a measured way, free from bureaucracy and political influence.

**In terms of structural reform, we urge the creation of a Health Protection and Promotion Agency that is national in scope... As a first step, we recommend that all the functions and activities currently in the Population and Public Health Branch at Health Canada be put into a new agency.**

As a first step, we recommend that all the functions and activities currently in the Population and Public Health Branch at Health Canada be put into a new agency, which can be created by Order-in-Council and which would initially be governed by a Transitional Health Protection and Promotion Board whose role would be to provide advice on legislation, mandate and governance of the new entity. The work of the Transitional Health Protection and Promotion Board should be done as expeditiously as possible.

The Committee also concurs with the Canadian Medical Association and the Naylor Advisory Committee that the structural reform envisioned must include a "Health Alert System"

**The structural reform envisioned must include a "Health Alert System" which would clarify the roles and responsibilities of each level of government and allow for a rapid, graduated and systematic approach to health emergencies.**

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<sup>13</sup> Naylor report, p. 21.

which would clarify the roles and responsibilities of each level of government and allow for a rapid, graduated and systematic approach to health emergencies. Once it has been established, the Health Protection and Promotion Agency could be asked, as a priority, to develop a Memorandum of Understanding with the provincial/territorial governments on the implementation of this health alert system.

Capacity enhancement is a broad term which encompasses a number of areas: surveillance systems, emergency preparedness and response, human resources, public health laboratories, information technology, communications and research. The Committee believes that a nationwide surveillance system must be a fundamental component of the health protection and promotion infrastructure. A strong national disease surveillance system will ensure real time notification of the occurrence of reportable diseases throughout the country. The Committee believes that the federal government must *immediately* provide additional investment to enhance and sustain disease surveillance in Canada.

**The Committee believes that a nationwide surveillance system must be a fundamental component of the health protection and promotion infrastructure... The Committee believes that the federal government must *immediately* provide additional investment to enhance and sustain disease surveillance in Canada.**

A critical element of an effective health protection and promotion infrastructure is its human resource base. Currently, Canada's health protection workforce is extremely thin. The Committee concurs with numerous witnesses that, in order to ensure self-sufficiency of the health protection workforce in the long term, a Virtual School of Public Health should be created, building on the strengths of current departments in some universities and colleges. Further, a plan for the rapid deployment of human resources during health emergencies should be developed; this requires that a fully trained "reserve" of health professionals (surge capacity) – also referred to as Health Emergency Response Teams (HERTs) – be maintained.

An effective health protection and promotion infrastructure also requires a strong capacity to communicate authoritative, evidence-based, information in a timely manner. The Committee concurs with numerous witnesses on the need to improve the current communication infrastructure to ensure timely exchange of information at all levels of the health protection and promotion infrastructure.

In addition, the Committee agrees with the Naylor report that the new agency should earmark funding to increase national capacity for research in the field of health protection and promotion. We strongly believe that federal, provincial and territorial governments must recognize that research is a core function of health protection and promotion and finance it adequately.

Once again in this report, the Committee repeats its call for a nationwide chronic disease prevention strategy and gives its support to the development of a national immunization program. We

**Once again in this report, the Committee repeats its call for a nationwide chronic disease prevention strategy and gives its support to the development of a national immunization program.**

recommend that these two initiatives be the responsibility of the Health Protection and Promotion Agency.

Finally, as was done in our previous reports, the Committee firmly believes that we must discuss how reform should be financed. We agree with the Naylor report that the set of changes needed can *only* be achieved with *both* existing and additional federal funding. We also strongly support the view of the Naylor Advisory Committee and numerous witnesses that federal funding transferred to other levels of government and institutions must be targeted and that those who receive these transfers – be they other governments, organizations or individuals – be accountable for their use of federal funds.

Our observations, conclusions and recommendations with respect to structural reform, capacity enhancement, immunization and chronic disease prevention, and funding are the subject of the four following chapters.

Finally, the Committee strongly believes that now it is *time to act*. We agree with Dr. Sunil Patel, President of the Canadian Medical Association, who eloquently stated:

**The Committee strongly believes that now it is *time to act*.**

We need leadership now more than ever. We cannot risk waiting for the next SARS.<sup>14</sup>

There is broad consensus, and often unanimity, among scientists, health professionals, non-government organizations and the Canadian public, on the changes that are needed to reform the infrastructure and governance of health protection and promotion. We must build on this momentum.

The Committee wishes to stress that failure to act promptly could severely erode public confidence in health protection infrastructure in Canada. Therefore, federal government inaction in this area would be totally unacceptable. The fact is that the federal government *must* live up to its obligations, both national and international. This is why, in the following chapters, we lay out a critical path for action, along with benchmarks against which progress can be measured.

**Federal government inaction in this area would be totally unacceptable. The fact is that the federal government *must* live up to its obligations, both national and international.**

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<sup>14</sup> Canadian Medical Association, “CMA Calls on All Governments to Step Up in the Wake of SARS Report”, *News Release*, 9 October 2003 (available on the Internet at [www.cma.ca](http://www.cma.ca)).





## CHAPTER TWO:

### CREATING A HEALTH PROTECTION AND PROMOTION AGENCY

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*The [new agency] will provide expertise, facilitation and coordination of an integrated pan-Canadian public health system. The Agency should be at arms' length from government, and report to Parliament through the Minister of Health. The Agency should be built on existing centres of expertise across the country, including regional centres, and should have spending authority to leverage action in municipalities, provinces and non-governmental organizations.<sup>15</sup>*

In this chapter we examine the question of the nature of the structural reforms that are needed in order to improve Canada's ability to deal with health emergencies across the country and to lay the institutional groundwork for better protecting and promoting the health of Canadians. We begin by looking at the rationale for creating a new national agency that would operate at arm's length from government. We then evaluate the potential models for such an agency, and indicate that we agree with the model proposed in the Naylor Report. This chapter concludes by outlining the mandate that the Committee proposes for the new agency and the immediate steps that need to be taken in order to make it a reality.

#### 2.1 The Advantage of Having a National Arm's Length Agency

Numerous witnesses explained to the Committee the important advantages that could be realized by the establishment of a new health protection and promotion agency that would be able to operate with a greater measure of autonomy than is now feasible for the Population and Public Health Branch of Health Canada. The Committee stresses that it does not interpret these remarks by witnesses, or the Committee's commentary on them, as implying any overt criticism of the dedicated and professional staff that work on public health issues within Health Canada. Rather, we need to view the lessons that have been learned in the wake of the SARS outbreaks as pointing to systemic weaknesses in the structures that are currently charged with dealing with the protection of the health of Canadians.

Witnesses also indicated repeatedly that Canada is not starting from scratch in thinking about how to improve health protection and promotion infrastructure. The Committee heard that while it would be an exaggeration to say that the country possesses a coordinated health protection system, there are nonetheless considerable resources available at the federal, provincial/territorial and local levels. It is thus the lack of adequate coordination and the absence of a sharp focus in the face of an emergency that is the problem, and it is clear that greater collaboration must be part of the solution.

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<sup>15</sup> Canadian Public Health Association, Brief to the Committee, p. 8.

It is in the Population and Public Health Branch (PPHB) of Health Canada that the most significant of these resources are housed. At the present time, the components of the PPHB include the Centre for Infectious Disease Prevention and Control, Chronic Disease Prevention and Control, Emergency Preparedness and Response, Surveillance Coordination, and Healthy Human Development. PPHB also has oversight of the National Microbiology Laboratory in Winnipeg and the Laboratory for Foodborne Zoonoses in Guelph.

Although PPHB represents the major concentration of federal involvement in health protection and promotion, other branches of Health Canada as well as other departments and agencies are also involved in various ways. Examples include the Health Products and Food Branch and the Healthy Environments and Consumer Safety Branch within Health Canada, and the Canadian Food Inspection Agency and the Office of Critical Infrastructure Protection and Emergency Preparedness, both of which report to federal ministries other than Health Canada.

Across the country the capacity and resources available for health protection and promotion activities vary greatly, as does the organization of these services. Many witnesses cited Quebec's National Institute for Public Health and the British Columbia Centre for Disease Control as excellent provincial examples of a coordinated and integrated approach to health protection and promotion.

As noted briefly in the previous chapter, however, there are significant defects in the overall approach to health protection and promotion in Canada, many of which were underlined by the SARS crisis. While there can be no doubting the courage, skill and dedication of frontline health providers, they were regularly confronted with having to improvise in situations where procedures, protocols and resources should have been in place beforehand.

The Naylor report identifies numerous serious systemic deficiencies in the response to SARS, including:<sup>16</sup>

- lack of surge capacity in the clinical and public health systems;
- difficulties with timely access to laboratory testing and results;
- absence of protocols for data or information sharing among levels of government;
- inadequate capacity for epidemiologic investigation of the outbreak;
- lack of coordinated business processes across institutions and jurisdictions for outbreak management and emergency response;
- weak links between public health and the personal health services system, including primary care, institutions, and home care.

A Consultation Report conducted by the Coalition for Public Health in the 21st Century that was presented to the Committee also identified inadequate funding, human resource shortages and lack of coordination between the various levels of government as key

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<sup>16</sup> Naylor report, p. 1.

barriers to the development of adequate health protection and promotion policies and services in Canada.<sup>17</sup>

How, then, would the existence of a national agency that operated at arm's length from government have made a difference?

Witnesses raised many points in addressing this question. However, witnesses were unanimous in their insistence on the need for a new agency. Their reasons can be grouped under seven headings. They argued that an arm's length, national health protection and promotion agency would:

1. *Concentrate and focus federal resources.* A new agency would enhance the federal government's ability to support local work in disease control and prevention and provide a clear focal point for Canada to manage health issues at its borders and to interact with the global community.
2. *Enhance collaboration amongst the various levels of government and providers.* A new agency would allow for a clearer definition of the different levels of responsibility amongst the various levels of government. It would also promote greater collaboration among federal and provincial health protection and promotion professionals because the federal representatives would not be part of the Health Canada bureaucracy, and they could therefore have greater flexibility in the ways in which they interacted with their provincial counterparts.
3. *Promote the integration of health protection and promotion activities.* A new agency would bring resources to the table, by placing agency personnel into organizations at the provincial or regional level, and by utilizing the new agency's financial resources to help fund the integration of activity amongst the various levels of government. This would allow it to leverage investments by other levels of government in such a way as to create greater uniformity and consistency in health protection and promotion interventions.
4. *Allow greater timeliness and flexibility in responding to emergencies.* A new agency would be designed to have the ability to act rapidly and efficiently in a way that is more difficult to achieve from inside a ministry. Decision-making would be much quicker and not as dependent on the cumbersome procedures of a major government department. The Committee was told by Mr. Ron Zapp, the Executive Director of the B.C. Centre for Disease Control, that this had been their experience with an

**National health protection and promotion agency would:**

- *Concentrate and focus federal resources*
- *Enhance collaboration amongst the various levels of government and providers*
- *Promote the integration of health protection and promotion activities*
- *Allow greater timeliness and flexibility in responding to emergencies*
- *Improve and focus communication*
- *Enable a longer-term planning horizon*
- *Better attract and retain health professionals*

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<sup>17</sup> "A Consultation Report on Current Public Health Issues", presented to the Committee on October 16, 2003 by the Coalition for Public Health in the 21st Century, p. 5.

independent agency. As he said: “I like to think of it as the ability to act, fleet of foot... in a ministry you are a lot more cautious about actions taken.”<sup>18</sup>

5. *Improve and focus communication.* The concentration of resources in the new agency would allow for an accumulation of experience in communicating both with health protection officials and with the public at large. This would foster consistent messaging. As was evident during the SARS crisis, it is vitally important to have professional, coordinated, communication in order to retain credibility with the public, and with international partners. Equally important, improved intelligence systems inside Canada would allow information to come to the agency and then be communicated quickly to the front lines.
6. *Enable a longer-term planning horizon.* A new agency should be designed so as not to be bound to the annual planning cycle of the government, but could plan for longer term risks such as chronic diseases over a period of 15 or 20 years.
7. *Better attract and retain health professionals.* A new agency would be much more competitive in striving to attract the type of scientists that are needed to have a truly world class health protection and promotion system. Moreover, it would provide a working environment that would result in a more meaningful career path for professionals and scientists in this field than exists today.

In subsequent chapters, we will examine the measures that a new agency could take in order to realize the gains described in the above seven headings. However, it is useful to try to imagine how such an agency might have influenced the actual course of recent events had it been in place prior to the SARS crisis. In his testimony to the Committee, Dr. Naylor gave an account of how things might have transpired if there had been an outbreak of SARS or some other infectious agent in a small province such as PEI, and a national agency had been in place. It is worth summarizing Dr. Naylor’s account in detail:

First, in this imaginary and positive alternative universe, the agency would continually monitor national and international incidents, and establish and participate in comprehensive surveillance systems that would provide the ability to detect potential risk. When the next SARS begins to emerge, alerts would be sent out widely. The first time that the infectious agent turns up in Berlin or Singapore or anywhere, a series of alerts would be issued worldwide saying that virus X or bacterium B is on the move. Those alerts would then rapidly and actively be transmitted through the Canadian public health and health care systems. Medical officers of health and health care leaders would both have immediate alerts from the new agency and from the desk of the public health officer of Canada saying that there is a problem.

If it were a known agent, a well-understood and agreed protocol as to what should be done would then be followed. There would also be a common set of business processes on how to respond. Therefore, instead of making it up as they went along, frontline responders would be guided by a national consensus

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<sup>18</sup> *Committee Proceedings*, 25 September 2003.

on best practices. If it were a new agent, as soon as the Government of Prince Edward Island called for help, the national agency would provide support on the ground based on already-existing protocols for collaboration.

Improved response thus involves a combination of factors. All jurisdictions in Canada could count on better technical support from the federal government. Agreed processes and plans, as well as reciprocal, collaborative, agreements with other jurisdictions, would mean that everything would be in place. It would not be a situation in which the people involved would simply be writing in a blank book. Gaps would still have to be filled in and many things would have to be understood and investigated, but the protocols and processes that were needed in Prince Edward Island would already be in place to fight the outbreak.

How costs for dealing with such a situation were shared would depend on the nature of the outbreak. It is clear that it would be up to the jurisdiction that was affected by an emergency to call in the emergency response team. Depending upon the nature of the threat, this intervention would be funded by the jurisdiction that called in the response team, or it would be co-funded.<sup>19</sup>

The Committee was also impressed by the fact that the model of a separate agency devoted to health protection and promotion is gaining currency internationally. Of course, the arm's length agency that remains in many regards exemplary is the U.S. Centres for Disease Control and Prevention headquartered in Atlanta.

**The Committee was also impressed by the fact that the model of a separate agency devoted to health protection and promotion is gaining currency internationally.**

In Britain, the Health Protection Agency was created in April 2003. It brings together into a single organization all the specialist personnel dealing with the various aspects of communicable disease prevention and control at the local, regional and national levels for England and Wales. It was initially established as a special health authority but will eventually become a non-departmental public body.

At the European level, a plan to create a European Centre for Disease Control was endorsed by the European Commission in July 2003, and now awaits passage by the European Parliament. The new centre would take over the existing communicable disease network and early warning and response system, while leaving responsibility for action with European member states. The new arrangement is designed to coordinate more effectively the responses of the 15 different health protection and promotion systems and to provide a structured and systematic approach to the control of communicable diseases.

The Committee wishes to emphasize strongly the fact that it did not hear a single dissenting voice from witnesses concerning the potential for an arm's length agency to improve Canada's ability to anticipate and cope with health emergencies, as well as to make a

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<sup>19</sup> See *Committee Proceedings*, 9 October 2003.

positive contribution to the health status of Canadians. The Committee heard from individuals and organizations representing the entire health protection and promotion community.

In summary, the Committee is firmly convinced, along with all the witnesses it heard, that a new agency operating at arm's length would contribute to enabling quicker, more efficient and nimbler responses in the face of health emergencies. It would also improve the chances for greater cooperation amongst all levels of government, thereby furthering the capacity to protect and promote of the health of all Canadians.

**In summary, the Committee is firmly convinced, along with all the witnesses it heard, that a new agency operating at arm's length would contribute to enabling quicker, more efficient and nimbler responses in the face of health emergencies. It would also improve the chances for greater cooperation amongst all levels of government, thereby furthering the capacity to protect and promote of the health of all Canadians.**

Although there was agreement in principle on the advantages of a new arm's length agency, various models have been proposed, and it is to selecting the best option that we now turn.

## 2.2 What Model for the New Agency?

A key question in choosing a model for the new agency concerns how to achieve the proper balance between having an agency that operates at arm's length from government and yet is still able to ensure an integration of health protection and promotion activities with the services provided in other parts of the health care system. Numerous witnesses stressed the fact that at the same time that it highlighted the need for an arm's length agency, the SARS outbreak also revealed the extent to which the two sectors, health protection and acute care, must work together in dealing with health emergencies. The SARS outbreak also emphasized the need for close collaboration with the veterinary sector given that infectious agents can be harboured by both humans and animals.

**A key question in choosing a model for the new agency concerns how to achieve the proper balance between having an agency that operates at arm's length from government and yet is still able to ensure an integration of health protection and promotion activities with the services provided in other parts of the health care system.**

Moreover, witnesses insisted that, on an ongoing basis, it is important to envisage the integration of health protection concerns with the delivery of services by the broader health care system. For example, Dr. Richard Massé, the Director of Quebec's National Institute for Public Health, described to the Committee the way that Quebec has attempted to integrate health protection and promotion within the network of community clinics (CLSCs) that already exist in the province. Dr. Massé also insisted on the need to build capacity throughout the health care system in order to be fully prepared for health emergencies.<sup>20</sup>

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<sup>20</sup> *Committee Proceedings*, September 25, 2003.

Another critical issue in thinking about the design for a new agency is the absolute need for close collaboration between the new agency, other levels of government and health professionals inside and outside of government. This interaction also includes people, agencies and government departments whose main focus is other than health. In this respect, it is clear that the health of Canadians cannot be protected by the health system working in isolation. The actions or inactions of many other sectors greatly influence our health. For example, we cannot be protected from communicable diseases if our water is unsafe, nor can we be protected from respiratory illnesses if our air is polluted, any more than from illnesses harboured in animals which can spread to humans.

Both the Naylor Committee and the Canadian Medical Association (CMA) reviewed the various options available for structuring the new agency. In its brief to the Committee, the CMA provided a useful summary of the three main choices:<sup>21</sup>

1. *Federal departmental entity*: Under this option, federal legislation would create the new agency as a departmental branch or agency, with the minister of health having general authority for its management and direction. The head of the agency would be answerable to the minister for the quality of management and advice provided by the office and for any actions taken by agency officials. The main difference from what exists currently is that the agency would be a separate entity reporting to the minister of health, as opposed to the current structure where the Population and Public Health Branch is an entity within the department. Canadian examples of this type of arrangement include the Canadian Food Inspection Agency (CFIA), while the U.S. Centres for Disease Control and Prevention constitutes an international example. This model also allows for combination of capacities of several departments into one agency as happened with CFIA.
2. *National arm's length agency*: This option consists of incorporating the agency as a not-for-profit entity with the federal and provincial governments as members/shareholders. The agency would be structured on a corporate model with a board, and the Chief Health Protection and Promotion Officer of Canada acting as CEO. However, instead of direct accountability to Parliament, the office would be accountable to the Conference of F/P/T Ministers of Health. This option would signal a more radical departure from current arrangements and would make the agency more of a joint venture with the provinces and territories. This is the model that has been employed in establishing Canadian Blood Services, the Canadian Institute for Health Information, and Canada Health Infoway.
3. *Federal arm's length agency*: A third option would consist of creating a more independent entity within the purview of the federal government. Under this approach, the agency would be structured on a corporate model in which decision-making powers are vested in a board. The board, in turn, would be accountable to Parliament and the public for the exercise of these powers. The Chief Health

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<sup>21</sup> Canadian Medical Association, *CMA Submission on Infrastructure and Governance of the Public Health System in Canada*, Brief to the Committee, 8 October 2003, p. 8.

Protection and Promotion Officer of Canada would be the CEO and would oversee the day-to-day operation of the office. The agency would be created through new federal legislation but would remain under the health portfolio, with accountability to Parliament through the federal health minister. Canadian examples of this type of structure include the Canadian Centre for Substance Abuse<sup>22</sup>. Internationally, the UK has adopted this model for its Health Protection Agency.

In deciding from amongst these various models, a final consideration that is very important to the Committee is the speed with which the new agency could be created. The Committee is convinced that the current alignment of forces favours the rapid creation of a new agency, and that it is essential to take advantage of these propitious conditions and to act *now*.

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From this point of view, if the creation of a new agency depended on reaching agreement amongst multiple levels of government, there is good reason to think that it would be impossible to expedite its birth. One has only to look at the tortuous gestation period currently afflicting the creation of a new national Health Council by the federal, provincial and territorial governments to realize how difficult this kind of process can be. In the Committee's view, this consideration all but rules out the second of the three options above.

**The Committee agrees with the Naylor report that a separate, arm's length agency reporting to the federal Minister of Health is the best option. In particular, it should allow the quickest path to the creation of the agency and also enable an easy integration into the agency of the activities currently carried out by the Population and Public Health Branch of Health Canada.**

The Committee also recognizes that there is not that much difference between the first and third models. The main difference is that the third model involves a structure that more closely resembles an independent corporation that reports to Parliament rather than to a specific Minister. The Naylor Committee recommended adopting the first option while the CMA has favoured the third. The Committee agrees with the Naylor report that a separate, arm's length agency

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<sup>22</sup> The CMA and the Naylor Report had slightly diverging views on which category best described the Canadian Institutes of Health Research (CIHR). The CMA placed the CIHR in its third category, while Naylor placed it in the first category. This dispute does not affect the Committee's assessment of which structure is most appropriate for the new health protection and promotion agency. However, it is worth noting that there is a fundamental difference between the CIHR and the Canadian Centre on Substance Abuse (CCSA), which is clearly in the third category. The CIHR is legally "an agent of Her Majesty" while the CCSA "has the capacity of a natural person" and it is explicitly declared in its constituting legislation that "the Centre is not an agent of Her Majesty".



reporting to the federal Minister of Health is the best option. In particular, it should allow the quickest path to the creation of the agency and also enable an easy integration into the agency of the activities currently carried out by the Population and Public Health Branch of Health Canada.

The Committee heard testimony that the Canadian Food Inspection Agency (CFIA), which typifies the proposed model, has put in place a well-developed system for coordination between the federal and provincial/territorial levels. One example brought to the attention of the Committee was the Canadian Food Inspection System Implementation Group that involves participants from the federal level and representatives from health and from agriculture from each province. As well, the CFIA has established explicit federal-provincial/territorial agreements and protocols that clearly set out which level of government has what responsibilities in dealing with food borne illnesses.

Witnesses indicated that Canada has a system of food inspection that is considered by world standards to be very good, with a very clear line of responsibility and accountability for the control of animal diseases in Canada.<sup>23</sup> Moreover, the CFIA maintains a close working relationship with the veterinary profession and is very active in communicating with the industry. Communication efforts include addressing professional meetings, publishing articles in professional journals, as well as ongoing contact with veterinary herd health advisors who inspect animals on the farm and maintain a professional relationship with individual farmers.

Thus, the Committee believes that this model offers sufficient flexibility to allow for the development of a cooperative working relationship between the new agency, other levels of government and the various professions involved in health protection.

The Committee proposes that the new agency be called the Health Protection and Promotion Agency (HPPA), and that it be headed by the Chief Health Protection and Promotion Officer of Canada (CHPPO). We will look in greater detail at how the new agency can fulfill its mandate in the following chapters, but it is important first to specify a number of organizational details.

**The Committee proposes that the new agency be called the Health Protection and Promotion Agency (HPPA), and that it be headed by the Chief Health Protection and Promotion Officer of Canada (CHPPO).**

The Committee recommends that the CHPPO be appointed by the Minister of Health and that the CHPPO be a health professional. The Minister would also appoint a Health Protection and Promotion Board that would receive regular reports from the CHPPO. The Health Protection and Promotion Board would be made up of highly regarded individuals with expertise in the field of health protection and promotion. It would deliver an annual report to Parliament through the Minister. The Health Protection and Promotion Board would not be chaired by the CHPPO, but by a member of the council who is independent of government.

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<sup>23</sup> *Committee Proceedings*, September 18, 2003.

Day-to-day functioning of the agency would be the responsibility of the CHPPO, who would also appoint a Chief Operating Officer (COO). The COO should be a highly qualified manager with experience in the health field.

Furthermore, in order to ensure sustained input from the provinces and territories, the Committee recommends the creation of an Advisory Council for the HPPA, consisting of the chief medical officers (or their equivalent)<sup>24</sup> from each province and territory. The Committee notes that a Council of Chief Public Health Officers already exists, and that this existing council could be adapted to fulfill an advisory role to the HPPA. In addition to ensuring a strong liaison with the provinces and territories, this advisory council would provide the CHPPO with regular scientific advice.

**In order to ensure sustained input from the provinces and territories, the Committee recommends the creation of an Advisory Council for the HPPA, consisting of the chief medical officers (or their equivalent) from each province and territory.**

As well, given the urgency of developing an overall strategy for human resource development, including the recruitment, training and retention of skilled professionals in the field of health protection and promotion, the Advisory Council could work closely with the CHPPO in developing a national human resources plan. Since many human resource issues fall under provincial jurisdiction, this would ensure input from the provinces and territories. Furthermore, it would allow serious consideration to be given to the most appropriate way forward to create a virtual school of health protection and promotion in Canada, for example by using networks of universities and community colleges from different regions of the country.

### **2.3 The mandate of the HPPA and the timetable for its creation**

The final issue that needs to be addressed is the scope of the mandate for the new agency. As already noted, the Committee heard compelling testimony with regard to the need for a comprehensive and integrated approach to health protection and promotion. At the same time, the Committee believes very strongly that it is essential to act quickly.

This means that the Committee favours a strategy that would allow immediate steps to be taken to create the arm's length agency that everyone agrees is required, even if this means that the agency will only subsequently grow to its full potential. The Committee is convinced that this can be done in such a way so as not to compromise the eventual expansion of the agency's mandate to encompass all the elements that are required to protect and promote the health of Canadians. In this regard, the Committee was

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<sup>24</sup> After careful reflection, the Committee recommends that this advisory council should be composed of provincial medical officers of health, who could draw on additional outside expertise as they saw fit. The Committee's believes that any attempt to create a new F/P/T mechanism for naming this advisory council, as would have to be done if it was composed of people other than the existing medical officers of health, would raise the spectre of interminable squabbling and prolonged delays.

told that the B.C. Centre for Disease Control has in fact been built up gradually in a similar fashion over the years.

As indicated in Chapter One, the Committee recommends that a Transitional Health Protection and Promotion Board for the Health Protection and Promotion Agency be struck as quickly as possible, but not later than three months from now. In the Committee's view, both the HPPA itself and the Transitional Health Protection and Promotion Board should be created through Order in Council if necessary. The Transitional Health Protection and Promotion Board would be charged with setting up the HPPA. It would be authorized to work with Health Canada in order to transfer all existing resources and staff from the current Population and Public Health Branch of Health Canada. These would serve as the initial core of the HPPA. The Transitional Health Protection and Promotion Board would begin the search for appropriate candidates to head the HPPA and would make a recommendation to the federal Minister of Health in this regard. The head of the Transitional Health Protection and Promotion Board would not be eligible to become the CHPPO, thus assuring impartiality and that no vested interests taint the design of the HPPA.

**The Committee recommends that a Transitional Health Protection and Promotion Board for the Health Protection and Promotion Agency be struck as quickly as possible, but not later than three months from now. In the Committee's view, both the HPPA itself and the Transitional Health Protection and Promotion Board should be created through Order in Council if necessary.**

The Committee believes that any foot dragging in establishing this Transitional Health Protection and Promotion Board, and enabling it to begin work on the creation of the HPPA, on the part of the Government would be unacceptable. In fact, *the Committee feels strongly that the Agency should be created, by Order-in-Council if necessary, before the end of the current fiscal year, that is before March 31, 2004.*

**The Committee feels strongly that the Agency should be created, by Order-in-Council if necessary, before the end of the current fiscal year, that is before March 31, 2004.**

The mandate of the HPPA would include the following:

- (a) Work with provincial and territorial authorities to articulate a coherent long-term vision for health protection and promotion in Canada, and develop a plan to realize this vision;
- (b) Partner with already existing provincial bodies (such as the B.C. Centre for Disease Control and the Quebec National Institute of Public Health) and help stimulate the development of similar comprehensive initiatives in regions of the country where they do not yet exist;
- (c) Ensure that Canada meets all its international health protection obligations;
- (d) Enhance disease surveillance and control in Canada;
- (e) Direct federal efforts to be prepared for any health emergency and work closely with P/T authorities to ensure that there is adequate capacity in all regions of the country;
- (f) Direct federal activity designed to improve all aspects of health protection and promotion infrastructure across the country;

- (g) Actively promote the health of Canadians, and, in particular, design and implement a National Chronic Disease Prevention Strategy as well as a national Immunization Program.

The Committee believes that, from the outset, the HPPA should comprise at least the following areas of responsibility: disease surveillance and control; emergency preparedness; immunization; and chronic disease prevention. Funding should be provided both for the core functioning of the agency itself, and also to enable it to channel clearly targeted funds to other levels of government, institutions, agencies and individuals (enabling, for example, the placement of epidemiologists in all necessary locations and jurisdictions across Canada or the funding of targeted research projects).

Therefore, the Committee recommends that:

**A new agency, to be called the Health Protection and Promotion Agency (HPPA), be created, and that it be headed by the Chief Health Protection and Promotion Officer of Canada (CHPPO). The HPPA would be a legislated service agency that reports to the federal Minister of Health.**

**The CHPPO be appointed by the federal Minister of Health and be a health professional.**

**The Minister also appoint a Health Protection and Promotion Board that would receive regular reports from the CHPPO and function as the Board of the HPPA. The Health Protection and Promotion Board should be chaired by someone other than the CHPPO.**

**In order to ensure sustained input from the provinces and territories, and to provide the HPPA with the best possible scientific advice, that an Advisory Council be created composed of the Chief Medical Officers from the provinces and territories. The advisory council should also contribute to working out a comprehensive human resource strategy by the HPPA.**

**The mandate of the HPPA should include the following:**

- (a) Work with provincial and territorial authorities to articulate a coherent long-term vision for health protection and promotion in Canada, and develop a plan to realize this vision;**
- (b) Partner with already existing provincial bodies (such as the B.C. Centre for Disease Control and the Quebec National Institute of Public Health) and help stimulate the development of similar comprehensive initiatives in regions of the country where they do not yet exist;**
- (c) Ensure that Canada meets all its international health protection obligations;**

- (d) Enhance disease surveillance and control in Canada;
- (e) Direct federal efforts to be prepared for any health emergency and work closely with P/T authorities to ensure that there is adequate capacity in all regions of the country;
- (f) Direct federal activity designed to improve all aspects of health protection and promotion infrastructure across the country;
- (g) Actively promote the health of Canadians, and, in particular, design and implement a National Chronic Disease Prevention Strategy as well as a National Immunization Program.

A Transitional Health Protection and Promotion Board for the Health Protection and Promotion Agency be struck as quickly as possible, through Order in Council if necessary. The Transitional Health Protection and Promotion Board would be charged with setting up the HPPA. The HHPA should come into being before the end of the current fiscal year (March 31, 2004). It would be authorized to work with Health Canada in order to transfer resources and staff from the current Population and Public Health Branch of Health Canada that would serve as the initial core of the HPPA. The Transitional Health Protection and Promotion Board would begin the search for appropriate candidates to head the HPPA and would make a recommendation to the Minister in this regard.



**CHAPTER THREE:**

**BUILDING DISEASE SURVEILLANCE AND EMERGENCY  
RESPONSE CAPACITY**

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*The public health system no longer has the capacity to conduct timely analyses; to accurately inform and support policy-makers, health stakeholders and the public; in addition to implementing appropriate services and community surveillance strategies.<sup>25</sup>*

There are many factors that contribute to Canada's ability to respond to a health emergency, especially one involving an infectious disease outbreak. Information about the outbreak must be gathered quickly, analyzed accurately and swiftly, and the results communicated clearly both to those involved in dealing with the outbreak and to those affected by it. Some of this work is an ongoing activity, and requires that people and resources be continually deployed. However, when an outbreak occurs, there may also be the need to mobilize additional resources and personnel to cope with an emergency situation. In other words, human resource planning in order to create a reserve or surge capacity is required.

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Some of this additional capacity involves resources that can be kept in storage and then drawn upon as needed. This is the case, for example, of the National Emergency Stockpile System that is currently managed by the Centre for Emergency Preparedness and Response that was created by the federal government in July 2000. It includes 165 emergency 200-bed hospitals that can be transported wherever needed on short notice. But, in many ways, as several witnesses told the Committee, surge capacity is needed in other areas, for example epidemiology. Moreover, surge capacity in a crisis is only as good as the ongoing day-to-day infrastructure.

If there are not sufficient trained personnel involved in health protection activities on a daily basis somewhere in the country, then there will not be people who can be called upon in an emergency. If there is insufficient laboratory capacity to handle routine cases, there will not be the ability to respond to a major increase in the volume of testing that must be done in the event of an emergency. If there is no regular communication between people in different regions of the country, then they are unlikely to be able to handle the intense exchanges that characterize an emergency situation. If information systems are antiquated, then they will probably not be able to cope with the speed with which outbreaks of infectious disease occur in a globalized world. If there are no procedures

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<sup>25</sup> Canadian Nurses Association, *Public Health in Canada – Strengthening the Foundation*, Brief to the Committee, 8 October 2003, p. 3.

and protocols in place to deal with ‘normal’ situations, they will not miraculously appear when the country is faced with an emergency.

Not only must this diversified capacity be in place for Canada to be able to deal with health emergencies, but it must all be coordinated so that the response is a coherent and effective one. This makes building up Canada’s capacity to be prepared for emergencies a very complex undertaking. Health emergencies always begin locally, even if they can rapidly escalate and involve multiple jurisdictions. This means that this coordination must involve all levels of government. Yet, recent history speaks eloquently to the difficulty of fostering federal/provincial/territorial cooperation in the health care field.

**Not only must this diversified capacity be in place for Canada to be able to deal with health emergencies, but it must all be coordinated so that the response is a coherent and effective one.**

Still, it is only when all the pieces are in place that it will be possible to say with confidence that Canada is as prepared as it should be to deal with whatever health emergency may arise. The need to ensure that all regions of the country possess the capacity to do their share of this inter-connected job is one of the reasons that it is imperative to establish the Health Protection and Promotion Agency that was recommended in the preceding chapter.

**The need to ensure that all regions of the country possess the capacity to do their share of this inter-connected job is one of the reasons that it is imperative to establish the Health Protection and Promotion Agency.**

In addition, the recent SARS outbreaks revealed the extent to which the weakness of Canada’s disease surveillance infrastructure, the lack of coordination of surveillance activities and the absence of sufficient surge capacity, are matters of considerable urgency. In the final analysis, the entire disease surveillance and control system is only as strong as its weakest link.

The Committee agrees with the Naylor report that it would be *imprudent* to put off beginning to deal with these insufficiencies until the new agency is fully established. It is therefore necessary to proceed along parallel tracks. At the same time that the new Health Protection and Promotion Agency is being set up, measures must also be taken to build up disease surveillance and emergency response capacity. As the new agency comes online, it will be possible for it to contribute to the maximization of these efforts.

In this chapter, we look both at the immediate measures that should be taken by the federal government to fulfill its responsibilities in this regard, and at how this federal effort could best contribute to the enhancement of disease surveillance and emergency response capacities across the country.

### **3.1 Disease Surveillance and Control**

Echoing widely accepted definitions, the Naylor report defines health surveillance as “the tracking and forecasting of any health event or health determinant



through the continuous collection of high-quality data, the integration, analysis and interpretation of those data into surveillance products (for example reports, advisories, alerts, and warnings), and the dissemination of those surveillance products to those who need to know.”<sup>26</sup>

In a review of Health Canada’s surveillance activities conducted in 2002 as a follow-up to a 1999 report, the Auditor General of Canada concluded that:

...national surveillance is still weak; many systems still lack timely, accurate, and complete disease information; and gaps in surveillance continue. These weaknesses, taken together, compromise Health Canada’s ability to anticipate, prevent, identify, respond to, monitor, and control diseases and injuries. Further, they compromise its ability to design, deliver, and evaluate public health activities.<sup>27</sup>

Although the Auditor General noted that Health Canada had made some progress in correcting deficiencies that had been identified in the 1999 report, the 2002 review made it clear that “an established approach to national health surveillance is still many years away.”<sup>28</sup>

Both the Auditor General and the Naylor report insist that there is a strong role for the federal government in providing national leadership in order to ensure that there is proper coordination across the different jurisdictions and that there is sufficient capacity to carry out disease surveillance in all regions of the country. As is often the case in health matters, there are thus two sides to the role of the federal government. In the first place, it must assume its own responsibilities for establishing the necessary national infrastructure, and, in the second, it must assist all provinces and territories in building up their own capacity. In the Committee’s view, both these aspects should ultimately be reflected in the structure and activities of the new Health Promotion and Protection Agency (HPPA).

There is also an important time dimension to dealing with the deficiencies in health and disease surveillance. A key lesson from the recent SARS outbreaks is that Canada cannot afford to wait the “many years” that the Auditor General expects it to take to create a fully integrated health surveillance system. Measures must be taken to enhance capacity in the short term, at the same time that efforts are begun to put in place all the elements of a comprehensive system that would be completed over a longer time frame.

The Committee believes that the recommendations contained in the Naylor report creatively address this complex interaction between regional and national dimensions of disease surveillance and control across both the shorter and longer terms. Naylor proposes a four-pronged approach that the Committee strongly endorses. More precisely, then, the Committee recommends that:

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<sup>26</sup>Naylor report, p. 80.

<sup>27</sup> Auditor General of Canada, *Health Canada – National Health Surveillance*, Chapter 2, September 2002 Report, p. 1.

<sup>28</sup> *Ibid.*, p. 6.

**The federal government should establish, under the aegis of the new Health Protection and Promotion Agency, a Communicable Disease Control Fund, that would be used to assist the provinces and territories in building up their disease surveillance and control capacity. Money from this fund should begin flowing immediately and be directed to preparing for the coming influenza season.**

**Work should begin immediately on building up existing F/P/T infrastructure with the goal of establishing a comprehensive network that would link disease surveillance and control activities across all jurisdictions.**

**The new Health Protection and Promotion Agency should make infectious disease surveillance a top priority and work closely with the new F/P/T network to build capacity. It should also work to develop over a longer period a comprehensive, national disease surveillance system.**

**Urgent efforts should be directed towards reaching memoranda of understanding between the various levels of government on the business procedures and protocols that would allow for greater immediate collaboration on disease surveillance and control.**

As a first step, the Committee believes it is essential for federal and provincial/territorial governments to agree upon a list of reportable communicable diseases. This would ensure that provinces have an obligation to report infectious disease outbreaks to the other provinces and to the federal government. Federal funding for the Communicable Disease Control Fund could be made subject to agreement on this list of infectious diseases.

In addition, the Committee believes that, as part of its efforts to show the way forward in building up surveillance capacity in Canada, the federal government should deploy federally-employed field epidemiologists in every region of the country. This would serve three purposes. In the first place, it would allow for a direct line of communication between the various regions of the country and the new Health Protection and Promotion Agency. The information would travel in both directions – from a province or region to the Agency and from the Agency to the province/region. This would assist the Agency in meeting its own responsibilities to report to international bodies. Second, these epidemiologists could be integrated into ongoing provincial and/or regional activities, thereby enhancing local capacity to monitor and control disease outbreaks. Finally, as indicated below, as federal employees, these epidemiologists could be rapidly deployed to wherever they might be needed in the event of a health emergency. They would thus contribute to the creation of the surge capacity that is required to handle this kind of emergency.

**The Committee believes that, as part of its efforts to show the way forward in building up surveillance capacity in Canada, the federal government should deploy federally-employed field epidemiologists in every region of the country.**

Witnesses suggested that there could be organizational hurdles to overcome in implementing this program, especially in some provinces. This will no doubt require a flexible program design that will allow provincial variations to be taken into account. But witnesses also pointed out that precedents exist for this type of federal initiative, and that currently a number of provinces have made use of federally-employed epidemiological personnel to strengthen their own surveillance capacity. In particular, the head of the B.C. Centre for Disease Control, Mr. Ron Zapp, told the Committee that federal epidemiologists had regularly and successfully been deployed in his agency.

Therefore, the Committee recommends that:

**The federal government take responsibility for deploying federally-employed field epidemiologists to every region of the country, in sufficient numbers so that they can be effectively sent wherever they may be needed to assist in dealing with a health emergency.**

It must be emphasized, with respect to this recommendation, that Canada must have a nationwide surveillance system if it is to meet its international obligations. In the absence of such a system, or if it relies on other governments to provide the required information, Canada runs the risk of not being able to fulfill its international commitments.

**Canada must have a nationwide surveillance system if it is to meet its international obligations.**

### **3.2 Building an Effective Health Emergency Response System**

Even when Canada has in place a fully functioning disease surveillance network, it will still be necessary to have additional capacity in reserve to deal with emergency situations. Moreover, it is extremely important that the necessary protocols be in place in order to ensure coordination between different jurisdictions in case of an emergency, and that the appropriate level of government assume a leadership role as required.

In its briefs to the Senate Committee and to the Naylor Committee, the Canadian Medical Association (CMA) proposed a formal health alert system that would clearly establish which level of government is expected to take what kind of action. The Committee agrees with this general approach and believes that something along the lines of the system proposed by the CMA should be adopted. This system would build further on the business procedures and protocols that, in the preceding section, the Committee recommended be negotiated as soon as possible amongst the various levels of government.

**The Canadian Medical Association (CMA) proposed a formal health alert system that would clearly establish which level of government is expected to take what kind of action. The Committee agrees with this general approach and believes that something along the lines of the system proposed by the CMA should be adopted.**

*Diagram 1* at the end of this chapter illustrates roughly how this system could work. It is based on a slightly modified version of the CMA's proposal. For the sake of clarity, we have combined the main elements of the CMA's proposal with a flow chart in which the Auditor General illustrated how, ideally, information on communicable diseases should reach the federal government. This system would help to ensure that there was a constant flow of information between the various levels of government, at all times. In the case of an emergency, depending on the severity of the risk to the health of Canadians, different levels of government would assume key responsibilities in dealing with a health emergency, and would have available to them the necessary legal powers to take appropriate action.

The Committee believes that one of the first tasks assigned to the Health Protection and Promotion Agency should be to develop a Memorandum of Understanding with each province and territory on the implementation of this health alert system. Therefore, the Committee recommends that:

**The HHPA develop, as a priority, a Memorandum of Understanding with each province and territory on the implementation of a Health Alert System. As a first step, the reporting of infectious disease outbreaks should be agreed on immediately.**

**The Committee believes that one of the first tasks assigned to the Health Protection and Promotion Agency should be to develop a Memorandum of Understanding with each province and territory on the implementation of this health alert system.**

Another essential component to ensure preparedness in the face of an emergency is to have sufficient trained personnel available. Clearly, given the sporadic nature of health emergencies, this personnel will normally be employed elsewhere, while making themselves available for ongoing training in their emergency response duties. There are two points in particular that the Committee wishes to highlight in this regard.

In the first place, the Committee believes that the federal government should contribute directly to creating this reserve capacity. As indicated above, the Committee recommends that the federal government do this by deploying sufficient numbers of federally-employed field epidemiologists to every region of the country.

Second, the Committee endorses the approach outlined in the Naylor report that builds on the idea of Health Emergency Response Teams (HERTs). These would be composed of professional health personnel specially trained and certified for rapid deployment to emergency sites across the country. HERTs could be established to fulfill the role of the national response team envisaged in the CMA health alert model but they could also be organized through other levels of government.

Another kind of HERT that was suggested by the CMA in its brief to the Committee,<sup>29</sup> would be a team to provide 'respite' relief to acute care workers who were

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<sup>29</sup> Canadian Medical Association, Brief to the Committee, p. 11.

involved in dealing with a health emergency. The need for this kind of additional capacity was plainly evident during the Toronto SARS outbreak.

As the Naylor report points out, the training and licensing of the qualified personnel needed to staff the HERTs will require cross-jurisdictional agreements. The Committee believes that work on setting out these agreements should begin immediately, under the aegis of the Transitional Health Protection and Promotion Board, and not wait until the new Health Protection and Promotion Agency has been fully established.

### **3.3 Human Resource Development**

The need to train emergency personnel points again to the importance of having a long term strategy for health human resource development. The Committee feels that this situation further underscores the importance of heeding the call for a national health human resources strategy that the Committee made in its October 2002 report *Recommendations for Reform* on the broader health care system.<sup>30</sup>

The Naylor report lamented the dearth of solid quantitative data on the state of human resource supply in health protection and promotion activities. Nonetheless, it was categorical in its affirmation that “no attempt to improve public health will succeed that does not recognize the fundamental importance of providing and maintaining in every local health agency across Canada an adequate staff of highly skilled and motivated public health professionals.”<sup>31</sup> This point was reinforced by witnesses who testified to the Committee that the SARS crisis had revealed just how thin on the ground the country is with respect to health human resources in general, and health protection human resources in particular. Also, the Committee was struck by the fact that the serious shortage of nursing personnel in general has grave implications for Canada’s ability to protect and promote the health of its population.

Several witnesses also spoke about how the absence of a clearly defined career path had a negative effect on recruitment to the field of health protection and promotion. The Committee was told that community medicine was not, in many provinces, a particularly well-compensated specialty compared to other high-tech procedural specialties in medicine, and that the career path in public health nursing is somewhat unclear. The Committee was also informed that it was unlikely that brilliant young epidemiologists would be attracted to a situation where the only jobs available to them in Canada have little or no impact on the actual functioning of the health protection system.

The Committee heard repeatedly that one of the exciting prospects associated with the creation of the new Health Protection and Promotion Agency is that it would define much clearer and more fulfilling career paths for scientists as well as other professionals. It would also allow people to both conduct research and to practice in the field. It could, for example, facilitate a career trajectory for public health nurses that would see them get their master’s degree in public health, go out and do some outbreak fighting

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<sup>30</sup> See Volume Six, *Recommendations for Reform*, Chapter Eleven, October 2002.

<sup>31</sup> Naylor report, p. 136.

and front-line health protection work, and then come back and do a Ph.D. in public health policy. They could then work for the new Health Protection and Promotion Agency and perhaps gain further experience abroad by acting as liaison with an international body or helping to build capacity in developing countries.

The Committee strongly agrees with the Naylor Committee that a long term, comprehensive, national strategy is needed in order to ensure an adequate supply of trained professionals in all aspects of health protection and health promotion. As indicated in Chapter Two, the Committee believes that one of the roles for the Scientific Advisory Committee to the new Health Protection and Promotion Agency should be to assist in the elaboration of this strategy.

The Committee also believes that there are measures that must be undertaken by the federal government immediately to increase the number of qualified professionals in the field of health protection and promotion. These measures should include helping to fund training placements as suggested by the Naylor Advisory Committee, as well as assisting in developing on the job training programs that would allow for the cross-training of other health professionals so that they could acquire the skills needed to be able to bolster surge capacity in all jurisdictions.

**The Committee strongly agrees with the Naylor Committee that a long term, comprehensive, national strategy is needed in order to ensure an adequate supply of trained professionals in all aspects of health protection and health promotion... The Committee also believes that there are measures that must be undertaken by the federal government immediately to increase the number of qualified professionals in the field of health protection and promotion.**

Witnesses told the Committee that the creation of a School of Public Health in Canada was a worthwhile objective. One possibility would be to envisage putting it in place as a ‘virtual’ school that would draw on the resources of several institutions that are already engaged in some of the teaching and training that is required. A ‘virtual’ school would also have the advantage of linking both university-based and community college-based programs so that students received both theoretical and practical training. Building such a virtual school on the strengths of existing institutions could eventually lead to the development of a world-class school of public health in Canada. The Committee believes that the federal government should play an active role in encouraging such a project.

Therefore, the Committee recommends that:

**Human Resource Development Canada, as part of its human resources sector study of physicians and nurses in Canada, devote specific attention to the current and future needs of health professionals in the field of health protection and promotion.**

**The federal government take immediate action to encourage the development of on-the-job training programs to assist health professionals in acquiring the necessary skills pertaining to health protection.**

**The federal government, in collaboration with provincial and territorial governments and in consultation with universities and community colleges, initiate discussions on the creation of a Virtual School of Public Health.**

### **3.4 Laboratories**

Public health laboratories are a central element of the health protection and promotion infrastructure. They are a key resource in infectious disease diagnosis and epidemiological surveillance, as well as in disease outbreak preparedness, investigation and response. They also play an important role in performing fundamental and applied health research.

Four levels of laboratories form the public health laboratory system in Canada: front-line laboratories (private, local or hospital-based); provincial public health laboratories; national laboratories; and international laboratory networks. These different levels of laboratories function as a hierarchy, although there are no formal relationships or structures. In an epidemic or an emergency, these different levels of laboratories may be supplemented or complemented by laboratories that are primarily based in academic institutions and whose primary role is research.

The Naylor report notes that, during the early phases of the SARS outbreak, there were two major impediments to an effective laboratory response: inadequate data management and lack of integration of epidemiological and laboratory data. Inadequate data management is mainly the result of the absence of a common information management system for outbreak responses in public health laboratories across the country. Better integration of epidemiological and laboratory data would permit data sharing and help avoid duplication.

The recommendations of the Naylor report include: undertaking urgently a review of the capacity and protocols of public health laboratories to respond effectively and collaboratively to the next serious infectious disease outbreak; developing immediately a laboratory information system so as to improve data sharing in a timely manner; expanding the Canadian Public Health Laboratory Network to include hospital and community based laboratories; participation of national laboratories in international laboratory networks.

The Committee agrees with these recommendations. Furthermore, given the important role played by public health laboratories in responding to disease outbreaks, we believe that immediate action needs to be taken. Therefore, the Committee recommends that:

**The federal government, in collaboration with provincial and territorial governments, urgently undertake a review of the capacity and protocols needed by public health laboratories to respond effectively and collaboratively to the next serious infectious disease outbreak.**

### 3.5 Information Technology and Communications Systems

There is clearly a pressing need to seriously upgrade information technology at all levels of the health protection and promotion infrastructure. The lack of a modern database accessible to local, provincial and federal health authorities had adverse impacts on the flow of information to the public and to international agencies. The absence of appropriate and shared databases and capacity for interim analyses of data, also interfered with outbreak investigation and management, and constrained epidemiological and clinical research into SARS. Agreements for data sharing between different levels of government, and the necessary information technology, were apparently not in place before the outbreak.

The Naylor report notes as well that numerous difficulties with communication surfaced during the SARS outbreak: communications with the public, communication of scientific information, communication with international agencies.

A secure communications system, however, is a key element in emergency response. In his written submission to the Committee, Dr. James M. Hughes, Director of the National Centre for Infectious Diseases (US CDC), stated that the rapid dissemination of information significantly facilitated CDC's response to the SARS outbreak in the United States. Critical information was shared through CDC's website, regular press conferences, and global videoconferences. As well, regular communications and teleconferences were maintained with state epidemiology and laboratory personnel and with clinicians, virologists, the academic community, and professional organizations and groups.<sup>32</sup>

The Naylor report recommends that all levels of government develop systems that provide health professionals and the public with timely, accurate and consistent information and directives during an outbreak of infectious disease. It also recommends that the new national agency be responsible for direct communication with the World Health Organization, the US CDC and other international organizations and jurisdictions.

In addition, the Naylor report recommends that the federal government seek the establishment of a working group under the auspices of Canada Health Infoway Inc. to focus specifically on the needs of health infrastructure and potential investments to enhance disease surveillance and link public health and clinical information systems.

The Committee concurs with these recommendations. We believe that it is essential for Canada to take full advantage of the most recent innovations in information and communication technologies. Therefore, we recommend that:

**The federal government immediately initiate negotiations with Canada Health Infoway Inc. to set up appropriate information technology to improve both surveillance and communication systems.**

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<sup>32</sup> Dr. James M. Hughes, Director, National Center for Infectious Diseases, US CDC, *CDC's Response to Infectious Disease Threats Including Preparedness Planning for Severe Acute Respiratory Syndrome (SARS)*, Brief to the Committee, 22 October 2003, p. 7.



### 3.6 Research

Throughout its study on health and health care, the Committee advocated strongly in favour of the full spectrum of health research activities – biomedical, clinical, health services and population health – and recommended increased federal funding for both in-house and extramural health research. In this report, we once again argue for enhanced federal research leadership and support, especially in the field of health protection and promotion. Our views are consistent with the observations and findings of the Naylor Advisory Committee.

The Naylor report points out that effective health protection and promotion requires a strong scientific foundation as well as a strong research capacity into infectious diseases when it states: “(...) critical capacity for epidemiological investigation and outbreak response is built in part by nurturing the related and fundamental science.”<sup>33</sup>

The creation of such strong scientific capacity is a long-term process. In light of the SARS outbreak, the report identifies *numerous* deficiencies in how Canadian research is organized to respond to health emergency situations and significant new infectious disease threats. These deficiencies include lack of leadership, the absence of a clear research agenda, low research capacity, insufficient funding, poor coordination, little data collection and management, limited data sharing, weak mechanisms to link epidemiological and clinical to laboratory data, lack of collaborative relationships between researchers and agencies, shortage of skilled scientists, and lack of advanced planning.

To address these concerns, the Naylor Advisory Committee recommends an increase of \$25 million annually in federal funding for research on health protection and promotion (particularly fundamental and applied research). These funds should be allocated to the new agency described in Chapter Two for the purpose of enhancing in-house research capacity as well as for contracting out research to partners such as the Canadian Institutes of Health Research. It is critical that a mechanism be designed for swift, targeted research to be done when needed while ensuring principles of excellence and peer review. The Naylor report also recommends that the new agency give special priority to linking research in government and academic institutions with a focus on infectious diseases. This would improve processes for rapid epidemic and outbreak investigation.

The Naylor report argues for the establishment of strong research networks that are operational in advance of an outbreak. In outbreak situations, data should be made available to all interested researchers. It also recommends that guidelines be developed in order to facilitate collaborative research and research publications during infectious disease outbreaks. Finally, the Naylor report stresses that the bolstering of research into health protection and promotion must be achieved while ensuring that appropriate ethical and privacy standards are in place.

The Committee agrees with the Naylor Advisory Committee. We feel strongly that research must be an integral component of health protection and promotion

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<sup>33</sup> Naylor report, p. 183.

infrastructure and that collaborative partnerships must be encouraged. In this way, the Committee believes it will be possible to build on existing human, technical and institutional resources across the country in order to enhance Canada's research capacity in this field.

**We feel strongly that research must be an integral component of health protection and promotion infrastructure and that collaborative partnerships infrastructure and that collaborative partnerships must be encouraged.**

### 3.7 Globalization

One clear lesson of the SARS outbreak is that health protection and promotion is international in scope, with developments in China capable of having near-immediate consequences for health in Canada. It is therefore in the interest of Canada to improve disease surveillance and control in other countries, as well as to improve international coordination in dealing with outbreaks of communicable disease.

The Naylor Advisory Committee recognizes the importance of international linkages for health protection, and its report recommends that the federal government, through the new agency, contribute to building capacity for disease surveillance and management in developing countries. In addition, the Naylor report advises the federal government to launch a multilateral process to better define the role of the World Health Organization in managing international cooperation on health issues, particularly outbreaks of infectious disease.

The Committee concurs with these important recommendations on international issues. Unless immediate steps are taken to standardize protocols and adopt common definitions for diseases, to relay information on disease outbreaks internationally, and to coordinate efforts to contain outbreaks (as well as to build capacity in developing nations to implement these protocols), Canada will remain vulnerable to serious disease outbreaks.

As noted previously, health protection and promotion infrastructure is only as strong as its weakest link. The Committee believes that this is true even if that weakest link is found outside Canada's borders. As such, we feel that it is important for the federal government, through the new Health Protection and Promotion Agency, to address adequately and in a timely manner the international dimensions of infectious disease outbreaks.

The Committee is also aware that Health Canada currently plays an important role in international disease surveillance through its Global Public Health Intelligence Network (GPHIN). GPHIN is an early-warning system that continuously scans Internet media sources for reports of infectious disease outbreaks around the world. This Internet-based system which provides information on a real-time, 24/7 basis. This information is then fed into the WHO's Global Outbreak Alert and Response Network. GPHIN currently reports approximately 40% of the outbreaks known to WHO. The Committee strongly believes that this early warning system must be strengthened and enhanced.

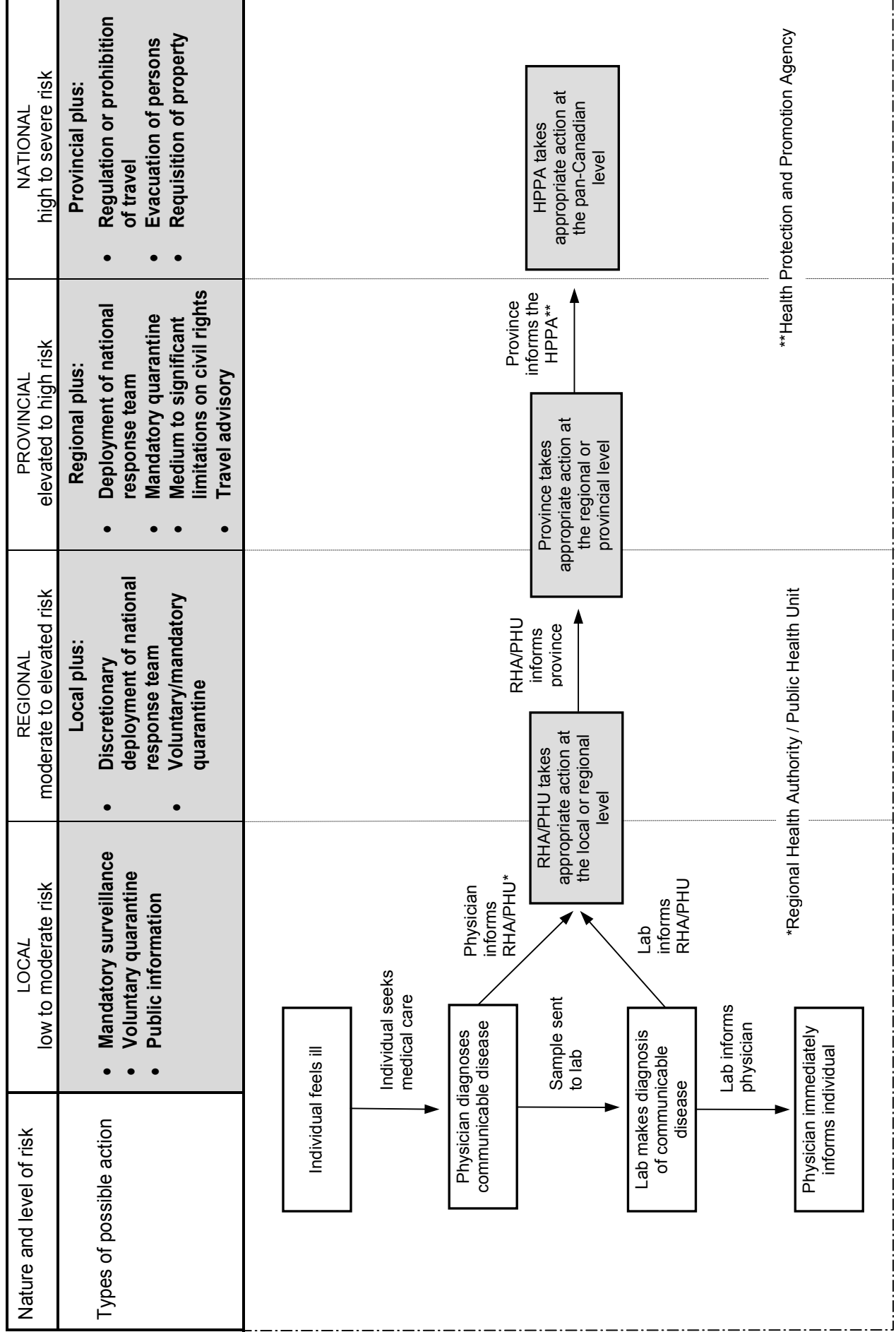
Therefore, the Committee recommends that:

**The Health Protection and Promotion Agency play a leading role, along with international partners, in the detection of global emerging diseases and outbreaks, including by working to enhance the Global Public Health Intelligence Network.**

**The Health Protection and Promotion Agency promote greater engagement by Canada internationally in the field of emerging infectious diseases, and, in particular, initiate projects to build capacity for surveillance and outbreak management in developing countries.**

**The Health Protection and Promotion Agency be the institution responsible for direct communication with the World Health Organization, the US CDC, and other international organizations and jurisdictions. During outbreak situations, the Agency should work to maximize mutual learning by ensuring an effective liaison with international organizations and jurisdictions.**

**DIAGRAM 1**  
**Possible Functioning of a Health Alert System**



## CHAPTER FOUR:

### IMMUNIZATION AND CHRONIC DISEASE PREVENTION

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*(...) the shift in mortality and morbidity profiles away from communicable diseases to chronic non-communicable diseases create(s) challenges for public health practice.<sup>34</sup>*

In its October 2002 report (*Recommendations for Reform*), the Committee recommended that the federal government contribute \$125 million annually to a national chronic disease prevention strategy.<sup>35</sup> In this chapter, we repeat our call for such a nationwide strategy. Also in this chapter, we strongly support the recommendation of the Naylor Advisory Committee to develop a national immunization program.

**In its October 2002 report (*Recommendations for Reform*), the Committee recommended that the federal government contribute \$125 million annually to a national chronic disease prevention strategy.<sup>1</sup> In this chapter, we repeat our call for such a nationwide strategy. Also in this chapter, we strongly support the recommendation of the Naylor Advisory Committee to develop a national immunization program.**

#### 4.1 Chronic Disease Prevention

Chronic diseases are the leading cause of death and disability in Canada and account for the largest proportion of the economic burden of illness. In *Recommendations for Reform*, the Committee indicated that about two thirds of total deaths in Canada are due to the following chronic diseases: cardiovascular disease (heart and stroke), cancer, chronic obstructive lung disease (bronchitis and emphysema) and diabetes. More specifically:

- Cardiovascular diseases, including coronary artery disease and stroke, are responsible for 38% of all deaths among Canadians each year, and are one of the leading reasons for hospitalization;
- Cancer is the second most important cause of death in Canada, responsible for 29% of all deaths each year, and accounting for almost one third of potential years of life lost.
- Chronic obstructive lung disease is the fifth most common cause of death in Canada and is the only cause of death that is increasing in prevalence. Asthma is the most common chronic respiratory disease of children; it is the leading cause of hospital admission and school absenteeism among children in Canada.
- Over one million Canadians live with diabetes. It is a major cause of coronary heart disease and a leading cause of blindness and limb amputations. Among Aboriginal Canadians, the prevalence of diabetes is

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<sup>34</sup> Naylor report, p. 45.

<sup>35</sup> Chapter Thirteen, “Healthy Public Policy: Health Beyond Health Care”, Volume Six, *Recommendations for Reform*, October 2002.

three times as high as among other Canadians. In total, diabetes accounts annually for about 25,000 potential years of life lost.<sup>36</sup>

In *Recommendations for Reform*, the Committee also stressed that many chronic diseases are preventable to a very large extent. Moreover, many chronic diseases often share common causes. More precisely, poor diet, lack of exercise, smoking, stress and excessive alcohol intake – all lifestyle issues – are recognized as the leading social/behavioural risk factors for these diseases. These risk factors are also often associated with other physical and psychological states that elevate the risk of chronic disease – including overweight or obesity, high blood pressure or hypertension, high blood cholesterol or hypercholesterolemia, and glucose intolerance or diabetes. If reduced or eliminated, these common lifestyle risk factors would greatly lessen the prevalence and economic burden of chronic diseases.

**In *Recommendations for Reform*, the Committee also stressed that many chronic diseases are preventable to a very large extent.**

The fact that the vast majority of Canadians are exposed to one or more of these common risk factors suggests that the overall health status of the population could be substantially improved by a stronger focus on chronic disease prevention, in parallel with controlling infectious diseases. There are currently diverse initiatives by some national health organizations, provincial governments and the federal government which focus on chronic disease prevention. However, as the Committee noted in *Recommendations for Reform*, these initiatives require much better integration and coordination.

For these reasons, the Committee recommended that the federal government take the lead role to initiate a national chronic disease prevention strategy. We felt that, while the federal government should act as a leader, it would be important to collaborate with provincial/territorial governments, the private sector, and the voluntary health sector partners in the development of this strategy.

**The Committee recommended that the federal government take the lead role to initiate a national chronic disease prevention strategy.**

In addition, the Committee enumerated in *Recommendations for Reform* the elements that should comprise the national chronic disease prevention strategy, including: public education efforts, mass media programs, policy development and programs, integrated research agenda and improved surveillance and monitoring systems for chronic diseases and their associated risk factors.

The Committee believes that the Health Protection and Promotion Agency recommended in Chapter Two of this report would be well-suited to lead this strategy. This is consistent with the observations of the Naylor Advisory Committee which recommends the establishment of a national public health strategy along with a public health partnerships

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<sup>36</sup> Mental illness and addiction are also important concerns as they account for the second cause of disability in this country. The Committee has undertaken a study on these issues and intends to release a report in 2004.

program, to be led by the new agency, and that would address both infectious and chronic diseases.

Therefore, the Committee recommends that:

**The Health Protection and Promotion Agency, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada) implement a National Chronic Disease Prevention Strategy.**

**The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.**

**The Health Protection and Promotion Agency contribute \$125 million annually to the National Chronic Disease Prevention Strategy. Funding for the Strategy should be part of the Agency's flow through transfers program designed to strengthen local and regional health protection and promotion capacity.**

**Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis and reports of any such evaluation made public.**

## 4.2 Immunization

During the early 1900s, infectious diseases were the leading cause of death worldwide. Now, as a result of health protection measures – such as immunization, sanitation, public health education and better living conditions – infectious diseases cause less than 5% of all deaths in Canada. This accomplishment places health protection measures, and in particular immunization, among the greatest achievements in health care of the 20<sup>th</sup> century.

Immunization is a central activity of health protection and promotion and a very cost-effective illness prevention measure, protecting millions of children and adults from contracting debilitating, disabling and sometimes fatal infectious diseases. Immunization has been responsible for the eradication of some vaccine-preventable diseases such as poliomyelitis and smallpox.

**Immunization is a central activity of health protection and promotion and a very cost-effective illness prevention measure, protecting millions of children and adults from contracting debilitating, disabling and sometimes fatal infectious diseases.**

The Naylor Advisory Committee reviewed a range of documents dating back to the 1990s and found substantial diversity among the provinces and territories in publicly-funded programs and legislation pertaining to immunization and vaccination. The Naylor report also notes concerns with respect to the

growing price of vaccines, safety issues with some vaccines, inequity of access to some vaccines (particularly newer ones), and uneven electronic recording of immunizations.

In recent years, proposals have been made for the development of a national immunization program with the goal of securing guaranteed delivery of vaccines across the country at the lowest possible prices through public purchasing. In its February 2003 budget, the federal government announced that it would provide \$45 million over five years “to assist in the pursuit of a national immunization strategy”.<sup>37</sup>

However, according to the Naylor report, the newly announced \$45 million is “nowhere near sufficient to catalyze a national immunization strategy.”<sup>38</sup> The Naylor Advisory Committee estimates that no less than \$100 million annually should be earmarked for a major reinvigoration of the national immunization strategy. Moreover, the Naylor report suggests that these earmarked funds should be transferred to a single purchasing body (e.g., Public Works and Government Services Canada). This would strengthen the buying power of the purchaser of these vaccines. Earmarked funds should be used to purchase only agreed-upon vaccines, particularly new vaccines for which there are gaps in public coverage. This funding should also serve to support a consolidated information system to track vaccinations and immunization coverage. The Naylor report recommends that the federal government invest the necessary \$100 million annually beginning within the next twelve to eighteen months.

The Committee strongly supports these recommendations. We believe that a national immunization program requires strong federal leadership, along with workable federal/provincial/territorial collaboration. The Committee recognizes that there will be those who would say that since immunization is a provincial responsibility, any immunization program should be the exclusive responsibility of the provinces.

**We believe that a national immunization program requires strong federal leadership, along with workable federal/provincial/territorial collaboration.**

The Committee passionately disagrees with this position. There are several reasons for this, the most important of which is that infectious diseases do not respect provincial or national boundaries. Second, although new vaccines are not cheap, a national program of vaccine purchase will dramatically reduce the cost per unit.<sup>39</sup> Third, vaccines are most cost-effective when they are delivered through large scale programs.

Therefore, the Committee reiterates the recommendation of the Naylor Advisory Committee that:

**The federal government, through the Health Protection and Promotion Agency, invest \$100 million annually beginning within the next 12 to 18**

<sup>37</sup> Department of Finance, *The Budget Plan 2003*, 18 February 2003, p. 75.

<sup>38</sup> Naylor report, p. 88.

<sup>39</sup> It is important to note that the responsibility for the distribution of vaccines will remain provincial and territorial.



months for the realization of a National Immunization Program whereby the federal government would purchase agreed-upon new vaccines to meet provincial and territorial needs, support a consolidated information system to track vaccinations and immunization coverage and track Vaccine-Associated Adverse Events through increased funding for surveillance and a mandatory reporting requirement, and provide funding for research on possible long-term adverse effects of vaccines.



## CHAPTER FIVE:

### FINANCING REFORM: AN INCREMENTAL APPROACH

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*Canada's ability to contain an outbreak is only as strong as the weakest jurisdiction in the chain of disease control and health protection.*<sup>40</sup>

The report of the National Advisory Committee on SARS and Public Health was published in early October. The Committee shares the view of all witnesses that the federal government must not let this report languish on the shelf. At the conclusion of their meeting in Halifax on September 4, 2003, all federal, provincial and territorial Ministers of Health agreed to make the enhancement of health protection activities across the country a top priority. The Committee strongly believes that the federal government must develop a plan to respond to the Naylor report recommendations in order to create a strong and well-resourced health protection and promotion infrastructure with adequate surge capacity and sufficient highly qualified professionals.

Immediate action must be taken. However, this requires federal leadership as well as substantial federal funding. One of the lessons the Committee drew from its examination of other countries studied in preparation of this report is that central government funding and leadership are vital to optimal programming, uniform standards and equity of services across the country. This chapter focuses on how much additional federal government funding is needed in Canada, and when it is needed.

#### 5.1 Federal Government Spending Recommended in the Naylor Report

According to the Naylor report, a sound, responsive, effective and timely health protection and promotion infrastructure in Canada would require an investment by the federal government totalling approximately \$1 billion per year by fiscal year 2007-2008. As shown in the table below, this sum would consist of an *existing* federal spending of some \$300 million and an *additional* federal spending of \$700 million.

The existing \$300 million would be *transferred* from Health Canada to the proposed new agency described in Chapter Two. This existing funding is currently used by the department for the purpose of health protection and promotion and covers, for the most part, the core functions of the Population and Public Health Branch (PPHB).

The Naylor report estimates that an additional investment by the federal government is needed to revitalize health protection and promotion in Canada. It recommends that this additional federal spending increase gradually over the next few years to reach \$700 million by fiscal year 2007-2008. In the view of the Naylor Advisory Committee, this is not an unrealistic amount: "This is what F/P/T governments currently spend on personal health services in Canada between Monday and Wednesday in a single

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<sup>40</sup> Dr. David Naylor, *Proceedings*.

week.”<sup>41</sup> In addition, when he appeared before the Committee, Dr. Naylor stressed that, under the circumstances, it is a *minimum* prudent investment to make. The Committee feels that it is especially true when compared to the cost in lives, illnesses and economic impact of less-than optimal health protection actions (e.g. impact of SARS in Toronto).

**THE NAYLOR ADVISORY COMMITTEE:  
FEDERAL GOVERNMENT SPENDING RECOMMENDATIONS**

Initiative	Funding (Millions of Dollars)		Proposed Timeframe
	New	Existing	
New National Agency: <ul style="list-style-type: none"> <li>▪ Existing Capacity Within Health Canada</li> <li>▪ Expanded Core Functions</li> </ul>	\$200	\$300	The \$200 million level is to be reached over the next 3 to 5 years
Flow Through Transfers for Local and Regional Capacity (protection, promotion and prevention of both infectious and chronic diseases)	\$300		Public Health Partnerships Program: Funding would rise over the next 2-3 years to reach \$300 million annually
Flow Through Transfers for Communicable Disease Surveillance	\$100		Would start immediately at a lower level and then rise over the next 2-3 years
Immunization	\$100		To be accomplished within the next 12 to 18 months.
<b>Total</b>	<b>\$700</b>	<b>\$300</b>	

Source: Report of the National Advisory Committee on SARS and Public Health.

Of this \$700 million amount, some \$200 million is to be allocated to the new agency for expanded core functions. In particular, it is to be used for the following purposes: enhancing national disease surveillance systems (\$15 million); developing a national public health strategy (\$5 million); improving health emergency preparedness and response (\$10 million); creating epidemic response teams and strengthening surge capacity (\$10 million); establishing a new network for communicable disease control (\$50 million); expanding human resources (\$25 million); bolstering research funding (\$25 million); enhancing protection and promotion in the fields of environmental health, mental health and injury prevention (\$30 million). These amounts, which actually total some \$170 million in additional annual federal funding, would gradually increase to \$200 million annually over the next three to five years.

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<sup>41</sup> Naylor report, p. 12.

The other \$500 million in additional federal funding is recommended to cover the following areas: earmarked flow through transfers to strengthen local and regional health protection and promotion capacity (\$300 million); flow through transfers to enhance communicable disease surveillance (\$100 million); and funding for a national immunization strategy (\$100 million).

As the Naylor report clearly points out, not all additional federal funding needs to be new. Some of the additional federal investment it recommends could be obtained from programs and initiatives that already exist (e.g. Canada Health Infoway Inc., Human Resources and Development Canada, etc.).

Furthermore, the Naylor Advisory Committee assumes that provincial and territorial governments will also increase their contribution to health protection and promotion over the next several years in order to put in place a strong national infrastructure which is supported by all levels of government.

The Naylor report also comments on the Grants and Contributions Program (G&C) currently managed by PPHB. Under the G&C program, which has an annual budget of some \$200 million, PPHB funds projects undertaken by non-government organizations (NGOs) across the country. These projects cover a range of issues from communicable and non-communicable diseases to wellness and healthy living/aging. Although many of these projects are valuable in that they clearly help to achieve the policy objectives of PPHB, the Naylor Advisory Committee heard mixed views on the value of the existing G&C program with respect to the policy objectives and mandate of PPHB. Concerns were also raised with respect to the politicization of the program and the magnitude of transfers to some NGOs. Perhaps more importantly, the September 2001 report of the Auditor General noted problems in the project management process of the G&C program.

For these reasons, the report of the Naylor Advisory Committee recommends that the G&C program be reviewed and that the use of the grants and contributions be *very* clearly aligned with the mandate and objectives of the proposed new agency. In addition, the Naylor report suggests that the funding of the G&C program be incorporated into the budget of the new agency.

When Dr. Naylor appeared before the Committee, he stated that the first funding priority for the federal government should be to prepare for this winter's respiratory virus season. As such, the first step would be to develop a set of directives, guidelines and protocols with respect to SARS for the use of hospitals, health professionals and front-line personnel. In Dr. Naylor's view, this would help prevent false SARS alarms that could be quite devastating.

The second priority, according to Dr. Naylor's testimony, would be twofold: to undertake the establishment of the new agency, while at the same time developing a much better surveillance system for infectious diseases with improved coordination among governments and institutions. The development of a network for communicable disease control would be his third priority. In the longer term, a legislative review will have to be

undertaken with the goal of harmonizing and improving federal and provincial health emergency legislation.

## 5.2 Federal Government Spending Recommended by the Committee

The Committee fully supports the recommendations in the Naylor report calling for the transfer of existing financial and human resources from PPHB to the agency described in Chapter Two, as well as the request for additional federal investment in health protection and promotion infrastructure. This will ensure that all regions in Canada can provide an adequate level of health protection and promotion in normal times, while their capacity is augmented by federal surge capacity during times of crisis. We agree with Dr. Naylor that the federal government should initiate planning to ensure that it can devote, in the long term, a total of about \$1 billion annually to health protection and promotion.

**The Committee fully supports the recommendations in the Naylor report calling for the transfer of existing financial and human resources from PPHB to the agency described in Chapter Two, as well as the request for additional federal investment in health protection and promotion infrastructure... Additional federal funding for the purpose of health protection and health promotion should, whenever possible, come from existing sources.**

However, the Committee believes that this investment must be made in a *fiscally responsible* manner. Accordingly, additional federal funding for the purpose of health protection and health promotion should, whenever possible, come from existing sources. In addition, we believe that relevant funding from the current G&C program at PPHB should be incorporated into the budget of the new Health Protection and Promotion Agency. This would provide the Agency with substantial additional funding from *existing* federal spending. We also concur with the Naylor Advisory Committee that the G&C program should be very carefully reviewed to ensure that only those projects with good value-for-money and which clearly further the policy objectives of the new agency should continue to receive federal funding.

Therefore, the Committee recommends that:

**Between now and the end of 2004, priority for federal spending on health protection and promotion should be given to the following twelve (12) initiatives:**

- **The establishment of the Transitional Health Protection and Promotion Board which should eventually lead to the creation of the Health Protection and Promotion Agency (3 months);**
- **The creation of the Health Protection and Promotion Agency by Order-in-Council before the end of the current fiscal year (4 months);**
- **The development of directives, guidelines and testing protocols to assist health professionals, hospitals and laboratories in preparation for the next respiratory virus season (3 months);**

- Initial investment to facilitate immediate preparedness for a possible return of SARS during the winter season of respiratory illnesses (3 to 6 months);
- Further investment in infectious disease surveillance and control with the view of enhancing surveillance capacity at the local and regional level initially (12 months);
- F/P/T review of the capacity and protocols of public health laboratories to respond effectively and collaboratively to the next serious infectious disease outbreak (12 months);
- Meeting of the F/P/T Conference of Deputy Ministers of Health to initiate discussions on a new network for communicable disease control (3 months);
- As a first step, increasing enrolment in existing university and community college programs in the field of health protection and promotion; then, undertaking the establishment of the Virtual School of Public Health (12 months);
- National Immunization Program (12 months);
- Begin F/P/T negotiations on the creation of the Health Alert System (12 months);
- Initiate negotiations with Canada Health Infoway Inc. to set up appropriate information technology to improve both surveillance and communication systems (12 months);
- Initiate transfer of physical and human resources from the Population and Public Health Branch to the Health Protection and Promotion Agency (12 months).

This set of recommendations clearly points to the need to make health protection and promotion the *priority* of the next federal budget.

**Table 1**  
**Summary of the Committee's Action Programme**

	<b>Within 3 months</b>	<b>Within 6 months</b>	<b>Within 12 months</b>
Infectious disease surveillance and control	<ul style="list-style-type: none"> <li>• Prepare for the next respiratory virus season</li> <li>• F/P/T Meeting on a new communicable disease control network</li> </ul>	<ul style="list-style-type: none"> <li>• Investment to facilitate immediate preparedness for a possible return of SARS</li> </ul>	<ul style="list-style-type: none"> <li>• Further investment to enhance capacity at the local and regional level</li> </ul>
Health Protection and Promotion Agency	<ul style="list-style-type: none"> <li>• Establish the Transitional Health Protection and Promotion Board</li> </ul>	<ul style="list-style-type: none"> <li>• Create the Health Protection and Promotion Agency by Order-in-Council by the end of the current fiscal year (March 31, 2004)</li> </ul>	<ul style="list-style-type: none"> <li>• Initiate transfer of physical and human resources from the Population and Public Health Branch to the Health Protection and Promotion Agency</li> </ul>
Other Programs and Infrastructure		<ul style="list-style-type: none"> <li>• Increase enrolment in existing university and community college programs in the field of health protection and promotion</li> </ul>	<ul style="list-style-type: none"> <li>• Establish the National Immunization Program</li> <li>• Create the Health Alert System</li> <li>• F/P/T review of public health laboratories</li> <li>• Initiate negotiations with Canada Health Infoway Inc.</li> <li>• Undertake the establishment of the Virtual School of Public Health</li> </ul>



## CONCLUSION

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Throughout this report, the Committee has indicated that it wholeheartedly supports nearly all the recommendations in the Naylor report. Moreover, many of these recommendations are essentially the same as those contained in a federal government inquiry ten years ago and were also recapitulated in an F/P/T working group report seven years ago. Witnesses also expressed strong support for the findings and recommendations of the Naylor report. *The Committee strongly believes that the time for study is over and the time for action has arrived.*

This is why, at the end of Chapter Five, the Committee put forward a precise timetable – a critical path – for the implementation of the key recommendations in the Naylor report. We believe that all of these measures can be implemented without the approval of any other government within the proposed timeframe.

**At the end of Chapter Five, the Committee put forward a precise timetable – a critical path – for the implementation of the key recommendations in the Naylor report. We believe that all of these measures can be implemented without the approval of any other government within the proposed timeframe.**

Despite widespread agreement on the need to move quickly to implement these recommendations, the Committee is aware that there are, nevertheless, barriers that might impede progress. For example:

- There may well be resistance to decreasing the size of Health Canada by moving the Population and Public Health Branch, and all of its employees and budget, into an arm's length agency. Similar human resource concerns were initially experienced with the creation of the Canadian Food Inspection Agency but were finally overcome.
- In spite of the international obligations of the federal government, some officials and politicians could be reluctant to support the deployment of federal employees across the country for disease surveillance purposes, based on the view that data collection is a provincial or local government issue. We believe that the deployment of federal epidemiologists or other public health professionals can allow for a swift, coordinated action when necessary without compromising provincial governments' roles and responsibilities.
- Organizations that currently receive funding under the Grants and Contributions Program of the Population and Public Health Branch may be upset if their grants/contributions are reduced or eliminated entirely, as the new agency tries to maximize the value it gets for the grant money it disburses.
- There will be individuals in the research community who may be unhappy with having the agency contract out specific research projects, rather than allocating the money through CIHR.

All of this potential disagreement with the measures that the Committee proposes the federal government adopt before the end of 2004 can easily be overcome if the

federal government believes, as strongly as the Committee does, that the time for action is *now*. The essential ingredient that is required is *decisive political leadership*.

If the federal government fails to implement the proposed measures, then Canadians will have no choice but to conclude that the federal government is incapable of making, or is unwilling to make, the prevention of illness amongst Canadians – through the implementation of a vigorous health protection and promotion program – as much of a priority as taking care of Canadians who are already sick. Thus, by the end of next year, Canadians will be able to judge for themselves how high a priority the federal government places on the recommendations of the Naylor report and on health protection and promotion.

Late in the fall of 2004, the Committee intends to ask the Minister of Health to appear at a public hearing in order to report to the Committee, and more importantly to Canadians, on what the federal government has done with respect to implementing the Committee's recommended action steps for 2004.

**The measures that the Committee proposes the federal government adopt before the end of 2004 can easily be overcome if the federal government believes, as strongly as the Committee does, that the time for action is *now*. The essential ingredient that is required is *decisive political leadership*... If the federal government fails to implement the proposed measures, then Canadians will have no choice but to conclude that the federal government is incapable of making, or is unwilling to make, the prevention of illness amongst Canadians – through the implementation of a vigorous health protection and promotion program – as much of a priority as taking care of Canadians who are already sick.**

LIST OF RECOMMENDATIONS BY CHAPTER

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The Committee recommends that:

**CHAPTER TWO:**

A new agency, to be called the Health Protection and Promotion Agency (HPPA), be created, and that it be headed by the Chief Health Protection and Promotion Officer of Canada (CHPPO). The HPPA would be a legislated service agency that reports to the federal Minister of Health.

The CHPPO be appointed by the federal Minister of Health and be a health professional.

The Minister also appoint a Health Protection and Promotion Board that would receive regular reports from the CHPPO and function as the Board of the HPPA. The Health Protection and Promotion Board should be chaired by someone other than the CHPPO.

In order to ensure sustained input from the provinces and territories, and to provide the HPPA with the best possible scientific advice, that an Advisory Council be created composed of the Chief Medical Officers from the provinces and territories. The advisory council should also contribute to working out a comprehensive human resource strategy by the HPPA.

The mandate of the HPPA should include the following:

- (a) Work with provincial and territorial authorities to articulate a coherent long-term vision for health protection and promotion in Canada, and develop a plan to realize this vision;
- (b) Partner with already existing provincial bodies (such as the B.C. Centre for Disease Control and the Quebec National Institute of Public Health) and help stimulate the development of similar comprehensive initiatives in regions of the country where they do not yet exist;
- (c) Ensure that Canada meets all its international health protection obligations;
- (d) Enhance disease surveillance and control in Canada;
- (e) Direct federal efforts to be prepared for any health emergency and work closely with P/T authorities to ensure that there is adequate capacity in all regions of the country;
- (f) Direct federal activity designed to improve all aspects of health protection and promotion infrastructure across the country;

- (g) Actively promote the health of Canadians, and, in particular, design and implement a National Chronic Disease Prevention Strategy as well as a National Immunization Program.

A Transitional Health Protection and Promotion Board for the Health Protection and Promotion Agency be struck as quickly as possible, through Order in Council if necessary. The Transitional Health Protection and Promotion Board would be charged with setting up the HPPA. The HPPA should come into being before the end of the current fiscal year (March 31, 2004). It would be authorized to work with Health Canada in order to transfer resources and staff from the current Population and Public Health Branch of Health Canada that would serve as the initial core of the HPPA. The Transitional Health Protection and Promotion Board would begin the search for appropriate candidates to head the HPPA and would make a recommendation to the Minister in this regard.

### CHAPTER THREE:

The federal government should establish, under the aegis of the new Health Protection and Promotion Agency, a Communicable Disease Control Fund, that would be used to assist the provinces and territories in building up their disease surveillance and control capacity. Money from this fund should begin flowing immediately and be directed to preparing for the coming influenza season.

Work should begin immediately on building up existing F/P/T infrastructure with the goal of establishing a comprehensive network that would link disease surveillance and control activities across all jurisdictions.

The new Health Protection and Promotion Agency should make infectious disease surveillance a top priority and work closely with the new F/P/T network to build capacity. It should also work to develop over a longer period a comprehensive, national disease surveillance system.

Urgent efforts should be directed towards reaching memoranda of understanding between the various levels of government on the business procedures and protocols that would allow for greater immediate collaboration on disease surveillance and control.

The federal government take responsibility for deploying federally-employed field epidemiologists to every region of the country, in sufficient numbers so that they can be effectively sent wherever they may be needed to assist in dealing with a health emergency.

The HPPA develop, as a priority, a Memorandum of Understanding with each province and territory on the implementation of a Health Alert

System. As a first step, the reporting of infectious disease outbreaks should be agreed on immediately.

Human Resource Development Canada, as part of its human resources sector study of physicians and nurses in Canada, devote specific attention to the current and future needs of health professionals in the field of health protection and promotion.

The federal government take immediate action to encourage the development of on-the-job training programs to assist health professionals in acquiring the necessary skills pertaining to health protection.

The federal government, in collaboration with provincial and territorial governments and in consultation with universities and community colleges, initiate discussions on the creation of a Virtual School of Public Health.

The federal government, in collaboration with provincial and territorial governments, urgently undertake a review of the capacity and protocols needed by public health laboratories to respond effectively and collaboratively to the next serious infectious disease outbreak.

The federal government immediately initiate negotiations with Canada Health Infoway Inc. to set up appropriate information technology to improve both surveillance and communication systems.

The Health Protection and Promotion Agency play a leading role, along with international partners, in the detection of global emerging diseases and outbreaks, including by working to enhance the Global Public Health Intelligence Network.

The Health Protection and Promotion Agency promote greater engagement by Canada internationally in the field of emerging infectious diseases, and, in particular, initiate projects to build capacity for surveillance and outbreak management in developing countries.

The Health Protection and Promotion Agency be the institution responsible for direct communication with the World Health Organization, the US CDC, and other international organizations and jurisdictions. During outbreak situations, the Agency should work to maximize mutual learning by ensuring an effective liaison with international organizations and jurisdictions.

## **CHAPTER FOUR:**

The Health Protection and Promotion Agency, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada) implement a National Chronic Disease Prevention Strategy.

The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.

The Health Protection and Promotion Agency contribute \$125 million annually to the National Chronic Disease Prevention Strategy. Funding for the Strategy should be part of the Agency's flow through transfers program designed to strengthen local and regional health protection and promotion capacity.

Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis and reports of any such evaluation made public.

The federal government, through the Health Protection and Promotion Agency, invest \$100 million annually beginning within the next 12 to 18 months for the realization of a National Immunization Program whereby the federal government would purchase agreed-upon new vaccines to meet provincial and territorial needs, support a consolidated information system to track vaccinations and immunization coverage and track Vaccine-Associated Adverse Events through increased funding for surveillance and a mandatory reporting requirement, and provide funding for research on possible long-term adverse effects of vaccines.

## **CHAPTER FIVE:**

Between now and the end of 2004, priority for federal spending on health protection and promotion should be given to the following twelve (12) initiatives:

- The establishment of the Transitional Health Protection and Promotion Board which should eventually lead to the creation of the Health Protection and Promotion Agency (3 months);
- The creation of the Health Protection and Promotion Agency by Order-in-Council before the end of the current fiscal year (4 months);
- The development of directives, guidelines and testing protocols to assist health professionals, hospitals and laboratories in preparation for the next respiratory virus season (3 months);

- Initial investment to facilitate immediate preparedness for a possible return of SARS during the winter season of respiratory illnesses (3 to 6 months);
- Further investment in infectious disease surveillance and control with the view of enhancing surveillance capacity at the local and regional level initially (12 months);
- F/P/T review of the capacity and protocols of public health laboratories to respond effectively and collaboratively to the next serious infectious disease outbreak (12 months);
- Meeting of the F/P/T Conference of Deputy Ministers of Health to initiate discussions on a new network for communicable disease control (3 months);
- As a first step, increasing enrolment in existing university and community college programs in the field of health protection and promotion; then, undertaking the establishment of the Virtual School of Public Health (12 months);
- National Immunization Program (12 months);
- Begin F/P/T negotiations on the creation of the Health Alert System (12 months);
- Initiate negotiations with Canada Health Infoway Inc. to set up appropriate information technology to improve both surveillance and communication systems (12 months);
- Initiate transfer of physical and human resources from the Population and Public Health Branch to the Health Protection and Promotion Agency (12 months).





**APPENDIX B**  
**LIST OF WITNESSES**

(2<sup>nd</sup> Session, 37<sup>th</sup> Parliament)

NAME	ORGANIZATION	DATE OF APPEARANCE
James Harlick, <i>Assistant Deputy Minister</i>	Office of Critical Infrastructure Protection and Emergency Preparedness	September 17, 2003
Gary O'Bright, <i>Director General of Operations</i>	Office of Critical Infrastructure Protection and Emergency Preparedness	September 17, 2003
Scott Broughton, <i>Assistant Deputy Minister, Population and Public Health Branch</i>	Health Canada	September 17, 2003
Paul Gully, <i>Senior Director General, Population and Public Health Branch</i>	Health Canada	September 17, 2003
David Mowat, <i>Director, Centre for Surveillance Coordination</i>	Health Canada	September 17, 2003
Andrew Marsland, <i>Acting Assistant General, Market and Industry Services Branch</i>	Agriculture and Agri-Food Canada	September 18, 2003
Gilles Lavoie, <i>Senior Director General, Market and Industry Services Branch</i>	Agriculture and Agri-Food Canada	September 18, 2003
Judith Bossé, <i>Vice-President, Science</i>	Canadian Food Inspection Agency	September 18, 2003
Dr. Karen Dodds, <i>Director General, Food Directorate, Health Products and Food Branch</i>	Health Canada	September 18, 2003
Mohamed Karmali, <i>Director General, Laboratory for Foodborne Zoonoses, Population and Public Health Branch</i>	Health Canada	September 24, 2003*
Frank Plummer, <i>Scientific Director, National Microbiology Laboratory</i>	Health Canada	September 24, 2003*

Paul Kitching, <i>Director, Winnipeg Laboratory</i>	Canadian Food Inspection Agency	September 24, 2003*
Judith Bossé, <i>Vice-President, Science</i>	Canadian Food Inspection Agency	September 24, 2003
Dr. David Butler-Jones, <i>Former Chief Medical Officer for Saskatchewan</i>	As an individual	September 25, 2003
Dr. Colin D’Cunha, <i>Commissioner of Health, Chief Medical Officer and Assistant Deputy Minister</i>	Ministry of Health and Long-Term Care Ontario	September 25, 2003
Dr. Richard Massé, <i>Chief Executive Officer</i>	Institut national de santé publique du Québec	September 25, 2003
Ron Zapp, <i>Provincial Executive Officer</i>	British Columbia Centre for Disease Control	September 25, 2003
Dr. Christian Mills, <i>President</i>	Canadian Public Health Association	October 1, 2003
Dr. Joseph Losos, <i>Director, Institute of Population Health</i>	University of Ottawa	October 1, 2003
Dr. Elinor Wilson, <i>Co-Chair</i>	Canadian Coalition for Public Health in the 21 <sup>st</sup> Century	October 2, 2003
Dr. Maureen Law, <i>Member</i>	Canadian Coalition for Public Health in the 21 <sup>st</sup> Century	October 2, 2003
Rob Calnan, <i>President</i>	Canadian Nurses Association	October 8, 2003**
Lucille Auffrey, <i>Executive Director</i>	Canadian Nurses Association	October 8, 2003
Dr. Sunil Patel, <i>President</i>	Canadian Medical Association	October 8, 2003
Dr. Isra Levy, <i>Director, Office for Public Health</i>	Canadian Medical Association	October 8, 2003
Bill Tholl, <i>C.E.O. and Secretary General</i>	Canadian Medical Association	October 8, 2003

Dr. John Frank, <i>Professor, Department of Public Health Science, Faculty of Medicine</i>	University of Toronto	October 8, 2003
Dr. David Naylor, <i>Dean, Faculty of Medicine</i>	University of Toronto	October 9, 2003
Dr. James Hughes, <i>Director, National Center for Infectious Diseases</i>	U.S. Centers for Disease Control and Prevention	October 22, 2003

\* Fact-finding activity

\*\* Fact-finding activity and public hearing



#### OTHER WRITTEN SUBMISSIONS RECEIVED:

Ken Thomson, Chair, Hub Team

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