COMMENTARY

The Complexities of Multi-level Governance in Public Health

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ABSTRACT

This article reviews some of the challenges to developing national public health programs, focussing on the distribution of constitutional authority for public health and governance challenges that arise from this.

Constitutional authority for public health resides primarily with the provinces. The federal government has obtained the authority to legislate in this area primarily through its power over criminal law. Challenges facing the establishment of national public health programs include the ambiguity over constitutional responsibility, challenges in managing externalities and spillovers, and issues related to funding and data ownership. Policy-making is also complicated by the importance of municipal and supranational governments in public health.

National programs need to be structured in a way that balances the advantages of regional approaches to public health challenges with the benefits of a coordinated central response. To do so, policy-makers need to address unique challenges to public health governance.

La traduction du résumé se trouve à la fin de l'article.

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In recent years, in response to high profile public health threats, Canada has embarked upon developing several large national public health initiatives, including the creation of a new national public health agency.[1-3] The success of these initiatives, and the ability of public health in Canada to respond to the many challenges that lie ahead, will largely depend on the ability of all levels of government to interact effectively. However, effective intergovernmental cooperation is one of the most significant challenges facing public health today. This article outlines some of the challenges associated with multi-level governance that have been encountered in developing effective public health programs.

The Constitution and Public Health

A government's fundamental role is to preserve the security of its citizenry, and as such it must be structured in a way that ensures that the health of its population is protected.[4] Canada's founding document, the *Constitution Act, 1867*, outlines the division of responsibilities between provinces and the federal government and was created at a time when infectious disease and other public health concerns that are re-entering into our collective awareness were everyday realities. Under the Constitution, the majority of *health care* responsibilities were given to the provinces. However, responsibility for public health was not as clearly allocated, with federal and provincial governments sharing responsibilities.[5-7]

Public health is considered primarily a provincial concern under section 92(13) of the *Constitution Act,* which gives the provinces responsibility for property and civil rights. Further provincial authority in this field is derived from the power they are given over matters of a local or private nature in the province (section 92(16)). Subsequent legal interpretations have recognized provincial jurisdiction over public health; specifically the prevention of communicable diseases and sanitation.[8] With this authority, provincial officials have passed legislation to govern public health.

The federal government has obtained legislative authority in the field of public health, specifically health protection, from a number of sources. Section 91(27) of the *Constitution Act* provides the federal government with power over criminal law. This allows Parliament to pass legislation to pre-

vent the transmission of a "public evil" that is a danger to public health.[9] Using this clause, the federal government has passed legislation to control transmission of health risks, including the *Food and Drugs Act* and the *Hazardous Products Act,* and in the area of environmental protection. The federal government has obtained further power under the national concern branch of the "peace, order and good government power", found in the preamble of section 91 of the *Constitution Act*, *1867*, which allows it to pass legislation to regulate matters of national health and welfare. These must be issues in which intra- and extra-provincial implications of the issues are linked, provinces are not able to regulate effectively on their own, and failure of one province to regulate would affect the health of residents of other provinces.[7,10] The extent of these powers, however, is uncertain. Specifically, the ability of the federal government to respond to a public health emergency, without the consent of the provinces, is dependent on how liberally the courts interpret federal powers that can be derived from the "peace, order and good government" clause.[11]

The federal government also obtains authority over public health by the power it is given to quarantine (section 91(11)) and regulate trade and commerce of an interprovincial or international nature (section 91(2)). As well, by virtue of the federal spending power, the federal government can involve itself in public health by providing conditional funding for public health programs or by entering into legal contracts to develop public health initiatives. Finally, by nature of its treaty-making power, the federal government can enter into international agreements and other international initiatives in this area.[12] There are, however, important limits to federal powers in public health. For example, while the *Statistics Act* and the *Department of Health Act* provide Ottawa with a mandate to collect information on public health risks of a pan-Canadian nature, Ottawa does not have the constitutional authority to require provinces/territories to transfer health surveillance data to Ottawa. These transfers must occur voluntarily.

Emerging challenges in Public Health governance

As a consequence of the initial outline of roles and responsibilities in the Constitution and subsequent interpretations, public health has emerged as a shared federal/provincial responsibility. However, there has been comparatively little jurisprudence in this area and there is ambiguity over ultimate constitutional responsibility in several specific public health domains. This has led to some important problems in the execution of public health activities, including the potential for overlaps to exist in public health functions, with multiple levels of government carrying out the same functions. Of particular concern is the possibility that important gaps may exist with no level of government carrying out important public health functions.[13] In response to this concern and concerns about variability in standards of public health practice, federal, provincial and territorial governments have developed several large collaborative public health projects.[14-16] While there is a general recognition by all levels of government that coordinated responses to public health problems are necessary, some emerging challenges in developing policies have the potential to undermine the successful execution of these programs, by leading to conflict between orders of government. These include managing issues related to *externalities and spillovers*, *funding*, and *data ownership*.

The issue of externalities and spillovers is closely linked to the primary reason why governments need to interact in public health. Threats to health produced in one region have the potential to spread and cause harm to individuals who live in other regions. For example, if one province chooses not to immunize its children against a certain condition, then the effectiveness of the immunization programs in other parts of Canada can be undermined by migration of individuals from the non-immunized province. The potential for externalities and spillovers to exist in public health necessitates coordinated governmental approaches. It also creates the need to develop national "minimum" standards. However, measures taken to protect against externalities and spillovers create situations in which one order of government may find itself coerced into action by another order.

Funding is, of course, a central concern in the current debate over health care and is also a contentious issue in public health. Once programs have been designed or established, a major obstacle is to determine which order of government is to be responsible for funding of the ongoing program. Disputes over funding have the potential to derail projects that, otherwise, have a large degree of support from all orders of government. Additionally, a unique problem that emerges in public health is the potential for the development of unfunded mandates. These mandates exist when one order of government is able to pass legislation requiring another order of government to act without providing it with the requisite funding. As an example, in the blood system, federal regulations mandating the introduction of safety measures to protect the blood supply produce costs for the provinces that place pressures on provincial health budgets.[17] Unfunded mandates are also a growing concern in provincial-local relationships as local governments are required to carry out responsibilities despite their limited revenue-generating ability and reductions in provincial funding. In the United States, the financial burden of unfunded federal mandates on state and local governments eventually resulted in the introduction of a bill under the Clinton administration curtailing the federal government's ability to introduce such legislation.[18]

Data ownership is another issue of concern to provinces entering into agreements with the federal government. For large national programs to be successful, there needs to be a sharing of data across provinces and between the provinces and the federal government. However, data sharing makes it easier for the federal government to tie funding for provincial programs to certain performance requirements. One of the obstacles to the successful institution of a national health surveillance system has been establishing national standards for data collections as well as developing data-sharing agreements between provinces and the federal government.[19,20]

Municipal and supranational governance

While the Constitution outlines the roles of the federal government and the provinces, in public health two other jurisdictions play crucial roles – local governments and supranational governments.

The salience of each of these orders of government has been made particularly clear by the response to the Severe Acute Respiratory Syndrome (SARS) outbreak. The management of the crisis was largely a local phenomenon, although close collaboration occurred with provincial and federal agencies.[21] And, while in this instance there was a commitment to fund the activities necessary to control the spread of disease, in general there is no legislative protection ensuring funding for local governments that are either mandated or choose to embark upon new public health activities. In contrast, the budget reduction initiatives of the 1990s placed considerable strain on local public health departments as the federal government reduced funding to the provinces and the provinces, in turn, downloaded these funding cuts to regional governments.[22]

On the other end of the governance spectrum are supranational governments. As we live in an increasingly global world, the importance and influence of this order of government continues to rise. A clear illustration of the impact of international agencies in the development of policy occurred when the World Health Organization announced a SARS travel advisory for the city of Toronto.[23] While supranational governance is essential in public health in order to manage externalities and spillovers that cross national borders, their actions can have enormous coercive power on the actions of a nation to whose people they are not directly accountable.[24]

Responding to Public Health governance challenges

The increasing recognition of a need for intergovernmental cooperation in public health has created a momentum to move away from states of governance, in which there are "islands of activity". The federal government could coerce greater intergovernmental coordination by using its spending power to influence the development of policy within provinces, in which case intergovernmental conflict may arise. Alternatively, more collaborative relationships could be developed through intergovernmental agreements in which federal/provincial/territorial governments develop consensus on a program.[25] This approach will minimize jurisdictional infringement, however, it will also result in more incremental policy development and creates the potential for either the federal government or one province/territory to obstruct the development of policy.[26] In general, governments have approached public health reform in a collaborative manner, the recommendations of the National Advisory Committee on SARS for public health renewal being the latest example of this and providing the most detailed approach.

Whatever form of intergovernmental relationship is developed, to be effective in the long run the structure will have to address the following issues. Governments will need to clarify who has responsibility for legislative, funding and delivery of service function to ensure that jurisdictional sovereignty is respected. Where concerns arise about infringements on sovereignty, effective dispute resolution mechanisms need to be in place to address the ensuing intergovernmental conflict. Governments should develop mechanisms by which to share funding early on in the decision-making process and, in particular, funding of programs at local levels needs to be protected. All governments need to ensure that the decision-making process is transparent and accountable – a particular challenge because many intergovernmental discussions are at risk of excluding the public due to the technical, low-profile nature of the public health issues being discussed. Further complicating effective intergovernmental relationships is the fact that all of these issues need to be addressed not only for federal and provincial/territorial interactions, but also for interactions between provincial/territorial and local governments; federal and local governments; and supranational and federal governments.

CONCLUSION

Public health programs need to be structured in a way that balances the advantages of regional approaches to public health challenges with the benefits of a coordinated central response. This challenge is particularly important for public health due to the real need for cooperation given the ease by which public health threats cross borders. The emergence of new public health threats has provided an impetus for Canadian governments to systematically address this challenge.

REFERENCES

1. The National Advisory Committee on SARS and Public Health. *Learning from SARS: Renewal of Public Health in Canada*. Ottawa: Health Canada; 2003. Available: www.hc-sc.gc.ca/english/protection/warnings/sars/learning.html (accessed 2004 May 20).
2. Schabas R. Public health: What is to be done? *CMAJ* 2002;166:1282-83.
3. "Public Health: how to ready Canada for the next crisis". Canadian Medical Association. May 12, 2003. http://www.cma.ca/cma/common/displayPage.do?pageId=/staticContent/HTML/N0/l2/advocacy/news/2003/05-12.htm.
4. Gostin L. Public health theory and practice in the Constitutional design. *Health Matrix. Journal of Law-Medicine* 2001;11:265-326.
5. Braen A. Health and the distribution of powers in Canada. Discussion paper No 2. Commission on the Future of Health Care in Canada. July 2002. National Library of Canada.
6. Constitution Act, 1867. U.K., 30&31 Victoria, c. 3.
7. *Schneider* v. *R.* [1982] 2 S.C.R. 112 at 142 as quoted in Jackman M. Constitutional jurisdiction over health in Canada. *Health Law Journal* 2000;8:96.
8. *Rinfret* v. *Pope* [1886], 12 Q.L.R. 303 (Q.B.).
9. *RJR-MacDonald Inc.* v. *Canada* (A.G.), [1995]. 3 S.C.R. 199.
10. *Attorney General for Ontario* v. *Canada Temperance Federation*, [1946] A.C. 193 (P.C.).
11. Some legal and ethical issues raised by SARS and infectious diseases in Canada. Chapter 9 in The National Advisory Committee on SARS and Public Health. *Learning from SARS: Renewal of Public Health in Canada.* Ottawa: Health Canada; 2003. Available: www.hc-sc.gc.ca/english/protection/warnings/sars/learning.html (accessed 2004 May 20).
12. Jackman M. The constitutional basis for federal regulation of health. *Health Law Review* 1996;5(2):3-10.
13. 1999 Report of the Auditor General of Canada. Chapter 14 National Health Surveillance: Diseases and Injuries. Office of the Auditor General of Canada and the Commissioner of the Environment and Sustainable Development. September 1999. http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9914me.html.
14. Health Canada. Overview of the Canadian Integrated Public Health Surveillance Program (CIPHS). Population and Public Health Branch, Health Canada, 10 October 2002. http://www.hc-sc.gc.ca/pphb-dgspsp/csc-ccs/ciphs_e.html.
15. Naus M, Scheifele DW. Canada needs a national immunization program: An open letter to the Honourable Anne McLellan, Federal Minister of Health. *CMAJ* 2003;168:567-68.
16. Health Canada. *Centre for Emergency Preparedness and Response.* 2002. http://www.hc-sc.gc.ca/pphb-dgspsp/cepr-cmiu/cepr.html.
17. Wilson K, Hébert P. The challenge of an increasingly expensive blood system. *CMAJ* 2003;168:1149-50.
18. Eastman JC. Re-entering the arena: Restoring a judicial role for enforcing limits on federal mandates. *Harv J Law Public Policy* 2002;25:931-52.
19. Wilson K. The role of federalism in health surveillance. A case study of the National Health Surveillance "Infostructure". Chapter 7 In: Adams D. (Ed.), *Federalism, Democracy, and Health Policy in Canada.* McGill-Queen's University Press, 2001; 207-37.
20. 2002 Report of the Auditor General of Canada. Status Report, National Health Surveillance. Office of the Auditor General of Canada. 2002. http://www.oag-bvg.ca/domino/reports.nsf/html/20020902ce.html.

21. Lessons from SARS. Editorial. *CMAJ* 2003;168:1381.
22. Tindal CR, Tindal SN. *Local Government in Canada*, 5th ed. Scarborough: Nelson, 2000;207-52.
23. World Health Organization. Update 37. WHO extends its SARS-related travel advice to Beijing and Shanxi Province in China and to Toronto Canada. World Health Organization. April 23, 2003.
24. Kickbusch I. The development of international health policies – accountability intact? *Soc Sci Med* 2000;51:979-89.
25. Lazar H, McIntosh T. *Federalism, Democracy and Social Policy: Towards a Sectoral Approach to the Social Union*. Kingston: Institute of Intergovernmental Relations, 1998.
26. Wilson K. Health care, federalism and the new Social Union. *CMAJ* 2000;162:1171-74.

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RÉSUMÉ

Dans notre article, nous abordons quelques-uns des défis liés à l'élaboration de programmes fédéraux de santé publique, notamment la répartition des pouvoirs constitutionnels et les défis qui en découlent aux chapitres de la santé publique et de la gouvernance.

Les pouvoirs constitutionnels en matière de santé publique appartiennent principalement aux provinces. C'est surtout par le biais de sa compétence en matière de loi pénale que le gouvernement fédéral a obtenu l'autorité de légiférer dans le domaine de la santé. La création de programmes fédéraux de santé publique pose certains défis, dont l'ambiguïté des responsabilités en vertu de la Constitution, la difficulté de gérer les effets externes et les retombées, ainsi que les questions de financement et de propriété des données. L'importance du rôle des administrations municipales et supranationales en santé publique complique également la formulation des politiques.

Les programmes fédéraux doivent être structurés de manière à équilibrer les avantages des réponses régionales aux défis de la santé publique et les avantages d'une intervention concertée au palier fédéral. Pour cela, les décideurs doivent se pencher sur les défis particuliers de la gouvernance du système de santé publique.

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