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24 November 2014

Standing Committee on Finance
Committees and Legislative Services Directorate
House of Commons
131 Queen Street, 6th Floor
Ottawa, Ontario K1A 0A6

Dear Sir/Madame,

Re: Finance Committee's Study of Bill C-43, Part 4, Division 20 (Amendments to the *Public Health Agency of Canada Act*)

Thank you for personally inviting me to make submissions to the House of Commons Standing Committee on Finance about Bill C-43, Division 20, concerning amendments to the *Public Health Agency of Canada Act*.

Based on my research, it is clear that our Chief Public Health Officer needs an independent voice and the ability to speak scientific truth to members of the public and to those in power.

This Bill, in splitting the Chief Public Health Officer's role in two – one technical, one administrative – removes the little independence that this position once offered. The Bill achieves this effect by demoting the Chief Public Health Officer from his current deputy minister rank, by making him subservient to a bureaucratic agency president, and by eliminating reimbursement for his public activities.

Any loss of independence matters because it erodes the trust that we can all place in the Chief Public Health Officer of Canada.

In reviewing this Bill, it seems to me that we have forgotten the harsh lessons of SARS. It was just 11 years ago, in 2003, when the World Health Organization slapped Toronto with a travel advisory, costing the city $2 billion and 28,000 jobs. This was not because of the number of SARS cases – Singapore had a similar number – but because the federal government did not have a trusted public health leader who could effectively coordinate with the provinces and communicate the outbreak's status to other countries.

SARS shone a light on the hurdles that Canada's version of federalism poses to effective pandemic responses. Significant changes followed, including establishment of a Public Health Agency of Canada and a Chief Public Health Officer.

The big idea behind all of this was that we needed to build trust: provinces and their public health departments needed a guarantee that the federal government's public health pronouncements were based on scientific principles rather than political talking points.

Unfortunately this guarantee was never realized; the Chief Public Health Officer was made an officer of *government* instead of an officer of *Parliament*, thereby preventing him from exercising full independence like our Auditor General or Privacy Commissioner. Let there be no doubt about it: that was a mistake.

But this Bill takes us even further away from where we need to be. At least the original legislation gave the Chief Public Health Officer some independent powers to speak and be reimbursed for those public activities. This encouraged the provinces to buy into a nationally directed system. The removal of these limited independent powers is not helpful.

On this basis, demotion and politicization of the Chief Public Health Officer is undoubtedly a wrong-headed move. With an Ebola outbreak raging in West Africa, this is not the right time to be weakening our national public health infrastructure. This change makes us far less prepared for Ebola and other diseases like it.

I understand that last week this Committee heard contradicting testimony from the new Chief Public Health Officer. I understand he said that shrugging off managerial oversight for his agency would free him to focus on providing scientific advice.

It is true these changes might win him back some of his time, but I think we all need to ask: after his demotion, will anybody be listening to him? Will his new bureaucratic boss even allow him to speak?

Ultimately, if this change must really go forward, I would suggest two very small revisions that lessen its harm.

The first is to add a provision granting scientific independence to the Chief Public Health Officer and legislatively allowing him to speak to provincial counterparts, public health entities, and Canadians without political interference. This would ensure the Chief Public Health Officer can serve that inter-provincial coordination function – shown to be so important in SARS – and, ultimately, be trusted by Canadians.

The second is to remove Section 258 of Bill C-43 that eliminates reimbursement for the Chief Public Health Officer in performing his public duties. I suggest this second revision because it is naturally hard to exercise independence when there is no funding to do so.

I would have suggested a third small revision, to maintain the Chief Public Health Officer's deputy minister rank – which is important for him to access federal decision-making tables – but I think I'm already pushing my luck by suggesting any revisions at all.

In submitting this letter and in presenting oral remarks to the Committee on Monday November 24, 2014, my only hope is that we will not need another SARS or an Ebola outbreak in Canada to make us realize the harm that the proposed changes will cause. I implore you to

do whatever you can to minimize this Bill's damage. We are all less safe with these proposed changes, and we are all going to suffer the consequences if this Committee allows them to pass.

Thank you again for inviting these submissions and considering them as part of your study of Bill C-43. In case additional thoughts would be helpful, I have included with this submission a one-page summary of an issue brief I co-wrote last year on strengthening national health systems' capacity to respond to future pandemics. The full issue brief is available online in both English and French at www.mcmasterhealthforum.org[1] along with a topic overview and a summary of the national stakeholder dialogue we hosted on November 4, 2013, for which this evidence brief was prepared.

Thank you in advance for your consideration.

Sincerely,

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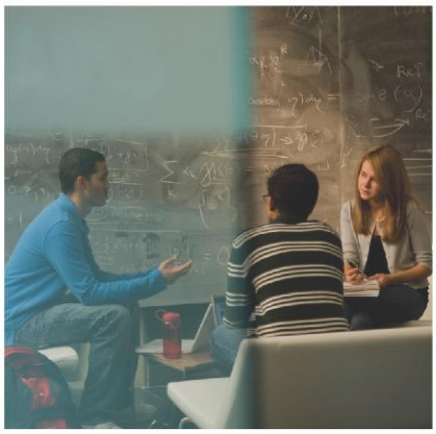
[1] The issue brief, topic overview and dialogue summary are available in both official languages on this webpage listed under the date November 4, 2013: http://www.mcmasterhealthforum.org/about-us/our-work/events.

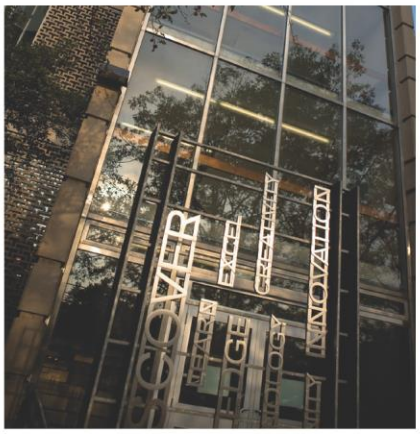
McMaster University

McMaster HEALTH FORUM



ISSUE BRIEF

STRENGTHENING NATIONAL HEALTH SYSTEMS' CAPACITY TO RESPOND TO FUTURE GLOBAL PANDEMICS



4 NOVEMBER 2013

EVIDENCE >> INSIGHT >> ACTION

KEY MESSAGES

What's the problem?

- The challenges to strengthening national health systems' capacity to respond to future global pandemics of infectious disease can be understood by considering six manifestations of, or contributors to, the problem:
  1) pandemics challenge conventional systems of governance;
  2) timely information sharing and evidence-informed decision-making is difficult;
  3) domestic and international partners often encounter coordination problems;
  4) public health and animal health perspectives can be difficult to reconcile when addressing emerging zoonoses;
  5) antimicrobial resistance represents a growing threat; and
  6) risk and protective factors for pandemics are changing.
- Moreover, existing programs, health system arrangements and implementation strategies may not be optimal:
  - programs and plans may limit capacity to respond to future pandemics;
  - health system arrangements complicate matters; and
  - some previously agreed upon courses of action have not been fully implemented.

What do we know about three elements of a comprehensive approach to address the problem?

- Element 1 – Enhance national health systems' ability to detect pandemic risk factors, identify causal pathogens, characterize emerging diseases and monitor how they evolve
  - We found a small number of systematic reviews that can be drawn upon to inform some components of element 1. We found benefits for key components of this element, including enhancing ongoing surveillance systems, building capacity for shared rapid data collection, analysis and assessment, and establishing collaborative interprofessional teams to conduct routine surveillance, particularly for zoonotic disease outbreaks.
- Element 2 – Strengthen the capacity of national policymakers and stakeholders and the public to more adequately respond to the variability of pandemics
  - We found several medium- and high-quality systematic reviews that identified benefits for key components of this element, including information products designed to support the uptake of systematic review evidence, public engagement to inform policymaking, risk-communication strategies and social networking.
- Element 3 – Strengthen the global pandemic governance system
  - We found a small number of systematic reviews that revealed benefits for specific sub-elements, including global health initiatives for disease control (specifically HIV/AIDS), contracting out healthcare services in developing countries, result-based financing, and developing international nursing curricula through cooperative partnerships (as a way to strengthen system capacity).

What implementation considerations need to be kept in mind?

- Potential barriers to strengthening health systems' capacity to respond to future global pandemics can be identified at the local level (e.g. governments and providers may be reluctant to spend time and money on re-training health workers to adopt new pandemic preparedness plans or the One Health model), provincial/state/territorial level (e.g. governments may resist letting national governing bodies take charge of defining priorities during pandemics), national level (e.g. governments may have limited funding and resources for new information and communication technologies) and global level (e.g. member states of multilateral organizations may guard their sovereignty and choose to act unilaterally).
- Efforts to address these issues need to be attentive to potential windows of opportunity, such as the revised North American Plan for Animal and Pandemic Influenza (2012) and calls from the 2011 Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, for increased pandemic preparedness through research, strengthened healthcare delivery systems and a multi-sectoral approach.