

**Public health and collaborative federalism:
Or why an allegedly weak system to prevent pandemics is not the result of
intergovernmental relations, collaborative or otherwise**

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ABSTRACT

The predominant view among public health specialists (or at least those who have had the opportunity to comment in print), is that federalism is inimical to the pursuit of good public health. In particular, there is a dominant public health argument that argues that, to effectively respond to public health emergencies, like a pandemic, the Government of Canada should have more authority. In this paper I argue that this particular public health critique of Canadian federalism is incorrect. It is built on a misunderstanding of the nature of Canadian intergovernmental relations, an overly simplistic and narrow interpretation of what motivates and constrains both orders of government and, more generally, betrays a broader tendency in public health to assume that science and social justice (or at least a particular conception of each) should drive the policy making process and trump politics leaving no room for federalism, collaborative or otherwise.

1. Introduction

Over the course of the last decade a new modifier of federalism has become more prominent, at least in Canada. To the existing pantheon of competitive, executive, legislative, open, collaborative, summit, and marble cake federalism, we now routinely see references to public health federalism. This is not surprising. The last decade has seen a series of public health challenges: the spread of the SARS virus on Toronto and parts of British Columbia, the contamination of water in Walkerton and North Battleford Saskatchewan, an outbreak of listeriosis in the food supply and, more recently, the H1N1 influenza pandemic. In each of these cases, we have learned a bit more about the ways in which the federal and provincial governments do and do not work together not to mention the often critical role of local government and regional health authorities and, at the other end of the spectrum, the increasing influence of international organizations notably the World Health Organization.

The predominant view, however, among public health specialists (or at least those who have had the opportunity to comment in print), is that these different episodes demonstrate how federalism is inimical to the pursuit of good public health. More specifically, the Canadian experience with SARS and the alleged inability of the federal and provincial governments to “learn the lessons” from that experience and put in place a proper system of disease surveillance is routinely attributed to the vagaries of yet another kind of federalism, in this case the collaborative federalism that allegedly¹ came to dominate Canadian intergovernmental relations in the late 1990s and into the first decade

¹ I say “allegedly” because I am not convinced that the era of collaborative federalism described by Simeon and Cameron (Cameron and Simeon 2002), and much cited since, was as collaborative as they suggested. At least one of the hallmarks of collaborative federalism, the Social Union Framework Agreement (SUFA), promised much but delivered little.

of this century. In much of the public health literature collaborative federalism is portrayed as a vice not a virtue. Attempts at intergovernmental are deemed to be the proximate cause of what critics see as a woefully inadequate system of gathering the necessary real time data to properly manage an outbreak of infectious disease (Attaran and Wilson 2007; Wilson 2004; Wilson 2006; Wilson, McDougall and Upshur 2006; McDougall 2009). As Amir Attaran has put it with respect to disease surveillance: “Parliament’s deference to the provinces on this issue has reached a ridiculous, potentially tragic, level. In a deadly epidemic, Ottawa’s laws to protect Canadian poultry are stronger than its laws to protect Canadian people.” (Attaran 2008) While much of the public health writing on federalism is focussed on the ability of governments to manage infectious disease, there is a more general tendency to argue that public safety is compromised by the decision by the Government of Canada to join with provincial and territorial governments and collaboratively manage the public health enterprise rather than proceed unilaterally.

This public health critique of collaborative federalism is overstated. In this paper I will argue that the critique is built on a misunderstanding of the nature of Canadian intergovernmental relations, an overly simplistic and narrow interpretation what motivates and constrains both orders of government and, more generally, betrays a broader tendency in public health to assume that science and social justice (or at least a particular conception of each) should drive the policy making process and trump politics leaving no room for federalism, collaborative or otherwise.

The structure of the paper is as follows. In the first substantive section I offer a summary account of the concerns raised with the practice of collaborative federalism as it has been practiced in arena of public health over the past decade or so. The second section offers a critical analysis of these concerns and argues that many are overstated and/or overly hypothetical. The third section addresses what I believe to be the main reason that intergovernmental collaboration is not (yet) highly codified namely the challenge of reconciling the sharing of surveillance data with provincial legislation governing the privacy of personal health information. The fourth and final section is more speculative and considers the extent to which some of the core ideas that drive public health, “social justice” and especially “science”, are in tension with the fundamental nature of federalism.

2. The critique of public health federalism and why it is overstated if not just wrong

At the outset it is critical to make it clear how the term “public health” is being deployed. Public health is *not* being used to refer to a publicly funded or a more or less publicly delivered health care services delivery system. Thus, the focus of this paper is not on public vs. private when it comes to health care service delivery or funding. Rather,

the term public health is used here to refer to the public health enterprise (Chambers and Sullivan 2007) designed to protect the public from the myriad of threats to their health or, more broadly still, what we “as a society, do collectively to assure the conditions for people to be healthy” (Institute of Medicine 1988, 19).

The scope of the public health enterprise is vast and includes, *inter alia*, promoting good health (e.g., by way of social marketing designed to modify individual behaviour) and helping prevent and control chronic diseases and injury, (e.g., addressing the rise in obesity and overweight among children). What often gets the most public and scholarly attention, however, is the control of infectious disease (e.g., SARS, H1N1). Thus, the concerns about the implications of collaborative federalism for public health are derived for the most part, from the Canadian efforts to put in place a system of disease surveillance that is to say a system of data collection and analysis with respect to the changing patterns of illness and death and the causes thereof (Horstmann 1974).

The general argument in much of the writing by on public health federalism is that the decision by the Canadian governments to opt for extensive intergovernmental collaboration has not yet resulted in a situation where Canada can respond quickly and efficiently to the threat of a serious pandemic and is not likely to do so any time soon. Rather, the dominant view among public health observers is that the optimal approach would be an aggressive expansion of the legislative and regulatory authority of the Government of Canada (Attaran and Wilson 2007; Wilson 2004; Wilson 2006; Wilson, McDougall and Upshur 2006; McDougall 2009). The critique of public health federalism as practiced in Canada over the past decade is multi-faceted. What follows is a description and evaluation of several elements of the critique

(a) Our experience with SARS

First, the Canadian experience with SARS is regularly and routinely referenced as very strong evidence to show that shared federal and provincial jurisdiction and authority over infectious disease control is suboptimal. The argument here cites the reports of the federal and Ontario commissions of inquiry that followed the SARS outbreak to show that shared jurisdiction led to ineffective or no communication between the Government of Canada and the Government of Ontario (Wilson, 2006; Campbell, 2004). This in turn led to problems with communicating with the World Health Organization (WHO) in Geneva. In effect, so the argument goes, the travel advisory was a result, not of the number of cases in Toronto (a similar number of cases occurred in Singapore) but rather the inability of Canadian authorities to clearly communicate the number of Canadian cases. (Wilson, et al. 2006; Campbell, 2004) The argument is that SARS demonstrates the inherent weakness of an informal intergovernmental system and that to be truly able to respond to a public health emergency a strong federal government role is essential. Until such time as the Government of Canada has the power to intervene, if only temporarily, Canadians are at risk (Lazar and Wilson 2006; Attaran 2008).

While there is no doubt that the SARS crisis demonstrated that, at that time, the public health enterprise was not well organized and was unable to move quickly, much has occurred in the interim. The creation of the Public Health Agency and the Pan-Canadian Public Health Network that brings together public health officials from across the country mean that the collaborative federalism of today is difficult to compare to the regime that was in place at the time of the SARS crisis (Butler-Jones 2008). Similarly, the advent of new international health regulations means that the decision by the WHO to impose a travel ban is a more codified process than was the case in 2002 (Aginam 2006; Wilson et. al. 2010). Our more recent experience with H1N1 in 2010-11 reveals a need to work on collaboration as between Ottawa and the provinces (notably on who gets to say what about the severity of the crisis /risk communication; vaccine distribution) but there is little evidence of a failure of provincial governments to communicate to Ottawa information about new cases of influenza (Public Health Agency of Canada 2010).

(b) There is a risk that a province will seek to minimise or hide the public health threat

In assessing the best way of managing the threat of a pandemic, in order to justify new federal emergency public health powers Kumanan Wilson suggests that we need to guard against the risk that our collective response to a crisis being hijacked by other concerns. As he puts it: "A province may be concerned about reporting because of [the] impact on industry or tourism" (Wilson, 2006, p. 37). So what are we to make of the concern that there is a risk that provincial or local governments will be slow to respond to the outbreak of a serious infectious disease or in fact try to suppress information about the outbreak? How likely is it that a province or city will want to limit information about a disease outbreak in order to protect local tourism or industry.

This concern arises, I expect, by transposing what we observe as having been past behaviour by states to make predictions about the future behaviour of local and/or provincial governments. So, for example, concerns have been expressed in the past about the willingness of governments in Asia to reveal information about the outbreak of influenza for fear of the economic consequences. [insert reference] The economic costs unreasonably imposed on Mexico for being reasonably transparent about the H1N1 pandemic (Barry 2010) might also lead to the conclusion that states will be once again reluctant to readily share disease surveillance information.

First, we need to ask why a local or provincial government is more likely to engage in this kind of foot dragging if not outright suppression of information as compared to the Government of Canada. McDougall/Wilson suggest that, unlike a local or even a provincial government, the federal government is accountable to a much broader array of voters across the country and is therefore likely to be less inclined to put the interests of all Canadians at risk for the benefit of a more localized minority. This assumes that this broad accountability is powerful enough to overcome the intense short-term political

pressures associated with managing the outbreak of an infectious disease. Alternatively, this line of argument ignores the fact that the government of a large province such as Ontario, Quebec or British Columbia is faced with a similar dynamic. Moreover, the claim that there is a risk that a local public health official will be ordered by the local mayor to downplay a disease outbreak (Attaran and Hébert 2008) is only a theoretical risk in those provinces, for example Ontario, where the public health function remains under the purview of local government. In several provinces the public health function is now the responsibility of relatively largely regional health authorities that are more and less accountable to provincial governments leaving local mayors and councils relatively powerless.

More fundamentally, while it is quite plausible to imagine that some public officials will have an incentive to minimize risks to public health for fear of damaging economic and tourism interests, the likelihood that a government will act on this incentive is much less a function of local or provincial vs. federal and much more a function of the relative autonomy of public health officials. In those jurisdictions where public health officials, notably the Chief Public Health Officer, enjoy a fair degree of provincial autonomy either by virtue of the legislative framework, by force of personality, or some combination of both, it is much less likely that local or public health provincial officials will be successful in trying to suppress information about an outbreak. In contrast, in those cases where autonomy is more limited (including the Government of Canada) there is a theoretical possibility that such a scenario might obtain. I say theoretical possibility because the other key variable is the professional autonomy or sense of professional duty of public health officials. Most if not all public health officials will feel a professional obligation (any may be required to by the rules governing their profession) to be transparent about the threat of a disease outbreak and not succumb to political pressure to “keep things quiet”. Moreover, the disaggregated nature of the Canadian disease surveillance system which begins with primary care including family doctors makes it that much more difficult to imaging a successful attempt to suppress information about a potential outbreak of infectious disease.

In summary then, while there is a theoretical possibility that in the face of evidence of the outbreak of an infectious disease local officials will succumb to pressure to keep things quiet so as to not jeopardize local economic and tourism interests, this risk is not necessarily going to be more prevalent at the local or provincial level and may be offset by the professional rules and procedures governing Canadian public health and health services delivery.

(c) There is a risk that other intergovernmental conflicts will prevent collaboration

Again, perhaps drawing from the pattern in how sovereign states interact with respect to managing pandemics, Wilson argues that there is a risk that a dispute between the federal and provincial governments in another area, he offers the example of fiscal

transfers, may negatively affect the relationship between the two orders of government (Wilson 2006) and, by extension, inhibit collaboration on addressing the risks associated with pandemic influenza and other public health threats.

This argument is highly implausible, to say the least. It rests on a misunderstanding of the nature of intergovernmental conflict, how it is managed and what effects it has on the rest of government. As a general rule, Canadian governments do not resort to linkage politics. When governments do seek to link a conflict in two or more areas, they do so in a measured, targeted way in response to extraordinary circumstances. Such linkage would be the result of a Cabinet level decision, making it a more difficult avenue to pursue. Moreover, linking one conflict with another is almost certainly going to be done in a highly visible way – the point is to draw public attention to an ongoing conflict and put pressure on the federal government to act. Thus, it is unlikely that a provincial government would resist collaboration with the Government of Canada on the management of infectious disease because of a conflict over fiscal transfers. While responding to the threat of pandemics is the purview of provincial departments of health, fiscal transfers are largely the domain of departments of finance and the departments and agencies responsible for intergovernmental affairs. To link transfers to disease surveillance would require a Cabinet-level decision and a public campaign that is hard to imagine.

(d) Provincial governments will refuse to provide the Government of Canada with information in a timely way

By far the biggest single concern expressed by some in the public health community with respect to collaborative federalism is that, absent a strong federal government role, Canada will be unable to provide the WHO with information about an infectious disease outbreak in a timely way. Being unable to provide this information could, so the argument goes, have two negative effects. First, Canada's inability to provide timely information could hamper efforts to control the disease outbreak. Second, being unable to provide the WHO with information could, as occurred with SARS, lead the WHO to declare a travel advisory with negative economic implications for Canada, even if such an action is justified given the magnitude of the public health threat.

The core of the argument turns on a perception of risk and risk management. Anything less than a formal intergovernmental agreement (Wilson 2006) or, better yet, according emergency powers to the federal government (Attaran 2008; Lazar and Wilson 2005) means that there is a risk that one or more provincial governments will be unwilling to share surveillance information in a time of crisis. Rather than come right out and argue that provincial governments will refuse to share information with the Government of Canada during a pandemic, the more common approach is to suggest that there is a risk that this will happen. This is the overriding theme is successive reports of the Auditor General of Canada (Canada, Auditor General of Canada. 2008).

This concern strikes me as unrealistic. First, provincial governments do share surveillance information with the Government of Canada on a regular basis subject to respecting the requirements of provincial legislation governing the privacy of health information. Second, any privacy-related and other concerns that a provincial government might have about such information sharing are likely to be set aside if the country is facing a real public health crisis. In the case of the H1N1 pandemic, even in the absence of formal bilateral agreements with all provincial and territorial governments, the Public Health Agency of Canada was able to get the disease surveillance information it needed and share this information with the WHO. Not only do provinces and territories routinely share data with the Government of Canada, during the H1N1 pandemic, an agreement was reached that included provisions for the sharing of epidemiologic and laboratory data (Public Health Agency of Canada 2010).

Third, information sharing is often portrayed as being something that has to happen very, very quickly in order to respond effectively to the risk of pandemic and respect Canada's obligations under the International Health Regulations. The claim is that, absent a formal intergovernmental agreement or, alternatively, a direct role for the Government of Canada, there is a risk that the public health enterprise will not respond quickly enough. Of course, if the goal is to reduce risk to as close to zero as possible, a powerful single actor is one obvious alternative. Admittedly, intergovernmental and inter-organizational collaboration is more complex to manage. However, dispersed authority also offers something of a fail-safe. Dispersed authority for surveillance and pandemic response means less reliance on a single and inherently fallible infectious disease reporting system managed by the Government of Canada. This speaks to one of the inherent virtues of federalism.

(e) The absence of a binding intergovernmental agreement

As suggested earlier, both the Auditor General and various public health critics have raised concerns that the federal, provincial and territorial governments have been unable to negotiate a set of formal intergovernmental agreements to ensure quick and efficient sharing of surveillance data in the event of a pandemic. (insert sources) Ottawa and the provinces have been working on negotiating bilateral agreements that would provide for information sharing with respect to surveillance information. To date, it would appear that only one formal agreement has been signed, this one between the Government of Canada and the Government of Ontario. (insert information) However, a more general Memorandum of Understanding has also been negotiated that has been endorsed by all the federal, provincial, and territorial governments in Canada. (insert information/reference)

Public health critics point to the fact that only a single agreement has been signed as evidence that intergovernmental collaboration cannot be relied upon to yield an

effective system for managing the risks associated with infectious disease pandemic. However, there are two potential flaws in this argument. First, this line of argument assumes that a bilateral intergovernmental agreement is binding on the parties. In fact, agreements between governments in Canada are largely political and governments are not obliged to respect their terms. While in some cases, there may be a political price to pay if a government does not live up to the terms of an intergovernmental agreement, the simple fact of being a signatory to such an agreement creates few if any binding legal obligations.

Second, in arguing that the absence of bilateral agreements puts public health at risk, typically, little if nothing is said about why governments have been unable to generate more than a single formal intergovernmental agreement. Only the Auditor General, who raises similar concerns, has addressed what is arguably the main stumbling block – privacy of health information.

3. In defence of public health federalism: privacy

In most of the critiques of public health federalism, issues of the privacy of personal health information are simply not mentioned. The inability of the federal and provincial governments to come to formal intergovernmental agreements to govern the sharing of surveillance information is not explained or, by implication, is attributed to some combination of ineptitude or the very nature of collaborative federalism. In a few cases, the issues surrounding the privacy of health information are mentioned in passing and/or are deliberately kept outside of the analysis. (McDougall 2009)

However, it is clear that privacy of health information is a major stumbling block to the sharing of surveillance data. The basic reason is straightforward enough. To control infectious disease it is not enough to know the number or even the location of cases. If this were sufficient the privacy issue would not be as serious because anonymized data would be all that was required. Rather, to effectively respond to the outbreak of an infectious disease, public health officials also need to know the identity of persons affected either because they wish to confine these persons to some sort of quarantine and/or they need to know with whom they have been in contact in order to try and track, and hopefully, stop the spread of the disease. In other words, if a family physician, family health team, emergency room physician or other health care provider diagnoses someone with a particularly serious infectious disease they are obligated to report the case, including the person's identity, to public health authorities. Moreover, as a matter of logic, they must report the case even in the absence of consent by the patient. Yet this is inconsistent with the central premise of most legislation governing the privacy of health information: to the extent possible patients must consent, directly or indirectly, to the sharing of their personal health information.

Of course, most legislation governing the privacy of health information includes clauses that allow for the disclosure of personal health information without consent in order to advance certain other, broader goals, including responding to a public health emergency. Consider, for example, the Pan-Canadian Health Information Privacy and Confidentiality Framework. This is a document prepared by the federal, provincial and territorial governments, and designed to “inform and influence” provincial privacy legislation affecting personal health information. The framework explicitly includes the principle that such health information may be disclosed for the purpose of public health surveillance without individual consent. Seems clear enough. However, the framework goes on to put some limits on such disclosure notably ensuring the highest level of anonymity, ensuring data sharing on a strict need to know basis, and alludes to the need to be able to demonstrate a significant risk to the health and safety of the public) (Canada, Health Canada, 2005).

In effect, putting in place an effective system of sharing of surveillance data to manage infectious disease outbreaks requires the sharing of personal health information. The challenge is to balance the broader goal of protecting public health with the equally valid goal of preventing unnecessary disclosure of private health information. Achieving such a balance is not straightforward given the depth and strength of concern with ensuring the privacy of health information. It is difficult to exaggerate the extent to which citizens are keen to ensure that information about their health remains confidential. The fact that it took the province of Ontario two tries to put in place legislation to protect the privacy of health information is testament to this reality. Similarly, in Saskatchewan health information privacy legislation was passed in 1998 but it was not until 2003 that the legislation was finally proclaimed. Much negotiation was required in the interim to address public concerns about access with legitimate concerns on the part of health providers that such information be accessible.

At a minimum, the fact that Ottawa has not yet signed bilateral agreements with all provincial and territorial governments with respect to the sharing of surveillance data (and relies, for the moment at least, on an overarching Memorandum of Understanding), may be the result of provincial legislation already allows for such sharing. This de facto sharing make a formal bilateral agreement unnecessary unless it can be demonstrated that a provincial government would unilaterally refuse to share surveillance data which, as I have tried to argue, is unlikely. Alternatively, the lack of a bilateral agreement with each provincial and territorial government may be the result of the fact that, as suggested by the Auditor General, the federal government is not yet fully equipped to receive such personal information in a way that ensures privacy. The existence of a bilateral agreement between Ottawa and the Government of Ontario, even in the absence of reforms to federal government practices, may reflect public concerns in that province post-SARS.

Whatever the specific reasons, the absence of bilateral agreements between Ottawa and the provinces with respect to the sharing of surveillance data does not, *ipso facto*, mean that such data will not be shared and that public health is at risk.

4. In defence of public health federalism: is the public health enterprise structurally opposed to federalism?

At first glance, one would be inclined to think that the public health enterprise would welcome the emphasis balancing local and central control and authority that lies at the heart of federalism. Public health remains, after all, an intensely local exercise. However, there is a strong current with the public health enterprise that seeks pan-Canadian responses to most challenges and looks to the Government of Canada to take action even if this means overriding provincial jurisdiction and more importantly, local and provincial expertise with respect to public health.

There are at least three overlapping reasons why the public health enterprise is, for the most part, a locally driven and defined exercise. The first is historical. Public health initiatives began, for the most part, as local efforts to address threats to human health caused by problems with water, sanitation, housing conditions and, in some places at certain points in time, poverty, income inequality and other broader social and economic determinants of health. The importance of local initiative is a hallmark of public health in the United Kingdom, in the United States and, by extension, in Canada (Power and Sheard 2001; MacDougall, 1990). The predominant role of local and city government in public health is manifest in both the origins of the public health movement in the mid to late nineteenth century as well as the “healthy cities” movement in the latter part of the twentieth century which was an effort to revive public health, offset the focus on medical care, and emphasize the important role of local conditions for the health of individuals (Kickbusch, 1989; Hancock, 1997).

Second, while there is broad consensus on best practices and the most effective approaches to addressing a myriad of public health challenges, the precise ways in which these practices and approaches are implemented vary from town to town, from city to city, and from province to province. For example, when it comes to the control of infectious disease, while all provinces require physicians to report to the local public health authority cases of specified infectious disease, in some provinces, but not all, this duty extends to other professions such as teachers. This difference reflects different jurisdictions coming to different conclusions as to how best to balance imposing challenging obligations on non-health professionals versus the desire to protect the public from the threat of infectious disease. Similarly, as part of the challenge of balancing public health considerations and concerns about safeguarding personal health information, in some provinces public authorities are effectively prohibited from releasing personal health information whereas in other provinces such information can be released when

local authorities conclude this is necessary to protect the general public (Gammon, 2006, p. 11).

Finally, the case for local or at least provincial control of the public health enterprise is also linked to one of the classic arguments for federalism: local experimentation and innovation. Local and provincial jurisdiction and leadership over public health mean that cities and to some extent provinces are able to innovate and experiment with different ways of delivering public health services and protecting the general public from public health threats. Some of this experimentation is an expression of local preference. So, for example, while fluoridation of drinking water is common in Ontario and Alberta, it is the exception in British Columbia and Québec. In other cases, the local innovation is the result of leadership designed to address emerging or newly recognized public health challenges. A good example of this latter phenomenon would be the efforts by public health authorities in Montreal and in Peel Region outside of Toronto to extend the remit of public health to include a broader range of health determinants including transportation and land use. In the case of Montreal this has led the local public health authorities to raise concerns about the impact on public health of the plans to replace a major highway interchange (Agence de la santé et des services sociaux de Montréal, Direction de santé publique. 2005). In the case of Peel Region, the local board of health has made land use and transportation a major focus and seeks to bring “health and well-being to discussions on land use and transportation planning across the region”.²

However, there is an equally if not stronger ethos within public health that argues against local variation and local control and for uniform approaches to addressing public health challenges. This centralising ethos has two parts: science and social justice (Krieger and Birn, 1998, Edwards 2009; Faden and Powers 2008). Individually and together these meta-ideas argue in favour, not of local control and experimentation, but rather for uniformity and commonality in the public health enterprise both within as well as between states. In this paper I will not deal with the tension between federalism and social justice and focus on the centralising effect of the application of a science of public health.

The centralising effect of a “science” of public health

In the last 25 years or so, a determined effort has been made to ensure that medicine and health care service delivery are, in not “evidence-based”. The general idea is that almost all that is done by way of health care should be based or informed by the best possible scientific evidence and that health care providers should strive, as much as possible, to ensure that both what they do and how they do it, reflects the best available

² See HealthyPeelByDesign.ca - <http://www.peelregion.ca/health/resources/healthbydesign/>

evidence.³ These emphases on evidence-based medicine have, not surprisingly, influenced public health and there is a parallel movement to try to make sure that public health interventions are based on the best possible evidence (Brownson et. al., 2010).

The embrace of science and evidence as the basis of public health is also the result, not just of the influence of the practice of medicine, but also the ongoing desire of public health officials to have a counterweight to parochial and local politics. Stated in the most negative way, the challenge for public health is that local officials will ignore the (best available) science and allow decisions to be unduly influenced by local prejudice and powerful local economic interests. This line of argument echoes the concerns about collaborative federalism and infectious disease surveillance cited earlier.

If science is to be a counterweight to local politics then it is not hard to see how a “scientific” approach to public health does not allow for a great deal of local variation. It assumes that public health practice, programs and policy can and should be designed solely on the basis of the best available scientific evidence which leaves little if any room for other considerations including, but not limited to, local preference.

Yet the arguments for any given public health interventions are rarely stated as either/or, yes or no. More often, the issue is framed in terms of risk and risk management. Precisely in order to allow for some degree of local preference the issue becomes one of coming to agreement on what level of risk a community is willing to live with. When the public health threat or benefit is local and contained, for example, the benefits associated with fluoridated water, it is relatively straightforward to imagine different towns, cities and indeed provinces coming to different conclusions about how to balance risk and reward. More complex is the case of infectious disease and public health surveillance raised at the outset of this paper, where the benefits are local (i.e., enhanced protection of personal health information) but the risks are both local and national and international (i.e., the rapid spread of infectious disease).

However, precisely because the issue is one of risk, risk management, and risk communication, the inherently political nature of public health is manifest. Risk management is fundamentally a political act. To be effective it requires a degree of trust – local residents are likely to have more trust in their local officials to make decisions that balance risk and benefits.

Conclusion

³ The literature on evidence-based medicine is enormous. For a basic introduction see Sackett, et. al. 1996. For an introduction to the allied notion of evidence-informed medicine see Lomas and Brown 2009. For a much more critical account of the whole evidence-based movement in health care see Holmes et. al., 2006.

Is, as suggested by Attaran and others, public safety compromised by the decision by the Government of Canada to join with provincial and territorial governments and collaboratively manage the public health enterprise (Attaran 2008)? Would it be preferable for the federal government to proceed unilaterally, either narrowly with respect to surveillance of infectious disease or more generally with respect to the protection of public health? The general argument presented in this paper is that the answer to both questions is no.

To assert that intergovernmental collaboration in surveillance of infectious disease puts public safety at risk assumes that the present is like the past and that governments have not learned from the experience with SARS. The most recent experience with the H1N1 pandemic suggests this is not the case. The assertion further assumes that a provincial government, more than the Government of Canada, has an interest and an ability to minimise the public health threat. In fact, this risk is not a function of the order of government and much more linked to the autonomy of the public health officials responsible and, in most provinces, they enjoy considerable autonomy from local officials. The suggestion that collaborative federalism endangers public health is also sometimes linked to the risk that governments will be unable or unwilling to collaborate with respect to health because of disagreements with respect to some other area. This paper argued that this is unlikely both because of the way in which governments operate and, more fundamentally, because it is difficult if not impossible to imagine a provincial government being able to sustain its unwillingness to collaborate on a matter of public health in the court of public opinion. Finally, the alleged public health risk is linked to the apparent inability of governments to conclude bilateral agreements on data sharing. This assumes that such agreements will, in fact, guarantee that such sharing will occur when, in fact, intergovernmental agreements are, by their very nature, hortatory, and not particularly binding (or, for that matter, justiciable).

Most importantly, the critique of public health federalism is, for the most part, silent on the reasons why, despite considerable effort, the federal and provincial governments have been unable to craft a series of agreements to govern the sharing of personal health information with a view to better managing a pandemic and allowing Canada to respect its obligations to share such information under international law. The reason is not simple incompetence nor is it the constraints imposed by the decision to collaborate. Rather, the fact that the federal and provincial governments have had difficulty coming to agreement rests on the tension between such information sharing and provincial legislation, existing and anticipated, that limits when and how personal health information is disseminated. While a formal intergovernmental agreement might reduce the risk of conflict and an inability to share information with the World Health Organisation (but could not eliminate it), signing such an agreement is made more difficult by the legislative undertaking of several provincial governments to restrict the sharing of personal health information.

More broadly, the critique of public health federalism as practiced with respect to pandemic planning raises the question of whether and to what extent there is a tension if not an outright conflict between certain core ideas of the public health enterprise and the federal idea or at least the practice of federalism. At first, glance, it would appear that public health enterprise would be enthusiastic or at least supportive of federalism insofar as much of public health began, and continue to be, a very much local enterprise with the inevitable and often desirable variations as officials seek to pursue public health goals in a manner that reflects local conditions and local preferences. However, this local orientation of public health is offset if not eclipsed by some of the meta-ideas that animate public health, specifically science and social justice. This paper briefly explores the more general tension between federalism (and the associated idea of variation in public health law and practice) and the important role that science, especially epidemiology, plays in public health. A science of public health assumes that scientific inquiry will produce evidence as to what works and, by extension that public health law, policy, programs and practice will reflect if not conform to the best available scientific evidence. This assumption flies in the face of what we know about how law and policy get made. To assume that public health policy should be based only, or at least primarily, on the best available scientific evidence is to transpose the problem-solving model of clinical medicine to the realm of public health policy (Fafard 2008). In reality, public health policy is and should be based on a combination of the best available scientific evidence and the judgement of elected and appointed officials. In a federation where state authority is divided between two orders of government this will often mean that the application of the best available science varies from one jurisdiction to another. This variation reflects and is the result of a combination of different judgements about the good and, by extension, interpretations of local conditions and preferences. This is the very essence of federalism.

In effect, as the Rowell-Sirois Commission concluded in 1940, "... there are pronounced regional differences in Canada in social philosophy which are bound to affect public health legislation. Centralization of jurisdiction might not, therefore, conduce to progressive action in public health, or to national unity in general" (Canada, Royal Commission on Dominion-Provincial Relations. 1940, p. 34). In other words, public health federalism, far from being a binding straightjacket or leading to suboptimal outcomes is, in fact, conducive to innovation and policies and programs that balance science with local preference.

References

- Agence de la santé et des services sociaux de Montréal, Direction de santé publique. 2005. *Le transport urbain, une question de santé, Rapport annuel 2006*, Montreal: Agence de la santé et des service sociaux de Montréal.
- Aginam, Obijiofor. 2006. "Globalization of health insecurity: the World Health Organization and the new International Health Regulations." *Medicine and Law* 25(4): 663-672.
- Attaran, Amir. 2008. "A legislative failure of epidemic proportions." *CMAJ* 179 (1) (July 1): 9. doi:10.1503/cmaj.080818.
- Attaran, Amir, and Paul C. Hébert. 2008. "[Response to] Butler-Jones, David, 'Disease Surveillance'". *CMAJ* 179(2)(July 15): 163.
- Attaran, Amir, and Kumanan Wilson. 2007. "Legal and Epidemiological Justification for Federal Authority in Public Health Emergencies, A." *McGill Law Journal* 52: 381.
- Barry, John W. 2010. "The Next Pandemic." *World Policy Journal* 27(2): 10-12.
- Brownson, Ross C., Elizabeth A. Baker, Terry L. Leet, Kathleen N. Gillespie, and William R. True. 2010. *Evidence-Based Public Health*. Oxford University Press US.
- Butler-Jones, David. 2008. "Disease surveillance." *CMAJ : Canadian Medical Association Journal* 179(2): 163-163.
- Campbell, A. 2004. *The SARS Commission Interim Report. SARS and Public Health in Ontario*. Toronto: Government of Ontario.
- Cameron, David, and Richard Simeon. 2002. "Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism." *Publius: The Journal of Federalism* 32(2): 49 -72.
- Canada, Auditor General of Canada. 2008. *Surveillance of Infectious Diseases - Public Health Agency of Canada*. (Ottawa: Auditor General of Canada).
- Canada, Health Canada. 2005. *Pan-Canadian Health Information Privacy and Confidentiality Framework*. Mimeo. <http://www.hc-sc.gc.ca/hcs-sss/pubs/ehealth-esante/2005-pancanad-priv/index-eng.php#provisions>. Accessed April 25, 2011.
- Canada, Royal Commission on Dominion-Provincial Relations. 1940 (1954). *Report of the Royal Commission on Dominion-Provincial Relations*. Book II: Recommendations. Ottawa: King's Printer.
- Chambers, Larry W, and Shannon M Sullivan. 2007. "Reflections on Canada's public health enterprise in the 21st century." *HealthcarePapers* 7(3): 22-30.
- Edwards, Nancy. 2009. "Revisiting our Social Justice Roots in Population Health Intervention Research." *Canadian Journal of Public Health* 100(6): 405-406.
- Faden, R. R., and M. Powers. 2008. "Health inequities and social justice." *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* 51(2): 151-157.

- Fafard, P. 2008. *Evidence and healthy public policy: insights from health and political sciences*. Montreal: National Collaborating Centre for Healthy Public Policy; Canadian Policy Research Networks.
- afard, P. 2008. *Evidence and healthy public policy: insights from health and political sciences*. National Collaborating Centre for Healthy Public Policy.
- Gammon, Keri. 2006. "Pandemics and Pandemonium: Constitutional Jurisdiction over Public Health." *Dalhousie Journal of Legal Studies* 15: 1.
- Hancock, Trevor. 1997. "Healthy cities and communities: Past, present, and future." *National Civic Review* 86(1): 11-21.
- Hawe, Penelope. 2009. "The social determinants of health: how can a radical agenda be mainstreamed?" *Canadian Journal of Public Health. Revue Canadienne De Santé Publique* 100(4): 291-293.
- Holmes, Dave, Stuart J Murray, Amélie Perron, and Geneviève Rail. 2006. "Deconstructing the evidence-based discourse in health sciences: truth, power and fascism." *International Journal of Evidence-Based Healthcare* 4(3): 180-186.
- Horstmann, Dorothy M. 1974. "Importance of disease surveillance." *Preventive Medicine* 3(4): 436-442.
- Institute of Medicine. Committee for the Study of the Future of Public Health, Division of Health Care Services. 1988. *The Future of Public Health*. Washington, DC: National Academy Press.
- Kickbusch, I. 1989. "Healthy Cities: a working project and a growing movement." *Health Promotion International* 4(2): 77.
- Krieger, N, and A E Birn. 1998. "A vision of social justice as the foundation of public health: commemorating 150 years of the spirit of 1848." *American Journal of Public Health* 88(11): 1603-1606.
- Lazar, Harvey, and Kumanan Wilson. 2005. *Planning for the Next Pandemic: Defining the Federal Role in Public Health Emergencies*. Institute for Research on Public Policy.
- Lomas, Jonathan, and Adalsteinn D. Brown. 2009. "Research and Advice Giving: A Functional View of Evidence-Informed Policy Advice in a Canadian Ministry of Health." *Milbank Quarterly* 87(4): 903-926.
- MacDougall, Heather Anne. 1990. *Activists and advocates: Toronto's health department, 1883-1983*. Dundurn Press Ltd.
- McDougall, Christopher W. 2009. "Still waiting for a comprehensive national epidemic surveillance system: A case study of how collaborative federalism has become a risk to public health." Kingston, Ontario: Institute of Intergovernmental Relations.
- Public Health Agency of Canada. 2010. *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic*. (Ottawa: Public Health Agency of Canada). http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2010-2011/h1n1/index-eng.php Retrieved April 25, 2010.
- Power, Helen J., and Sally Sheard. 2001. *Body and City: Histories of Urban Public Health*. Surrey, U.K.: Ashgate Pub Ltd.

Sackett, David L, William M C Rosenberg, J A Muir Gray, R Brian Haynes, and W Scott Richardson. 1996. "Evidence based medicine: what it is and what it isn't." *BMJ* 312(7023): 71 -72.

Wilson, Kumanan. 2004. "The complexities of multi-level governance in public health." *Canadian Journal of Public Health*. 95(6): 409-412.

Wilson, Kumanan. 2006. "Pandemic Threats and the Need for New Emergency Public Health Legislation in Canada." *Healthcare Policy* 2 (2) (November): 35-42.

Wilson, Kumanan, Christopher McDougall, and Ross Upshur. 2006. "The new International Health Regulations and the federalism dilemma." *PLoS Medicine* 3 (1) (January): e1. doi:10.1371/journal.pmed.0030001.

Wilson, Kumanan, John S Brownstein, and David P Fidler. 2010. "Strengthening the International Health Regulations: lessons from the H1N1 pandemic." *Health Policy Plan*.
<http://heapol.oxfordjournals.org.proxy.bib.uottawa.ca/cgi/content/abstract/czq026v1> (Accessed August 16, 2010).