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Understanding the Role of Intergovernmental Relations On Public Health Policy: A Case Study of Emergency Preparedness and Response

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responsibility over most issues affecting public health as well as medical services in the case of a health emergency, whatever the cause. However, given the broad implications of ensuring health security the federal government also has some key responsibilities. These include potential authority over national emergencies, border control, intelligence networks within the country and with other nation-states, and relations with foreign governments and international organizations. In the public health sphere more specifically, Ottawa's powers are more limited. Yet these powers are integral to the overall effectiveness of Canada's public health regime, including for example, quarantine and criminal legislation affecting public health, among other responsibilities.

Together then, the need to rethink Canada's approach to emergency preparedness and response in the public health domain, and the federalism / intergovernmental backdrop against which this will take place, provide the subject matter of this case study. The principal organizing effort for the purposes of this study is the Government of Canada's announced "federal strategy" to improve Canada's public health system generally, and to better prepare for and respond to public health emergencies more specifically. Central to the federal government's plan is the newly-created PHAC and the appointment of the CPHO, a prime responsibility of both being to prepare for future public health emergencies. The third key component of this federal strategy is the creation of the Pan-Canadian e

BACKGROUND

of any one jurisdiction, and, they, therefore, required advanced processes and institutions to manage intergovernmental, and intra-governmental, cooperation. However, at the time, there was no specific legislation, policies, or agreements that linked the separate components of public health functions among the three orders of government. No formal agreements existed to clearly assign roles and responsibilities to deal with issues such as information sharing and ownership, privacy, and the consequences of governmental non-compliance with these terms. Instead, "there is a void; current health surveillance activities are largely carried out on an ad hoc basis" (Auditor General of Canada 1999, 11). The follow-up report three years later in 2002 recognized that "limited progress" had been made, but maintained the core of its criticisms from 1999, finding the situation still worrisome (Auditor General of Canada 2002).

A second key event was the terrorist attacks on the World Trade Center in New York City in September 2001, and the subsequent anthrax attacks in the United States throughout the fall of 2001. The fear of future attacks of this nature led to a complete rethinking of Canada's approach to national security, preparation for possible terrorist threats and its emergency planning in the case of conventional or chemical, biological or radio-nuclear (CBRN) terrorism. In the immediate aftermath of the attacks, Health Canada quickly expanded the National Emergency Stockpile System to respond to the increased need for various pharmaceuticals (e.g., vaccines, etc...) to treat and protect Canadians from chemical agents like anthrax and from infectious diseases such as small pox (Health Canada 2002a, 32). As well, in October 2001, the federal-provincial / territorial (F/P/T) Deputy Ministers of Health created the Special Task Force on Emergency Preparedness and Response and charged it with developing recommendations on how best to prepare the country for any kind of possible health emergency. The recommendations brought forward by this intergovernmental group led to the creation of the F/P/T Network on Emergency Preparedness and Response that began the process of creating a more integrated and seamless emergency response system in Canada on health-related issues (Health Canada 2003, 100-2). At the same time, the federal government also began rethinking its national emergency response protocols and legislation given the

In the aftermath of the SARS crisis, it was soon obvious to both Ottawa and to Queen's Park that a serious reexamination of the public health system was called for, particularly related to emergency preparedness and response. In fact, the Ontario government had committed to a public enquiry on June 10, 2003, even before the crisis itself was officially over.[2] For its part, the federal government responded even more quickly with the announcement of the National Advisory Committee on SARS and Public Health on May 6, 2003. Chaired by Dr. David Naylor, Dean of Medicine at the University of Toronto, the committee was struck specifically to provide a "third party assessment of current public health efforts and lessons learned for ongoing and future infectious disease control." This committee would release the most influential of the SARS reports, *Learning from SARS: Renewal of Public Health in Canada* in the fall of 2003. This report highlighted many of the health and governance-related deficiencies that contributed to the severity of the SARS crisis in Toronto and made a series of recommendations on how to prevent another SARS outbreak. More importantly, however, and picking up on previous criticisms of the public health framework in Canada, *Learning from SARS* laid out an ambitious series of recommendations that would in many ways reinvent the public health system in Canada, particularly at the federal level.

In his report, Dr. Naylor proposed a number of innovations: the creation of a national public health agency; the appointment of a national public health officer; an advisory panel to guide the work of the agency and the CPHO that would include provincial and territorial representation; and, the development of a national public health strategy to guide the work of the agency. Taken together, these recommendations amounted to a wholesale reinvention of the Canadian public health system, with a particular emphasis placed on the question of emergency preparedness and response. Remarkably, for an investigation of what was chiefly a complicated medical crisis, a heavy emphasis had been placed on questions of jurisdiction and governance, both in terms of problems with the system and the proposed solutions, as had been the case with the reports made by the Auditor-General in 1999 and 2002. For the federal government, designing a response to

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public health and made a long series of specific recommendations to strengthen and clarify provincial powers in the event of another public health emergency, including significant amendments to Ontario's *Health Protection and Promotion Act* and *Emergency*

(Wilson & MacLennan 2006, 3-13).[5] This clause can be utilized for issues in which intra and extra provincial implications of the issues are linked, for when provinces are not able to regulate effectively on their own and for when failure of one province to regulate would affect the health of residents of other provinces (*Schneider* v. *R.* 1982. 2 S.C.R. 112 at 142 qtd. in M. Jackman 200, 96).[6] Infectious disease outbreaks could be argued as meeting each of these three criteria, particularly at early stages of the outbreak where the nature of the disease and how it is spread is not clearly understood.

However, it is under POGG's emergency branch that the clearest jurisdiction exists for the federal government to legislate in relation to a public health emergency. The federal parliament has enacted two pieces of legislation to equip the government's preparations for and response to national emergencies when they occur, including those related

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can be traced back to the efforts of F/P/T Ministers of Health who in 2003 agreed to work collaboratively on a number of key issues related to emergency response (e.g.,

emergency management. An integral part of this framework is the identification of the international migration of infectious diseases and the possibility of bio-terrorist attacks as key security threats to Canadians. In response, the policy reiterated the federal decision to create the public health agency and the appointment of the CPHO. It also called for a number of specific actions including: the creation of health emergency response teams; the replenishment of the National Emergency Services Stockpile System; enhanced laboratory capacity; enhanced public health surveillance; $300 million to provinces and territories for the National Immunization Strategy; and, $100 million to provinces and territories to support public health systems "at the front line." In sum, the national security framework intends to integrate its efforts to renew the federal leadership in public health with the government's broader action plan for emergency preparedness.

PUBLIC HEALTH IN THE INTERGOVERNMENTAL CONTEXT

There is a great deal of interdependence among the three orders of government when it comes to managing public health in general, and in preparing for and responding to public health emergencies more specifically. Clearly, each order of government has certain tools to bring to the table. As well, even after a cursory look at the new public health "regime" put in place at the federal level, the basic form of intergovernmental relationship that is intended is one of collaboration. In fact, the government explicitly chose this form of intergovernmental relationship for new Federal Strategy as part of the process in creating the new structures. In recommending the need for a more robust federal role in public health, the Naylor Report considered a more-centralized model in which the federal government, through legislative mechanisms or strong conditions attached to transfers, would direct provincial or local public health activities. This course was rejected explicitly due to the perceived increased potential for intergovernmental conflict. Instead the report suggested that Canada adopt a model in which the federal government, largely through a new national public health agency, would work"collaboratively" with the provinces and regions (Health Canada 2003).

collaborative intergovernmental mechanisms to manage public health and public health emergencies. These mechanisms would be based on respect for jurisdictional responsibilities, flexibility in allowing for provincial variation and accountability through meaningful and measurable outcomes. The resulting recommendation by the Working Group was the creation of the Pan-Canadian Health Network to provide a new "intergovernmental framework focused around a 'rules-based' approach to federal/provincial/territorial relations." The other components of the strategy, the national agency and the CPHO, would be about "aligning federal resources and responsibilities in order to effectively exercise national leadership – in other words, getting the federal house in order" (Health Canada 2004).[9]

In their assessment of the overall federal approach, public health officials spoken to for this study, whether federal, provincial or local, all characterized the new system in Canada as collaborative, where cooperation among officials and health care workers from all three levels was the watchword. What's more, many officials argued that there was a clear linkage between the type of collaboration that was developing and the way in which emergencies themselves develop. In their view, public health emergencies, whether from infectious disease outbreaks or stemming from natural disasters, always begin locally. And while, they can usually be contained at the local level with local resources, they can sometimes grow in threat and become either a province-wide emergency or, eventually, a national concern requiring federal action. As one representative noted: "[i]n terms of emergencies, I think we still have to stick by the same idea that the response is local first, then provincial and then national for a variety of reasons. One, in terms of recognition and immediate response...most emergencies will be local, certainly if they're natural disasters, but public health emergencies, infectious diseases, as well will probably be local. Therefore, our role nationally would be...to assist in the ability of those other levels of government to intervene. If it became a national emergency then the responsibility to lead, coordinate, ensure collaboration, and so on and so forth is different, but I still think that the premise that one starts locally and moves from there is still the same. However, that means that we have to be involved in improving the capacity at the local level in order to respond."

One implication from this reasoning is that the form of collaboration that is developing on public health emergencies is one that is molded to the subject matter itself, rather than to constitutional roles and responsibilities. On the issue of emergencies in particular, it appears as though the federal government is cultivating a truly collaborative approach, in recognition of the vital role played by the provinces. At the same time, moreover, it is creating the necessary federal institutions and tools to enable it to lead in setting national priorities on public health while effectively showing leadership in the exercise of those national interests. To what extent the initiatives that flow from this federal leadership within a collaborative framework will produce the necessary changes called for by Dr. Naylor and the other committees looking into SARS and public health in Canada remains to be seen.

It is still very early in the process to evaluate the effectiveness of the intergovernmental relationships that are being developed in public health emergency and response. At the time of the writing of this paper, the new public health agency and CPHO are still in their infancy and the Pan-Canadian Sl я ‘ Ⅵ ♣ ╓ ₴ tgof d

gaps themselves. The irony here seems to be that, everyone sup

Another policy expert underscored the fact that the new strategy, particularly the Pan-Canadian Public Health Network, was bringing a new clarity to the efforts that have been ongoing since at least fall 2001. The vast majority of the work of this network, which as noted is comprised of senior representatives from federal and provincial / territorial governments, is executed by a series of "expert groups," including the pre-existing Expert Group (formerly F/P/T Network) on Emergency Preparedness and Response. This group, which had been charged with developing a national framework, now has an F/P/T body dedicated to public health and made up largely of public health professionals to which it reports and takes direction on an ongoing basis. As was noted, "this expert group occupies the full spectrum of professional streams that need to be consulted and engaged when developing public health policy for managing...public health emergencies."

While the majority of opinion certainly favoured the intergovernmental *approach* that had been chosen to put in place to build the new public health emergencies framework called for by Naylor and others, a few voices raised concerns about the actual *effectiveness* of the measures taken thus far to close the policy gap. Here the argument is reasonably simple and driven in large part by the relatively early days of the new F/P/T process that has been put in place under federal leadership. Some felt it was too early to assume that the collaborative efforts currently underway – and it is important to point out that even here the approach was not questioned, just the results – would necessarily lead to a well-coordinated, emergency response framework capable of meeting the next pandemic. As one official cautioned, "I'm an avid believer in that these [collaborative efforts] are the right ways to go, but they just have not been implemented yet in an effective way and it will take some time.

Communications Management

On the question of communications, the SARS crisis made readily apparent the utter lack of coordination across the three levels of gover

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governments under the International Health Regulations. At one point, the Martin government appeared to recognize this problem with its intended comprehensive overhaul of federal public health legislation into a single, integrated public health act, but in the end it remained an unmet priority, and it was never clear if specific changes were in the offing in regards to the government's emergency powers. What is clear is that the federal government needs some type of in-between legislation to allow it a greater role in the event of a serious public health emergency – but one which may not necessarily constitute a national crisis. Whether this is a separate public health emergencies act or special emergency powers as part of a greater federal public health act, the government needs to more clearly identify its role in the event of another SARS and equip itself ac¾ u þ מ ♣ ` מ Y M ` ╣ ▒ \

Table 1 Overview of Government Approach

Key Elements:

1. **National Public Health Agency –** responsible for coordinating and building national readiness ta Þ M ƨ e len ₹ e in a ﻍ e Þ Z ₴ ɱ ▒ ╔ ╔ ⊓ ⌠ M ╣ M **ɬney**

Table 2 Overview of

Table 3 Allocation of Roles and Responsibilities in Emergency Preparedness and Response

Activities	Federal	Provincial/ Territorial	Local	Supranational
Agenda/standard setting	X	X	X	X
Legislative authority	X	X		
Regulation and/or safety assessment	X	X	varies	
Funding responsibilities	X	X	varies	
Inspection and enforcement	X	X	X	
Promotion and related funding	X	X	X	
Information provision	X	X	X	

Table 4 Nature of the Intergovernmental Relationship in Emergency Preparedness and Response

	Hierarchical	Interdependent	*Form of Relationship*
Federal-provincial	No	Yes	Collaborative
Federal-local	No	Yes	Collaborative
Provincial-local	Varies	Varies	Varies

Endnotes

[1] Ontario declared that SARS was a communicable and virulent disease. This allowed the medical officer of health, under the Health Protection and Promotion Act, to "by a written order…require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease." Such orders include "requiring any person that the order states has or may have a communicable disease or is or may be infected with an agent of a communicable disease to isolate himself or herself and remain in isolation from other persons". Health Protection and Promotion Act R.S.O. 1990, Chapter H.7

[2] The SARS Commission was created by Order-in-Council of the government of Ontario on June 10, 2003 with Ontario Justice Archie Campbell appointed as chair. The goals of the commission were to examine the introduction, spread and management of SARS in lth Protecing any Coomnage

2002. “Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy,” *University of Toronto Law Journal* (50):163-252.

[5] See also Choudhry, S. 2002. "Recasting Social Canada: A Reconsideration of Federal Jurisdiction Over Social Policy." *University of Toronto Law Journal* 52(3):163-252.

[6] See also Peter W. Hogg. 2004. *Constitutional Law of Canada* (Student Edition 2004) Scarborough: Thompson Canada Ltd.: 446, where he notes: “It seems, therefore, that the most important element of national concern is a need for one national law which cannot realistically be satisfied by cooperative provincial action because the failure of one province to cooperate would carry with it adverse consequences for the residents of other provinces.”

[7] Available at http://www.pco-bcp.gc.ca/default.asp?Page= which n

February 2, 2004, 7 and *Speech from the Throne*, October 5, 2004, 8. See also Government of Canada. 2005. *Securing an Open Society: One Year Later. Progress Report on the Implementation of Canada's National Security Policy*: 19-20.

[14] See Kumanan Wilson and Harvey Lazar. 2005. "Planning for the Next Pandemic Threat: Defining the Federal Role in Public Health Emergencies," *Policy Matters* 6 (5).

[15] *Emergencies Act* (R.S. 1985, c. 22 (4th Supp.)).

[16] On the government's use and the public's response to the *War Measures Act* see Christopher MacLennan. 2003. *Toward the Charter: Canadians and the Demand for a National Bill of Rights, 1929-1960*. Montreal: MQUP.

[17] See Kumanan Wilson and Harvey Lazar. 2005. "Planning for the Next Pandemic Threat: Defining the Federal Role in Public Health Emergencies," Policy Matters 6 (5).

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