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MLI

True North in Canadian public policy

Commentary

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The Public Health Agency of Canada: The risk of mission creep and the need for review

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Introduction

The Public Health Agency of Canada (PHAC) celebrated its twelfth anniversary last month. Its first dozen years have been eventful. The period has been marked by new and evolving public health issues, the growing spec-tre of pandemics and bioterrorism, and pathbreaking insights into disease and injury prevention. There is little doubt that the next 12 years will witness a new set of public health opportunities and challenges. PHAC will presumably be at the centre of these developments and trends.

Yet, despite PHAC's important mandate, its activities and functions do not tend to generate much public attention, especially in the absence of a health crisis such as the Listeriosis outbreak in 2008 and the H1N1 flu pandemic in 2009. What is PHAC's origins? What does it do? Why does it exist? What can it do to deliver better on its mandate?

This short essay seeks to answer these questions. It provides some insight into PHAC's origins, its size and scope, how its work may interact with the provinces and territories, and possible reforms to focus its efforts and resources on its core responsibilities. Our analysis builds on MLI's ongoing work on the role of the federal Department of Health and its attendant agencies.

This year-long project began with a working hypothesis that federal policy-makers, the media, and the general public have not given enough fundamental thought about Ottawa's role in health care. How did it start? What is its role? Why do we have a federal Department of Health but no Department of Education? We have sought to answer these questions and more in an effort to make judgments about the extent to which the federal government helps or hinders progress on improving health outcomes in Canada.

This final installment recognizes that there is indeed a national role for emergency and pandemic preparedness as well as managing federal laboratories. But there is also a great risk of "mission creep." Ottawa should reverse any of PHAC's activities that duplicate provincial and territorial efforts or activities undertaken by the federal Department of Health or funded by the Canadian Institutes of Health Research.

The federal government should thus launch a comprehensive principle-based review to affirm PHAC's activities that are firmly rooted in areas of national scope such as international and interprovincial health emergencies and withdraw activities that overlap with the Department of Health or fall within provincial and territorial purview. The review should in particular target PHAC's activities and spending related to "Health Promotion and Disease Prevention," which presently comprises 55 percent of the agency's budget and is most at risk of duplicating other federal activities and intruding into provincial and territorial responsibilities.

Origins of the Public Health Agency of Canada

PHAC came into effect in 2004/05. It is the newest institutional part of Ottawa's health portfolio.[1] The agency was created to strengthen Canada's ability to respond to public health threats and disease epidemics such as the 2003 SARS crisis (Canadian Press 2017). The agency's establishment was driven in large part by a report produced by an independent commission led by health scholar David Naylor. This report argued in the aftermath of the SARS crisis that:

> The current federal arrangement puts public health professionals inside a very large department with a highly process-oriented culture geared to meeting the political issues of the day. Vesting those functions in an arm's-length agency would enhance the credibility and independence of federal activities in public health, and offer more flexibility in terms of employment and partnerships with NGOs. An agency could also better foster a collaborative F/P/T [federal, provincial, territorial] culture rooted in shared expertise among public health professionals. The creation of an agency cannot depoliticize interactions among jurisdictions, but it can reduce the chances that the health of Canadians would inadvertently be held hostage in a jurisdictional disagreement among levels of government. Among our key recommendations therefore is that the Government of Canada create a new Canadian Agency for Public Health, led by a Chief Public Health Officer of Canada. (Naylor et al. 2003, 4)

This background is important because it can be easy to forget that PHAC's current role is the result of new and deliberate choices in the modern age – a consolidation of activities that occurred less than 15 years ago.

Previously these responsibilities were principally carried out by the public health branch inside the Department of Health. This group's activities included Infectious Disease Prevention and Control, Chronic Disease Prevention and Control, Emergency Preparedness and Response, Surveillance Coordination, and Healthy Human Development. It also oversaw the National Microbiology Laboratory in Winnipeg and the Laboratory for Foodborne Zoonoses in Guelph (Naylor et al. 2003).

The SARS crisis and the Naylor commission prompted a reconsideration of Ottawa's institutional structure for health policy, research, and emergency preparedness. The Naylor commission argued that the old model was ineffective due to a lack of funding and capacity, the invariable role of interprovincial politics, and the absence of centralized coordination in the event of a crisis. Its report pointed to the US Centers for Disease Control and Prevention and Australia's federal spending on public health as better models for Canada to emulate.

The commission lamented the lack of "national health goals," a "national strategy," and a "national strategic plan." Basically variations of "national strategy" appear dozens of times in the commission's report. One gets the sense that the commission members were frustrated with Canada's constitutional architecture and provincial/

territorial responsibility for health care administration and delivery. Instead their underlying vision sought a "seamless multi-tiered public health system, knitted together by inter-governmental agreements and harmonized legislation or regulation" (5).

This line of thinking is not uncommon in Ottawa. Politicians, public servants, and stakeholders pay lip service to federalism. But a centralizing impulse was alive and well then and remains vibrant today. Euphemisms about the inherent virtues of national strategies on one hand, and the self-evident flaws of so-called "patchworks" on the other hand, provide the vocabulary for this persuasion (Speer 2018b). This tendency is certainly present in the ongoing agitation for a federal pharmacare scheme (Speer 2018c).

It was also the case in the context of the Naylor commission's report. The then-Liberal government, which was concurrently in the process of expanding Ottawa's role in health care in the form of the 10-year health accord, accepted the commission's arguments and in turn launched the Public Agency of Canada in 2004.

This does not mean that the Naylor commission's findings were unjustified or there was no case for PHAC. The combination of the September 11 attacks and the subsequent SARS crisis were powerful and tragic reminders of the risk of global terrorism in general and the possible threat posed by bioterrorism in particular. The SARS crisis also demonstrated the need for a strong federal role in coordinating a response to a global pandemic. The Naylor commission's observation about separating these issues from day-to-day politics is sensible.

These extraordinary circumstances require a degree of centralized, evidence-based leadership that can work with international organizations and coordinate a cross-national response. This is the primary reason that PHAC is led by Canada's Chief Public Health Officer. The person in this role is the Deputy Minister responsible for PHAC who reports to the Minister of Health. As the federal government's lead public health official, the Chief Public Health Officer also coordinates with federal officials, his or her provincial and territorial counterparts, and international bodies on pandemics and heath-related emergencies. He or she also tends to have a greater level of public engagement than most senior public servants. The current Public Health Officer is Dr. Theresa Tam. The pediatric infectious disease specialist was appointed in June 2017. She is the third person to occupy this role (Canadian Press 2017).

It is notable however that while PHAC's initial conception came out of the SARS crisis, its mandate was much more expansive essentially from the outset. The agency's mandate is rooted in the *Public Health Agency of Canada Act*, which was effectuated in 2006. The law's preamble basically spells out the government's thinking about PHAC and its mission:

> WHEREAS the Government of Canada wishes to take public health measures, including measures relating to health protection and promotion, population health assessment, health surveillance, disease and injury prevention, and public health emergency preparedness and response;
>
> WHEREAS the Government of Canada wishes to foster collaboration within the field of public health and to coordinate federal policies and programs in the area of public health;
>
> WHEREAS the Government of Canada wishes to promote cooperation and consultation in the field of public health with provincial and territorial governments;
>
> WHEREAS the Government of Canada also wishes to foster cooperation in that field with foreign governments and international organizations, as well as other interested persons or organizations;
>
> AND WHEREAS the Government of Canada considers that the creation of a public health agency for Canada and the appointment of a Chief Public Health Officer will contribute to federal efforts to identify and reduce public health risk factors and to support national readiness for public health threats. (Public Health Agency of Canada Act 2006)

This broad and general mandate for PHAC self-evidently exceeds significant yet narrow concerns about the threat of health-related emergencies. The focus on "collaboration" and "cooperation" is a euphemistic reflection of the then-government's greater federal role in the Canadian health care system. The 2004 Health Accord was the signature expression of this impulse (Speer 2016).

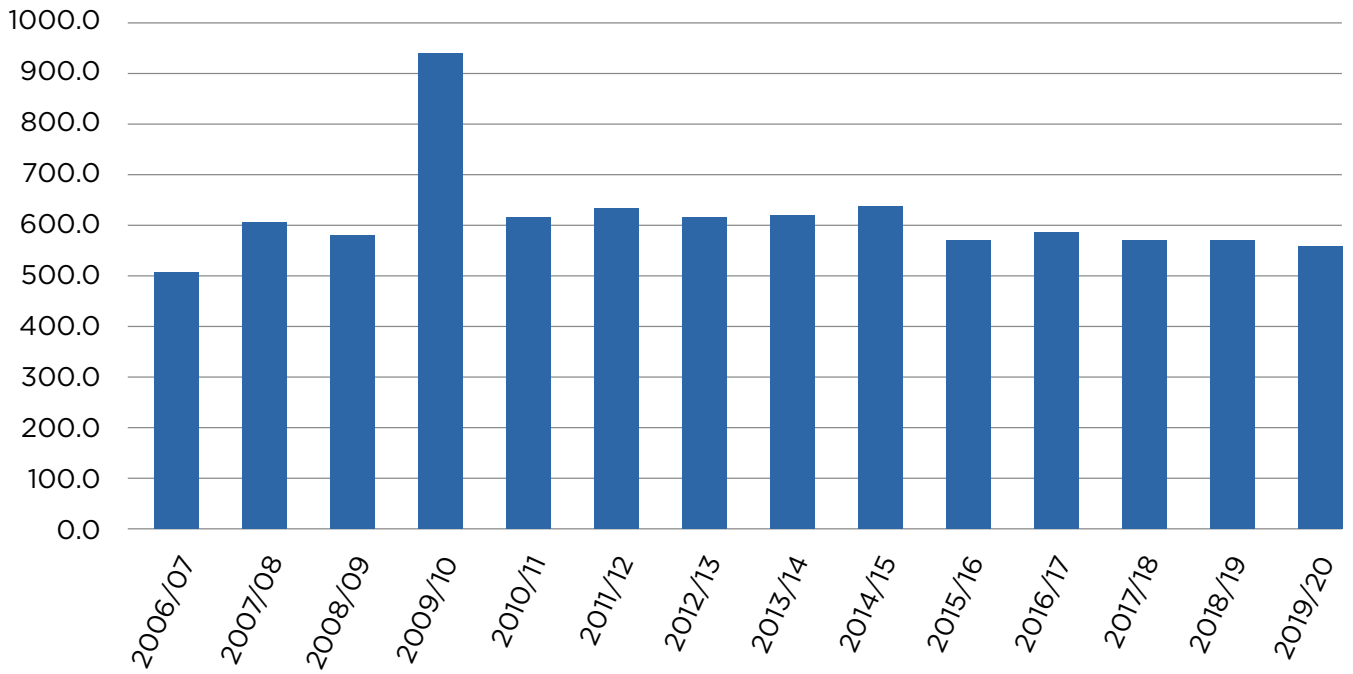
The proximity between the health accord and the creation of PHAC exhibits the centralized impulse of the era. The 10-year health accord was reached in February 2003 (Department of Finance Canada 2012). PHAC's founding is the result of an order in council in September 2004 (PHAC 2009). And if there was any doubt, PHAC's first departmental report to Parliament notes: "The creation of the Agency marks the beginning of a new approach to federal leadership and to collaboration with provinces and territories toward efforts to renew the public health system in Canada and support a sustainable health care system" (Dosanjh 2005, 9).

This origin is important to understand that PHAC's risk of "mission creep" was inherent from the beginning. It was basically embedded in the agency's DNA at its conception. The government and its independent commission basically transformed legitimate concerns about Canada's capacity to respond to major health-related emergencies such as SARS into the basis for a major, new federal agency involved in various aspects of the health care system. As we examine in the next section, this trend of aggrandizement away from PHAC's initial impetus risks producing overlap and duplication with the federal Department of Health as well as health care activities of the provinces and territories.

Current primer on the Public Health Agency of Canada

Today PHAC employs about 1800 people and its current budget is roughly $570 million per year (Philpott 2018). Its budget resources have fluctuated a bit (see chart 1) due to short-term issues, such as when it had to deal with the listeriosis outbreak in 2008 and H1N1 in 2009.

CHART 1: PHAC'S ANNUAL BUDGET, 2006/07 TO 2019/20 ($MILLIONS)



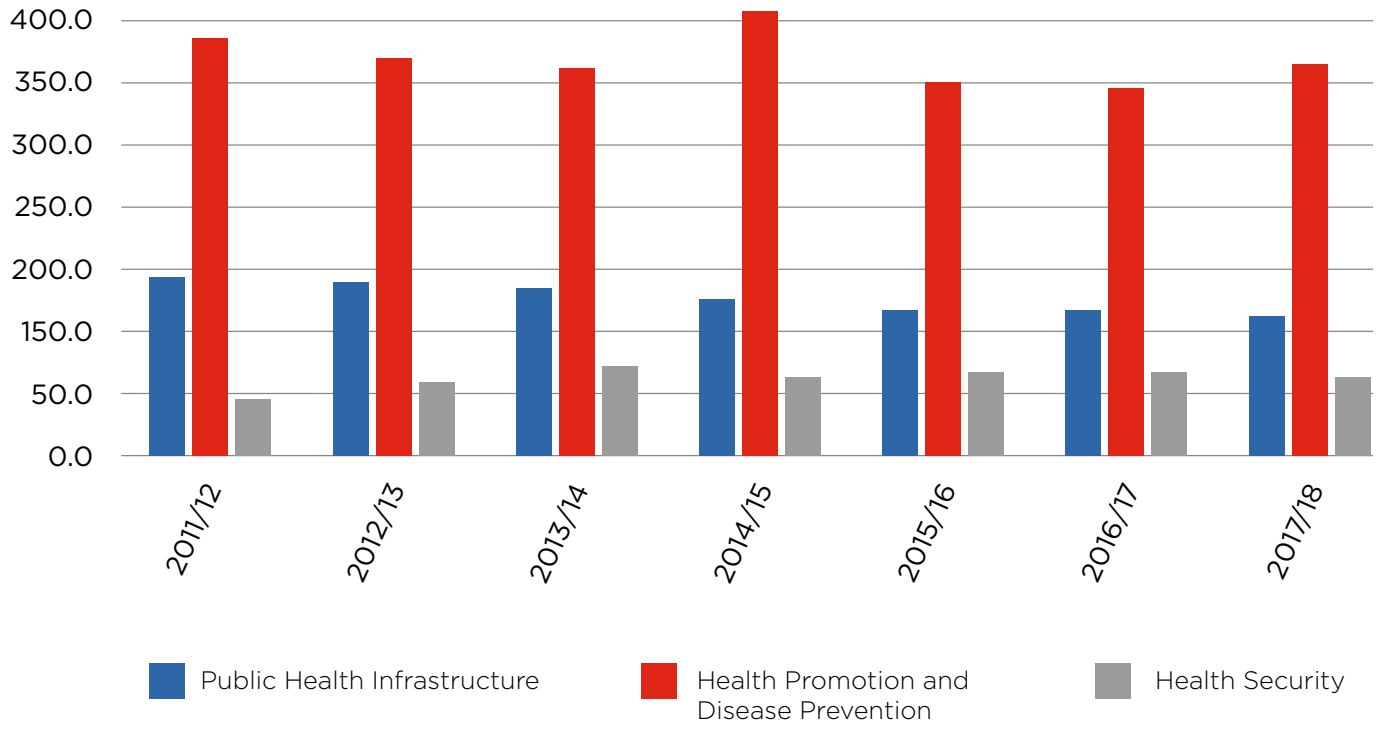
Source: PHAC 2016

This type of fiscal responsiveness is intuitive in light of PHAC's activities related to emergencies and pandemics. But that does not tell the full story. It is worth drilling down a bit into the composition of its spending to better understand how its resources are allocated.

PHAC currently has three programmatic areas: (1) Public Health Infrastructure, which involves managing public health laboratories, (2) Health Promotion and Disease Prevention, which involves dissemination of health research and information, and (3) Health Security, which involves prevention and preparedness for major public health events and emergencies. Internal services are the other source of spending.

The agency has used this programmatic structure to report on its activities for seven years since 2011/12. Previously its activities and spending were organized in several different areas. The current organization enables us to track spending in these different areas over time to observe the overall composition of PHAC's spending and whether it has changed (see chart 2).

CHART 2: PHAC'S SPENDING BY PROGAMMATIC AREA, 2011/12 TO 2017/18 ($MILLIONS)



Source: PHAC 2016

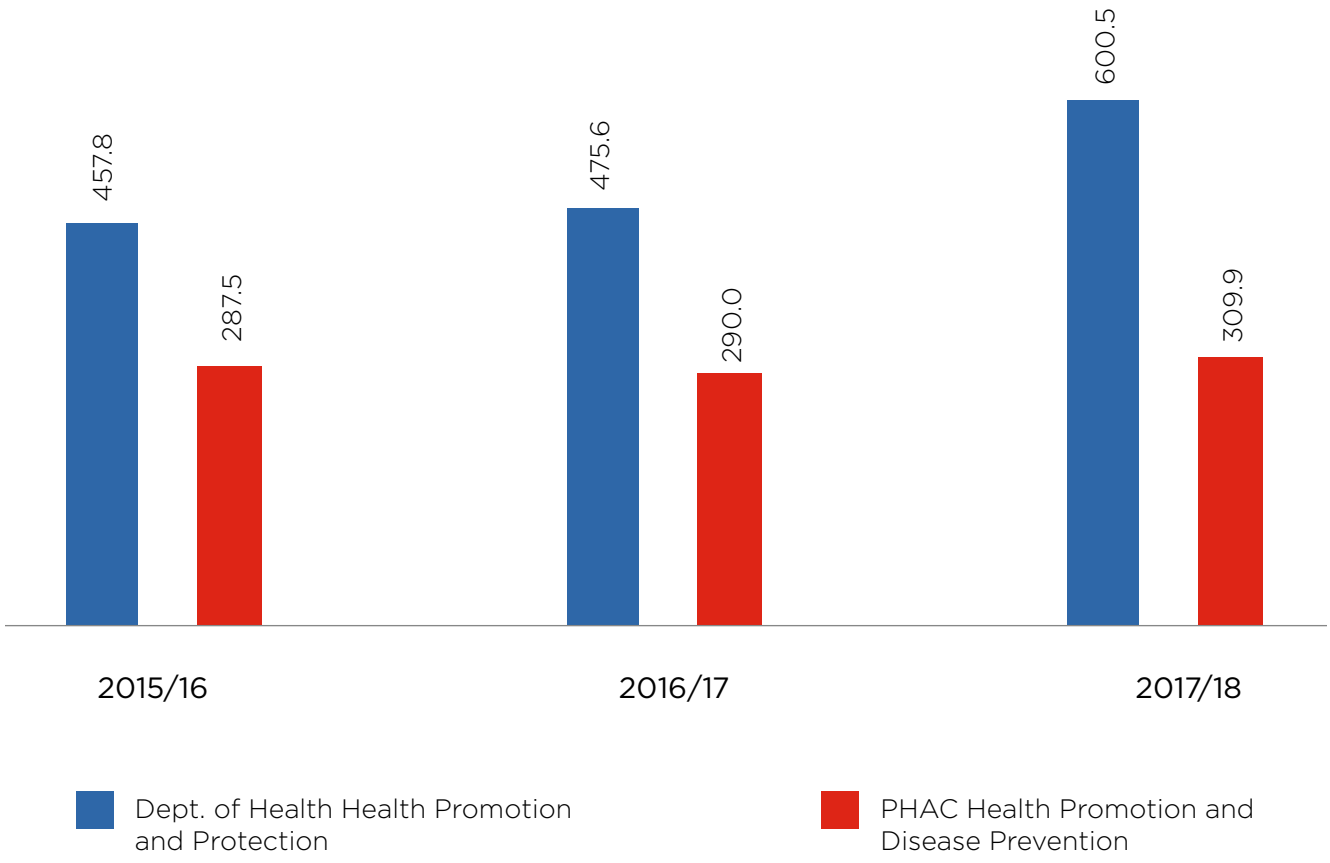
What is interesting about this fiscal distribution is the relative importance of health security, which of course was the major impetus for PHAC in the first place. There were various considerations that led to the agency, but remember its origins ultimately stem from the SARS crisis and the view of the Naylor commission and others that Canada's health care system needed greater coordination to respond to such crises. This seems like a highly defensible perspective and indeed a rightful role for the federal government given that health emergencies (such as pandemics) do not respect international or provincial borders.

PHAC's role managing and overseeing public laboratories also seems like a basic "public good," as is typically described in public administration literature. It is notable for instance that the agency's National Microbiology Laboratory played a significant role in developing an Ebola vaccine that helped to respond to public health crises abroad including most recently in the Democratic Republic of Congo in August 2018 (Canada 2018).

PHAC's second programmatic area – Health Promotion and Disease Prevention – is however seemingly further outside the federal government's core functions and responsibilities. And that it is 55 percent of the agency's overall budget appears to conflict with the ideas and imperatives that shaped its creation in the first place. This spending is presumably the most at risk of intruding into provincial and territorial jurisdiction and duplicating activities presently undertaken by the federal Department of Health (Speer 2018a).

This ought to be a sign that there is scope to scrutinize PHAC's activities and spending relative to the provinces and territories and the federal Department of Health. We identified a similar issue in an earlier report on the Department of Health. It is notable for instance that the Department of Health is also spending roughly $600 million this year in the name of "health protection and promotion" (see chart 3) (Speer 2018a). The tally reaches more than $900 million in the most recent fiscal year when combined with PHAC's spending on ostensibly similar activities and functions.

CHART 3: DEPARMENT OF HEALTH AND PUBLIC HEALTH AGENCY OF CANADA, HEALTH PROMOTION AND PROTECTION/DISEASE PREVENTION, 2015/16 TO 2017/18 ($MILLIONS)



Source: Speer 2018a.

The same applies to PHAC's activities and spending relative to the provinces and territories. Several of them are also highly active in the areas of health promotion. The Ontario government for instance had a minister responsible for health promotion from 2005 to 2010. It now has an arm's-length organization called Public Health Ontario that provides scientific and technical advice on public health issues and manages Ontario's public health laboratories. Public Health Ontario (n.d.) has roughly 1000 employees and a budget of about $165 million per year.

It is incumbent on federal policy-makers therefore to conduct a comprehensive spending review to determine the extent to which PHAC's "Health Promotion and Disease Prevention" spending duplicates and overlaps with the Department of Health's "Health Promotion and Protection" activities and functions. This seems especially relevant at a time when Ottawa is running a structural budgetary deficit.

It of course does not mean that PHAC ought to be eliminated or that its budget necessarily must be significantly cut. But its health promotion budget should be scrutinized relative to the Department of Health's health promotion budget and any duplication and overlap should be eliminated one way or the other.

> "[PHAC's] health promotion budget should be scrutinized relative to the Department of Health's health promotion budget.

A similar exercise should occur vis-à-vis the provinces and territories in the name of achieving fiscal efficiencies and greater "exclusivity" – what legal scholar Asher Honickman (2017) has called "watertight compartments." It can be a bit cliché but federal policy-makers cannot forget that there is only one taxpayer. It is thus counterproductive for Ottawa and the provinces and territories to spend scarce public resources in essentially the same areas.

Such an intergovernmental review should thus include participants from the provinces and territories who are well-positioned to identify areas where Ottawa is meddling in provincial and territorial jurisdiction and contributing to sup-optimal outcomes. As former NDP finance minister Janice MacKinnon (2013) has put it: "I always tell my students that health care has been like a car. The federal and provincial governments are trying to steer it, and when we have two drivers at the steering wheel, it always goes into the ditch."

Public health promotion is a useful role for government. A wide body of research shows that public spending in this area can produce large positive spillovers for society (Merkur, Sassi, and McDaid 2013). Preparing for and responding to global pandemics and the threat of bioterrorism is also a key role for the state. But this does not mean that all or any government activities or spending in these areas are useful – particularly if it involves overlap and duplication.

A high-level review of PHAC's activities and spending relative to the Department of Health and the provinces and territories (including for instance Public Health Ontario) implies that we may have reached a point of diminishing or even negative returns.

This short essay postulates this is largely a consequence of PHAC's original conception, statutory mandate, and funding. A comprehensive review can help to clarify. Legislative reforms might logically follow. The result would not be the elimination of PHAC but rather a greater focus on its core mission and mandate.

Conclusion

PHAC's mission and mandates stems from the Naylor commission's report following the 2003 SARS crisis. The basic premise that Ottawa ought to have a role to play in heath emergencies and global pandemics is sensible. But the agency's activities have exceeded this role since its origins.

Today roughly 55 percent of PHAC's spending is about health promotion and disease prevention. Determining if or how these efforts are markedly different than what the provinces, territories, and Department of Health are doing requires a comprehensive, principle-based review.

The major takeaway of this short essay is that Ottawa should conduct a comprehensive review of PHAC's mandate and spending to ensure that it does not overlap with the Department of Health or the provinces and territories. It would enable PHAC to get back to its core mandate and minimize its intrusion into provincial and territorial jurisdiction. And, most importantly, it would ensure that PHAC is focused on the new and evolving challenges it will invariably face in its next 12 years of existence.

About the Author

Sean Speer is a Munk Senior Fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic advisor to the Prime Minister and director of policy to the Minister of Finance. He has been cited by *The Hill Times* as one of the most influential people in government and by *Embassy Magazine* as one of the top 80 people influencing Canadian foreign policy. He has written extensively about federal policy issues, including personal income taxes, government spending, social mobility, and economic competitiveness. His articles have appeared in every major national and regional newspaper in Canada (including the *Globe and Mail* and *National Post*) as well as prominent US-based publications (including *Forbes* and *The American*). Sean holds an M.A. in History from Carleton University and has studied economic history as a PhD candidate at Queen's University.

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Endnote

1 The Canada Food Inspection Agency was shifted from the agriculture portfolio to the health portfolio in 2013. But this involved the transfer of responsibility for a pre-existing agency rather than the creation of a new one (Canadian Press 2013).

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