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Missed Opportunities: Public Health Disaster Management in Canada

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Three recent Canadian public health crises present an illustration of both the opportunities for reform and the challenges that may impede progress and public health renewal in federalist nations. While the three crises examined exposed serious flaws in emergency preparedness and fuelled demands for vital public health reform, evidence indicates that fundamental challenges have not been addressed and may have even heightened over the last decade given a move to “open federalism” and the significant fiscal impacts of ongoing austerity measures. With future pandemics inevitable, we identify the missed opportunities to optimize Canada’s emergency response capacity and procedures and examine the seemingly intractable barriers of federalism and path dependency thinking that continue to impede learning and reform and ultimately undermine effective disaster management.

In Canada, authority for public health management and emergency response is shared between all three levels of government: federal, provincial, and municipal. This creates a complex public policy environment that presents significant challenges most visibly and often distressingly in the context of emergency response and public health renewal. Three recent Canadian public health crises present an illustration of both the opportunities for reform and the challenges that may impede progress and public health renewal in other federalist nations such as the United States.

In 2003, Canada saw a provincial outbreak of Severe Acute Respiratory Syndrome (SARS). Following the outbreak, scathing criticism of Canada’s health units emerged. SARS had tested Canada’s public health systems, showing them to be “woefully inadequate” (Bretscher et al. 2010). The serious challenges presented by SARS were seen as a rare opportunity to reform and invest in public health in Canada and ensure that vital emergency preparedness systems were up to the task and prompted major reforms and significant economic investment across all three levels of government. In just a few years, Canada suffered two more public health emergencies: the 2008 listeriosis outbreak and the 2008-2009 H1N1 novel influenza pandemic. In spite of major institutional reforms and significant investment, Canada’s public health systems were again chastised for serious deficiencies, forcing critics to conclude that the hard fundamental lessons from 2003 had not been learned and addressed.

Our paper draws on numerous inquiries and reports that have revealed a recurring pattern of managerial and institutional frailties including poor coordination, integration and
communication; weak leadership; inadequate strategic planning, monitoring and surveillance; bureaucratic inflexibility and lack of adaptive capacity; and blurred lines of authority and flawed procurement and vaccine supply chains. While it is possible to analyse and explain the findings using a range of organisational and public management theories, our main contention is that the failings highlighted are largely symptomatic of the deeper tensions and politics generated by Canadian federalism. Consequently we focus on the seemingly intractable challenges that federalism presents for emergency preparedness in the context of preparing for future pandemic threats.

By analyzing three of Canada’s major public health emergencies of the last decade, we also identify opportunities for public health reform. In particular, we highlight the need for increased federal leadership and oversight in public health emergencies; the need for continued economic investments, but with enhanced oversight; and the development of coordinated intergovernmental relationships and communication protocols that transcend strict jurisdictional boundaries.

In advocating for these reforms, we also recognize and argue that in Canada the challenges of federalism may have heightened over the last decade in tandem with the federal government’s adoption of a laissez–faire approach to intergovernmental relations under the current Prime Minister, Stephen Harper. Coined “open federalism” it has also been labeled “absentee federalism” by critics due to the Harper government’s reluctance to play a national coordinating role. Furthermore, the fiscal resource base of the federal public health agency has been severely impacted by the government’s ongoing austerity measures and media and public fears concerning the threat of pandemics such as avian flu appears to have waned. Consequently, ten years after SARS provided a “window” for substantive reform of public health and emergency management in Canada, the opportunity to learn from previous mistakes and adapt for future emergencies appears to have diminished substantially.

With future pandemics inevitable, we identify the missed opportunities to optimize Canada’s emergency response capacity and procedures for emergency reform, and examine the significant barriers presented by federalism, political ideology and path dependent thinking that continue to impede learning and undermine effective emergency preparedness and response. While focused on Canada, we believe the paper may have wider implications for the latest multilateral North American Plan for Animal and Pandemic Influenza (NAPAPI) drafted in 2012. Given the extremely high level of integration between Canada and the United States and between Mexico and the United States, the launch of a North American pandemic plan makes obvious sense. That said if collaboration and cooperation between levels of government in a single country appears to be unrealistic it does not bode well for international agreements that have yet to be tested.

We begin by examining Canadian federalism and the constraints and challenges that this poses for emergency preparedness and response. We then outline and analyze the three case studies, drawing out the key implications and themes, and conclude by assessing the prospects and options for future reform.

FEDERALISM AND PUBLIC HEALTH IN CANADA

In Canada, responsibility for public health and emergency response is shared between federal, provincial-territorial, and municipal governments. These complex jurisdictional and institutional arrangements for public health can be traced back to the broad and decentralized nature of providing public health across a geographically massive country and the lack of explicit jurisdiction given when such lines of authority were drawn in the Constitution Act, 1867.

Canada’s geographical challenges and constitutional constraints have given rise to
institutional and organizational tensions within the overall governance structure. In addition to collaborative working relationships that extend “vertically,” between the federal, provincial (state) and municipal levels of government, there is also evidence of “horizontal” governance in Canada’s political institutions. Many organizations work in tandem with, and alongside, other peer organizations at the same level of government. For example, the Public Health Agency of Canada (PHAC) works alongside the federal department Health Canada on many issues related to health. In addition, safety issues related to food are handled by three federal entities: the Canada Food Inspection Agency, Agriculture and Agri-Food Canada, and Health Canada. In this way fragmentation in vertical governance is further accompanied by fragmentation in horizontal governance (Bakvis and Skogstad 2007). Consequently, the division of responsibility across multiple organizations at the same level of government further compounds the complexity of assigning responsibility or authority for many public health issues.

The polycentric and disparate context of health in Canada should not be underestimated. As Fierlbeck notes, “if one area of public administration best exemplifies the interdependent nature of modern governance, it is that of public health (Fierlbeck 2010, 2). This presents a number of specific challenges for policymaking and coordination when it comes to planning for emergency preparedness and response.

Typically, interdependence creates a governance structure in which multiple actors share responsibility for outcomes. This sharing can lead to difficulties defining tasks and developing clear lines of responsibility and accountability. Above all else, effective emergency responses demand seamless, expedient actions facilitated by a clear chain of command. A lack of clarity and ill-defined roles will necessarily hinder well-coordinated responses and can instill complacency based on the oft-mistaken belief that “someone else” will deal with the crisis. The second main challenge to policymaking presented by federalism concerns the impact of interdependence on decision-making. As decentralized governance structures grant authority and status to a multitude of potential actors, they can also render the creation of a gridlock effect termed a “joint decision trap” by McDougall (2009). When, as a result of jurisdictional considerations, no level of government is able to act alone without formal agreement from all governments, McDougall predicts that “default decision-making” and “frozen institutional arrangements” will typically result (2009).

Three recent public health crises underline key challenges presented by these institutional arrangements for emergency response in Canada and provide excellent case studies: the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) and the reform efforts made in its wake, the handling of the 2008 outbreak of listeriosis, a foodborne illness, and, third, the 2008–2009 novel flu pandemic, H1N1. We address them in chronological order, as (in addition to being interested in each individual case), we are also looking to capture the degree of learning, adaptation and reform that resulted over the entire period.

CRITICAL INCIDENTS: THREE “MOMENTS OF TRUTH”

2003: Severe Acute Respiratory Syndrome (SARS):

The first cases of SARS among humans emerged in a southern province of China in the winter of 2002. By 2003, SARS had spread not only to neighbouring Hong Kong, but also to Canada. In July 2003, the World Health Organization (WHO) reported that Canada had seen 251 probable cases of SARS and 43 deaths had been attributed to the disease (Naylor, Chantler, and Griffiths 2004).

While the actual outbreak of SARS was unavoidable, criticism surfaced regarding aspects of the response. Doubt arose that perhaps it could have been contained earlier. As a
result of perceived failures, a key question emerged: did the failures simply reflect the inherent difficulties in preparing for, responding to, and recovering from catastrophes? Or were the impacts of SARS the result of oversights or neglect that could have been avoided? Perhaps testament to suspicions of the latter, three major committees were formed, each charged with producing their own authoritative report. These were: the National Advisory Committee on SARS and Public Health (The Naylor Report 2003); the Ontario Expert Panel on SARS and Infectious Disease Control (The Walker Report); and the Ontario SARS Commission (The Campbell Report, 2004-2006).

All three of the reports commissioned after SARS concluded that the response was less than adequate. Their conclusions identified elementary mistakes and oversights that were deemed to be unreasonable for an advanced health care system to fall victim to. As stated in the Campbell Report, “SARS showed Ontario’s central public health system to be unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate” (Campbell 2004). Investigators focused on the processes and systems established to deal with the outbreak. Evidence provided to the investigators confirmed that mistakes were made and that the devastation wrought by SARS was not merely the result of the inherent difficulties in containing such an outbreak. Rather, as the Campbell Commission concludes, “it is likely that [Toronto’s first outbreak of] SARS could have been contained more quickly and with less damage had the right systems been in place in Ontario” (Campbell 2004).

The Campbell Commission alone highlights a lengthy list of twenty-three major problems faced over the course of the SARS outbreak in Toronto. These problems range from the declining investment in public health, a lack of transparency, a lack of preparedness, a lack of laboratory capacity, inadequate infectious disease information systems, blockages of vital information, lack of central expertise, and poor coordination with the federal government (Campbell 2004).

Similar criticisms were echoed in the other two reports. The jurisdictional issues also featured prominently in subsequent academic papers and reports:

In addition to the lack of capacity and planning in the health system to deal with SARS, Ontario faced serious jurisdictional issues. Who was responsible for government’s response to the crisis? The Ministry of Health and Long Term Care and the Commission for Public Health are legally responsible for health emergencies, while the Ministry of Public Security and Safety and the Commissioner for Public Safety are legally responsible for emergencies affecting the entire province. In the ex post analysis of the SARS crisis, jurisdictional conflicts made it evident that the government needed clear lines of authority for decision making. (Bretscher et al. 2010)

The World Health Organization also commented on Canada’s relatively poor performance in containing and dealing with SARS, noting that the major shortcoming was a “lack of intergovernmental communication” (Wilson and MacLennan 2005). A key finding was that, during SARS, the province of Ontario did not readily communicate data to the federal government because there was no legislation that obligated them to do so, and there was much confusion regarding the impact of privacy rights on information sharing between the provinces and the federal government (Campbell 2004).

Lacking clear lines of authority, central direction and leadership, many government officials became involved and several acted as spokespersons to the media on behalf of Canada, often presenting conflicting or confusing information. The absence of clear direction was unsettling not only for the population, but it also caused “many local Medical Officers of Health [to feel] abandoned during SARS, devoid of support and guidance” (Campbell 2004).
Compounding these difficulties, Ontario had no plan for pandemic response in place at the time of the SARS outbreak (Campbell 2004). Pandemic plans establish a process for a staged response and are of value in establishing ultimate authority for the management of outbreaks, a chain of command that was, in fact, never clarified or established during the SARS outbreak.

In the wake of SARS, and the resulting investigations, there emerged a growing consensus among government officials that Canada’s public health systems were not up to the task and improvements were needed. The shock and fall-out from SARS prompted many to focus on much-needed public health renewal in Canada. According to one report published by the federal department, Health Canada: 1

The lessons learned from SARS are critical pieces of information for determining the improvements needed in Canada’s public health system...the knowledge gained from SARS should help Canada put in place a public health system that will be capable of not only dealing with the next outbreak, but the next pandemic. (Public Health Agency of Canada 2003).

A desire to update and strengthen public health was evident. Many social scientists have long spoken about the impacts of “focusing events” – sudden catastrophes, often unexpected, that may advance policy issues (Baumgartner and Jones 1993; Cobb and Elder 1983; Kingdon 1995). In this way, the devastating circumstance of the SARS outbreak functioned in this manner - it highlighted problems demanding attention. Subsequently, this outbreak galvanized government resources, political will, and public health investment.

By putting public health reform firmly on the agenda, SARS would serve as a catalyst for the many reforms that would occur over the next few years. Major changes did occur after the 2003 outbreak: for example, the federal budget of February 2004 committed a sizeable 665 million dollars (CAD) to the task of strengthening the country’s public health system. Second, the Public Health Agency of Canada (PHAC) was established on September 24, 2004 to serve as the main agency responsible for public health in Canada and to provide federal leadership in health programs, research, surveillance, and emergency response. Third, a new intergovernmental mechanism termed the “Pan-Canadian Public Health Network” was formed to support the mitigation of public health challenges. The network is intended to link federal, provincial, and territorial health operations, assist during emergencies, collaborate on day-to-day operations of public health and provide advice and reporting to the Deputy Ministers of Health. The network’s objectives demonstrated considerable potential because they were based on an understanding of the challenges posed by federalism and offered a concrete, realistic solution to the diffuse system.

In spite of the reforms made, a number of important changes suggested in the reports were overlooked that could, and perhaps should, have been made. For example, legislation that would obligate the provinces to share health surveillance information with the federal government was not developed in the years after the SARS outbreak. Such data collection is necessary to undertake effective national health surveillance and to help ensure early detection of emerging outbreaks and to trigger early interventions.

In addition, fundamental issues in Canada’s emergency management legislation were not amended after the SARS outbreak. Current regulations are written in such a way that the federal government is not permitted to unilaterally engage in disaster relief if the emergency is contained within one province; intervention is only permissible once the

1 Authorship of this report was later transferred to the Public Health Agency of Canada upon the agency’s creation in 2004.
disaster has already spread across a provincial border (Wilson 2006). As an area of policymaking, there are key aspects of pandemic response that justify a centralized approach: aggressive early intervention is required, significant resources are needed, and the consequences could be significant for both Canadian citizens and international citizens “if a province sought to address the challenge on its own and failed” (Wilson 2006, 38). However, even after the SARS crisis, legislation was not amended to give the federal government the authority to intervene. Such inaction seemingly reflects the reluctance of Canadians to engage in reforms that involve constitutional change or changes in entrenched federal-provincial relations and powers. Lack of legislative change in this area contributed to the development of a key barrier that would later impede implementation of the policy changes under consideration: the federal government simply lacked the authority to undertake appropriate actions.

2008 Listeriosis outbreak reforms tested

Although the reforms following SARS were not as far reaching as some had hoped for, they were, nonetheless, significant and well-funded, owing to SARS’ role as a focusing event. Five years after the SARS outbreak, these reforms were put to the test as Canada was again host to another public health emergency. In 2008, an outbreak of listeriosis arose as a result of contamination by the listeria bacterium at a Maple Leaf Foods meat packing plant in Toronto. This would become, according to investigator Sheila Weatherill, “one of the worst foodborne illness emergencies in Canadian history” (Weatherill 2009).

Foodborne illness response, just like pandemic response, is marked by a similar set of complex intergovernmental relations. This area of response is also a prime example of fragmented horizontal as well as vertical governance structures. The federal department of Health Canada develops policies and standards for the nutritional composition, quality, and safety of food. In addition, Health Canada works with the Canadian Food Inspection Agency (CFIA) to produce legislation regarding food inspection in tandem with other federal departments such as the Department of Fisheries and Oceans and Agriculture and Agri-Food Canada. Furthermore, provincial-territorial and federal governments both carry out food inspection and the roles of local governmental organizations (municipalities, regional health authorities, and local health units) vary across the country (Gabler 2008).

Federalism remained a key issue and an underlying factor in the ineffectual implementation of the proposed changes. As in the case of SARS, many of the same challenges arose and yet, in spite of the reforms and added safeguards, Canada’s public health systems were again criticized for their inability to clarify roles and responsibilities between the almost fifty local, provincial, and federal partners who were involved in the response. According to a major report commissioned by the Government of Canada, “no single organization took the overall role of coordinating the actions of various parties involved.” As a result, a “vacuum in senior leadership” was created, causing “confusion and weak decision-making” (Weatherill 2009).

Many Canadians were clearly concerned and affected by the notable absence of leadership. During the crisis, both the provincial and federal governments and the private company implicated issued their own news announcements. There was confusion regarding why the Chief Public Health Officer - head of PHAC and an individual responsible to report to the Minister of Health - was not providing the leading national voice as intended following the post-SARS reforms (Wilson and Keelan 2008). According to the Weatherill report, such a multiplicity of authorities fueled misunderstanding and anxiety and prevented Canadians from understanding which level of government was in charge of the crisis. Once again, jurisdictional ambiguity severely hindered emergency response and resulted in an ill-
coordinated effort marked by poor communication to the public.

The Weatherill report noted further significant shortcomings in the federal government’s attempts to manage the crisis. An intergovernmental agreement detailing best practices for the handling of foodborne outbreaks was in existence, having been ratified by federal and provincial-territorial governments in 2004, but few of those involved with the listeriosis outbreak were even familiar with the agreement, titled the “Foodborne Illness Outbreak Response Protocol” and it was never formally activated during the crisis. While the need for intergovernmental cooperation was recognized in the same report, a lack of tangible and sustained measures ensured that jurisdictional ambiguity persisted once the outbreak occurred.

Criticisms regarding poor central organization were particularly disappointing in light of the newly minted reforms. The expenditures needed to create PHAC in the wake of SARS were justified to the public on the basis that the new federal agency would play a key role in the management of public health emergencies. However, PHAC had not yet provided the necessary clarification of roles and responsibilities that it had been tasked with and a further round of blame, excuses and obfuscation ensued.

2009 H1N1 influenza outbreak: confirming fears

As we have outlined, the SARS and listeriosis outbreaks renewed concerns about federal-provincial coordination of emergency planning and highlighted severe weaknesses in both responses. In 2009, Canada was host to another public health crisis: the H1N1 influenza outbreak. This provided a further test and another opportunity to adapt and improve.

In April 2009, an outbreak of an influenza-like illness occurred in Mexico. The Centre for Disease Control in the United States reported seven cases of a novel A/H1N1 influenza. Shortly thereafter, the World Health Organization (WHO) declared H1N1 a pandemic. There was speculation that the new virus might result in illness and death on a massive scale and cripple global trade. To put it bluntly, “it was feared that the H1N1 pandemic of 2009 was the next Spanish Flu” (Bretscher et al. 2010). By early February 2010, Canada had 33,477 cases of H1N1 and 348 deaths had been caused by the outbreak (CHICA 2010). Public response to the government’s actions was exceedingly negative. As Maclean’s reported: “most Canadians have reached the same conclusion: the country’s public health authorities – federal, provincial, and local – have failed us miserably” (Friscolanti and Guillì 2009).

The vast majority of the problems experienced during the H1N1 outbreak occurred in relation to the rollout of the vaccine, which again illustrated the problem of shared and ambiguous responsibilities. The inoculation campaign intended to lessen the impact of the virus in fact exposed major inconsistencies across provinces and regions, poor implementation, and no national standards. To contextualize this discussion, it is worth noting that all vaccination plans were limited because there were ongoing problems with supply shortfalls that resulted from production limitations at GlaxoSmithKlein, the company responsible for manufacturing Canada’s H1N1 vaccines. As a result, most of the provinces and territories waited on delayed shipments of the vaccine, many of which arrived with substantially fewer doses than promised.

Amid shortages of the H1N1 vaccine, equitable distribution of the vaccines became a prime concern, and this was where the federal government failed in its attempts to deal with the situation. News reports criticized the inoculation campaign’s relative lack of national standards. The Canadian Broadcasting Corporation (CBC) reported that, the H1N1 inoculation campaign exemplified a “patchwork” of varying provincial, municipal, and even regional regimes. There was “precious little in the way of consistency or uniformity in terms
of rolling out the vaccine from one coast to another” (McKenna 2009).

A particularly controversial example of the lack of uniformity occurred in the Canadian province of Alberta. Amid supply shortfalls, the Public Health Agency of Canada determined that the vaccine should be rolled out on a priority basis, with those who would benefit most to receive it first in order to minimize serious illness and overall death (Public Health Agency of Canada 2010). However, during the H1N1 outbreak, the then Premier of Alberta, Ed Stelmach, called Alberta the “province that is offering flu vaccines for every Albertan, not just to the high-risk groups” (Friscolanti and Guilli 2009). This contradicted PHAC’s stated strategy to provide doses to every province with the understanding that they would be reserved for high-risk groups, in part to provide greater protection for the herd. Premier Stelmach’s comments were indicative, however, of the independence and capacity for inconsistent approaches that the provinces could take in the absence of more coercive, national legislation or oversight – yet another result of federalism. A coordinated inoculation regime did not occur. Instead, Canadian citizens across the country were provided with varying levels of treatment according to where they lived.

In addition to the lack of national standards, inequity was also a key concern in respect of which groups were entitled to receive the vaccine. Those groups considered to be most at risk were instructed to go for their immunizations first, but in many instances little or nothing was done to turn away low priority individuals who were determined to get their “shots” early. High profile examples of queue jumping caused further outrage when it was found that that board members of certain hospitals secured advanced access to the flu shots and even some professional NHL hockey teams were given the vaccine early at their rinks (Wingrove, Paperny, and Walton 2009), while at risk groups, including the elderly and the very young, were expected to wait in the seemingly endless lines that formed each day.

Not only were people inconvenienced (or put off altogether) by standing in line for several hours, but the system risked exposing healthy and at risk groups to those who were already infected. Effective pandemic and infection control discourages large social gatherings and require the sick to be isolated, but the vaccination procedure appeared to violate both these measures and actually increased the likelihood of contagion.

The public and the media were highly critical of the way the immunization process was handled and even the Chief Medical Officer of Ontario accepted that it was far from satisfactory:

The picture, presented repeatedly by the media, of people lining up for hours to get themselves and their children immunized was a disturbing one. It hinted at possible widespread panic, and a system not able to cope. Neither of those things, as it turned out, was true, but there is no question that the H1N1 immunization process could have been better handled. It boiled down to problems of supply and capacity. (Ontario Chief Medical Officer, 2010, 13)

Although Ontario’s Chief Medical Officer of Health was prepared to acknowledge some of the provincial failings in his report, federal ministers were adamant that they bore no responsibility since health matters, including vaccinations, are a provincial matter.

When asked in an interview if Ottawa bears any blame for the flawed vaccine rollout in Alberta, Manitoba and Ontario, which saw just over a third of their populations inoculated against the pandemic virus. Health Minister Leona Aglukkaq responded: “Provinces and territories deliver health care.” (Alphonso 2012)

Provinces, on the other hand, argued that their planning was curtailed by a lack of clarity regarding the quantity of vaccine they would receive each week from the federal government. As a result of the constant jurisdictional squabbling and intergovernmental “turf
wars,” Alphonso believes the public “grew impatient, confused and eventually turned off from the vaccine,” which may help explain why the take up rates in some provinces was less than a third (2012). The next section explores these themes further in the context of possible reforms.

**ANALYSIS: THEMES FOR PUBLIC HEALTH REFORM**

The three infectious outbreaks studied, and the numerous inquiries they triggered, highlight three central themes for public health reform in Canada. First, the case studies signify the need to develop coordinated and cooperative intergovernmental relationships. As Bretscher et al. conclude, “[t]he SARS crisis demonstrated that all orders of government needed to develop an integrated and effective pandemic plan, while putting the appropriate institutions in place to deal with a future crisis” (2010).

Despite investments in public health that were made in the wake of SARS, ongoing challenges of intergovernmental cooperation have not fully been addressed and, as such, there remains a gap between policy and practice in this area of public health reform. In spite of cooperative rhetoric and several new institutions, federalism continues to promote and sustain jurisdictional ambiguity in emergency response and provides fundamental barriers that remain firmly entrenched in spite of a decade of reform and considerable investment. Analysis of these three case studies highlights a number of barriers faced: imperfect coordination and those in authority were unable to demand compliance – in particular due to a lack of enforceable federal oversight under current emergency management protocol. These problems, however, have their roots in federalism and its resultant system of diffuse responsibility and a multiplicity of actors and agents. What is perhaps most interesting is that reforms such as the creation of PHAC and the pan-Canadian Public Health Network reflect the knowledge that intergovernmental cooperation is imperative. However, efforts to facilitate and institutionalize cooperation remain largely ineffectual in the absence of intergovernmental negotiations to further clarify roles and responsibilities. Jurisdictional ambiguity, and a seeming lack of ability to address the constitutional authority for public health, is an ongoing concern as failure to confront the broader jurisdictional aspects ensures that emergency response will continue to undermine the institutional and procedural reforms that have been undertaken.

Second, the case studies demonstrate that while the involvement of local governments is critical, there is a need for increased federal leadership and oversight in public health emergencies. There are key elements of emergency response that necessitate strong federal leadership: public health emergencies demand a rapid response, seamless integration across the country, and tremendous resources. Pandemics such as SARS pose serious threats to populations globally and not just within national borders. Any failure to appropriately contain or limit the spread of an outbreak could have significant repercussions for neighboring countries and beyond, which creates an added responsibility to respond effectively to public health crises.

There are distinct advantages to a response led by the federal government: a single representative body organizations such as the World Health Organization (WHO), a clear line of accountability and responsibility, a coordinating body, and a strong resource base that can be engaged at short notice including the military and scientists. Under the rules of the WHO, reporting responsibility for disease outbreaks rests with the national government. Ottawa’s delay in reporting new cases to the WHO headquarters in Geneva resulted in a lack of timely information from Ontario, undermining confidence that the situation was under control and ultimately prompting the WHO to issue a travel advisory against travelling to Toronto (Branswell 2013).
Effective communication within the country, to citizens and government representatives alike, also requires a well-defined federal role. Effective communication with the public is critically important to managing an outbreak. As Bretscher et al. (2010) point out, maintaining the trust of the media and general public is crucially important to ensure compliance with public health measures. In order to establish trust, the government’s response to an emergency must appear to be effective, credible and orderly. In each of the three cases we analyzed, the sharing of responsibility for communication between different levels of government and various agencies appeared to undermine trust and confidence through the provision of different, and often contradictory, advice and information. SARS and H1N1, in particular, revealed major weaknesses in inter-jurisdictional communication, and highlighted the need for better local, national and international reporting and communication.

Third, there is a need for continued economic investments in public health. Clearly, the lack of vaccine supplies (as witnessed in the H1N1 case) not only increases the risks of the virus spreading but also engenders a sense of panic among the public. While governments may not be able to purchase or store sufficient vaccines, even if they exist, they need to ensure that they are distributed in a timely fashion and target the highest-risk groups first. Although we, and a number of the reports cited, argue for more investment in public health and emergency preparedness, this has to be managed wisely if benefits are to be realized and public support for further investment is to be maintained. A number of issues came to light in the case studies, suggesting resources had not been managed appropriately. For example, it transpired that one of the reasons for the shortage of the H1N1 flu vaccine was the federal government’s decision to negotiate a sole sourced contract with a single Quebec-based supplier. Such an approach to procurement is inconsistent with practices adopted in the United States and even inconsistent with Canada’s approach to the production of seasonal (rather than pandemic) flu vaccines, where multiple suppliers are utilized in order to guard against the impact of a problem experienced in a single manufacturing site. Procurement must focus on strategic health needs rather than regional, economic, industrial or other criteria.

The efficiency and effectiveness of public health policies can also be undermined by mis-management and corruption. Following the SARS outbreak in Toronto, the province of Ontario invested heavily in developing electronic medical records establishing the “eHealth” agency. However, by 2009 there was little to show for the investment and Ontario Auditor General “slammed” the province for spending more than $1 billion at eHealth and its predecessor agency, Smart Systems for Health Agency. Describing it as the “worst case of rule-breaking that he had ever seen” the Auditor General found that: procurement policies were circumvented to allow sole sourcing for outside consultants; board members were deceived and former CEO Sarah Kramer operated with virtually no accountability (Greenberg 2009). The scandal led to the resignation of a Liberal Minister, but could not alter the fact that after nearly a decade of sizeable investment the province was still years away from being able to rollout electronic health records.

The full significance of the eHealth scandal would soon be revealed by the H1N1 outbreak which demonstrated how crucial electronic health records are to effective immunization programs. The absence of a medical database was later identified as a major factor in the confusion and mayhem that accompanied Ontario’s long line-ups for vaccine. As Ontario’s Chief Medical Officer for Health confirmed, the need for a database and improved technology is pressing:

[We] do not have the capacity to track and manage an immunization program. I am absolutely suggesting that on this, we can do better. The technology exists
today. It is a pan-Canadian solution called Panorama that has been in development since after SARS. There have been numerous delays to ensure the system can be adapted to the needs of all provinces and territories. The time is right to move forward. There must be no more delays. Panorama will allow us to track who is getting immunized and when. It will help us with surveillance so we can be ready to respond to outbreaks of disease. It will improve administration, workflow and overall efficiency. It will give us a 21st century tool for dealing with pandemics in the 21st century (Ontario Chief Medical Officer of Health 2010).

Further challenges face governments looking to manage resources efficiently. In times of health crises, governments are faced by both responsibility and public pressure to provide all available treatments, and must make evidence-based decisions regarding an appropriate course of action. This is the case with the flu drug oseltamivir (Tamiflu) that has been used increasingly in pandemic situations and has become the focus of recent debates about the costs of emergency preparedness. Tamiflu, it should be noted, is not intended to be a substitute for the flu vaccine. Instead, it is an antiviral drug (“neuraminidase inhibitor”) that is claimed to shorten recovery times and help reduce the symptoms of influenza. However, there is ongoing debate about the evidence base for this class of drugs, with Cochrane Collaboration research concluding that effectiveness against the symptoms of influenza is modest and that efficacy against complications (i.e. pneumonia) or transmission has not been proven (Jefferson et al. 2009). Especially concerning for policymakers, independent efforts to assess the current evidence on treatments of oseltamivir for influenza are limited by a paucity of crucial evidence and a lengthy history of unwillingness regarding Tamiflu producer Roche’s release of crucial data, even in light of a campaign spearheaded by the prominent British Medical Journal (Cochrane Collaboration 2012).2

However, in spite of the fact that medical evidence about the efficacy of neuraminidase inhibitors is mixed, governments around the world have invested billions of dollars in order to stockpile oseltamivir. In Canada alone the government has more than $18-million (CAD) worth of Tamiflu in federal and provincial warehouses. Tamiflu, like all drugs, has a limited shelf-life. Health officials thus have an ongoing obligation to decide on the value of spending public dollars to restock antiviral drugs in case of a future pandemic (Alphonso 2012). This task is complicated, if not compromised, by the limited evidence and increased prevalence of reports that some senior public health officials and “independent” medical advisors receive payment and benefits from the makers of Tamiflu which have been surfacing in the popular press (CBC News 2012).

A recent audit of PHAC suggests that Tamiflu is just one aspect in a bigger problem of stockpiling. The agency has a national emergency stockpile with an estimated value of $300 million which is stored at 10 federal warehouses and 1,300 supply centres throughout

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2 The Cochrane Collaboration continues to cite concerns about the availability of evidence from the producers, Roche. In 2009, Roche made a public commitment to share full study data with investigators. After the release of the updated Cochrane review in January 2012, for which this full data was still not available, the British Medical Journal launched the Open Data Campaign, which “aims to achieve appropriate and necessary independent scrutiny of data from clinical trials.” Focused on Tamiflu as its first initiative, the Open Data Campaign may subsequently may help ensure access to the data Roche has not fulfilled its obligation to share.
Canada (Kennedy 2010). However, the audit states that “mandate and strategic objectives” of the stockpile requires “clarification” because the system dates back to civil defence risks stemming from the Cold War and lacks proper maintenance and management (Kennedy 2010).

The optics of inefficiency matter, particularly in times of austerity. Effective public health measures do not come cheap. The total costs of the H1N1 response in Canada are estimated to be about $2 billion (CAD). Stockpiling resources for events that may never happen, and will more than likely never be used, will always prompt difficult questions about efficiency and effectiveness. Nevertheless, in order to continue funding on the scale required, the public needs to see tangible improvements in public health capacity, procedures to assess efficacy and ensure evidence-based decision-making, and outcomes and feel confident that the country is well prepared and that resources have been utilized in a responsible manner.

CONCLUSION

Missed opportunities and the prospects for reform

The threat of new airborne infections is ever-present, and requires vigilance and preparation to minimize loss of life and serious illness. The economic costs of pandemics can also be devastating to cities and national economies. With the SARS outbreak in Toronto, for example, Bretscher et al. (2010) estimate that direct health costs to the province of Ontario were approximately $945 million (CAD), the long-term impact on tourism cost the industry over $700 million (CAD) and, despite being geographically concentrated in Toronto, SARS resulted in a 1% – 1.5% decline in the third quarter GDP (2003) growth. They conclude that the message for governments is clear: emergency planning and effectively dealing with a pandemic crisis is critically important to protect human lives, and the economy as a whole (Bretscher et al. 2010).

In its damning assessment of Canada’s response to SARS, the Campbell Report concluded that, “there was an obvious breakdown of communication” between the federal and provincial governments that, if not addressed in the future, would place Canadians at greater risk of infectious disease and make the country “look like fools in the international community” (Campbell 2004). Anyone who witnessed the subsequent fiasco of the H1N1 pandemic would have to concur with Campbell’s harsh but fair assessment.

In spite of the opportunities that SARS and subsequent public health threats have provided for learning and adaptation, analysis of the three most recent outbreaks suggests that while lessons have been learned, and some improvements made, little has been done in the Canadian context to address the fundamental barriers impeding effective emergency preparedness and response. It seems that the institutional barriers to change, and to the necessary clarification of roles and responsibilities, have been too significant in a federalist nation. In assessing prospects for future crises and reform, it is hard not to think that a rare opportunity for substantive change in the wake of the SARS crisis has been missed. Moreover, in 2013, the prospects for improved intergovernmental cooperation and alignment have deteriorated in recent years due to a combination of political, economic and, social factors.

In 2005, shortly after the SARS outbreak, the Canadian Prime Minister Stephen Harper articulated his vision of “open federalism” as an approach to intergovernmental relations composed of four key aspects: “a recognition and a respect for the constitutional division of powers; a recognition that there exists a fiscal imbalance in the federation; a commitment to redress this vertical fiscal imbalance; a related commitment to rein in the federal spending power in areas of exclusive provincial jurisdiction; and, finally, a
commitment to work with the Council of the Federation to improve the management and workings of the Canadian federation” (Courchene 2008, 19).

Despite the pressing need for a re-envisioning of intergovernmental relations and the need for a stronger federal role in the sphere of public health, Prime Minister Harper’s embrace and promotion of “open federalism” and “small government”, reinforced by an increasingly restricted fiscal environment, have diminished significantly the prospects for a stronger and expanded federal role in emergency management. This supports Fierlbeck’s assessment that “federal inaction in public health has become exacerbated contemporaneously with a commitment to open federalism” (2010, 17). Harper’s reluctance, and to some extent inability, to take a strong national leadership role in public health and other important sectors such as infrastructure and transportation, is why open federalism has also been dubbed “absentee federalism”.

While “open” federalism may constitute an appropriate political philosophy for conceptualizing federalism in the abstract, it has potentially dangerous implications for the very real challenges and practicalities of dealing with emergency situations when strong leadership and firm decisive action is required. Ontario’s Chief Medical Officer of Health expressed this point powerfully in his report following the H1N1 pandemic:

> We also need to extend our chain of command to the local level. The system as it is presently constructed does many things well in what I will refer to as “peace time.” In “war time,” however, when people are getting sick and people are getting scared, the health system needs to accommodate the kind of strong central oversight and management that currently doesn’t exist. The Chief Medical Officer of Health must have the authority to direct public health units in real time as he or she sees fit. That authority didn’t exist during this pandemic. I or my successor needs to have it the next time around (2010).

Without a determined federal commitment to assume a stronger role, it is difficult to see how jurisdictional barriers to change will be addressed, particularly as the provinces continue to cherish their independence and are generally unwelcoming of, as many see it, federal “incursions” into provincial affairs.

Perhaps the greatest pressure for Canada to find a solution to this problem will come from beyond Canada’s borders. Not only are new and more deadly pandemic threats likely to emerge in the near future, but, Canada is also under pressure to improve its leadership and information sharing because of new regulations from the WHO. As of 2012, new binding International Health Regulations (IHRs) came into effect. Most notably, the IHRs imposed upon Canada (as well as all other member states) new obligations in health surveillance and management of emergencies. Under the IHRs, Canada is under an obligation to report to the WHO any case within Canada’s border that qualifies as a public health emergency of international concern and must communicate with the WHO from a single national office. According to McDougall, cooperation between all levels of government is “evidently critical” if Canada is to meet the requirements of the new IHRs. The most recent NAPAPI plan may also pressure the Canadian, Mexican and US governments into taking a stronger national lead in order to fulfill their international obligations to work together to coordinate a North American pandemic response. However it remains to be seen how seriously national governments will take commitments to cooperate and share resources when faced with a major outbreak and the domestic public and political pressures that will inevitably accompany it.

SARS was thought to be the event that focused Canadians on the need to reform public health and provided an opportunity to ensure vital systems were up to task for this and
future public health threats. Instead, it became the “wake up call that was never answered” (McDougall 2009, 34). Ten years later, as public and media fears of avian flu and other pandemic threats have waned, the opportunity to learn from SARS and adapt for subsequent emergencies appears to have diminished also. A combination of international pressure, a change in government and/or political ideology and an improving economic situation may gradually re-open a window for substantive change. Ironically, it is, of course, another badly mishandled public health crisis that may, devastatingly, provide the greatest impetus for change, at potentially great cost to the health, wellbeing, and economic development of the population.

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