

---

# COVID IS OUR MOMENT TO RENEW PUBLIC HEALTH

Esyllt Jones, Heather MacDougall and Laurence Monnais | October 29, 2020

Since the introduction of medicare in the late 1960s, public health and prevention have slipped to the margins of health policy in Canada. As hospital and medical services become more expensive, we neglect preventive capacity. The novel coronavirus outbreak is an opportunity to re-balance prevention and cure, creating true resilience in a changing disease landscape.

COVID-19 is a stark reminder of the importance of maintaining the basic tenets of communicable disease control; and that the burden of disease does not fall equally on all. The pandemic reflects and reinforces differential health impacts due to poverty, racism, and inequality.

We should be planning an integrated approach via sustained public health programming and capacity building for disease outbreaks, as well as investment focused on the underlying social structures of health and disease, to reduce health inequities.

Public health receives a tiny sliver of overall Canadian investment in health – in some provinces as little as 1.5% of the health budget. The consequences of this chronic under-funding are now being felt even more acutely by Canadians as the latest wave of Covid-19 causes a surge in infections. And, as typically happens during a public-health emergency, public-health officials are under increased scrutiny, and a blame game has started.

Agencies such as the Public Health Agency of Canada (PHAC) have been doing their best in a difficult context. And more importantly, the challenges facing public health are decades in the making.

For most of the past fifty years, Canadian policy-makers's fundamental approach to prevention (including health promotion and social determinants) has been to talk a lot about how important it is to controlling health care costs, while simultaneously starving public health of resources.

Publicly insured medical services should not undermine prevention. In the 1930s and 1940s, models for fully socialized medicine called for equal access to health care, but also the need to integrate prevention and cure. The recommendations of the Hall Commission (1964-65), however, promoted national health insurance for hospital and medical care but said very little about prevention and public health.

In an unintended consequence of the introduction of medicare in 1966, prevention and cure have been pitted against each other in a competition for limited resources. This is a contest public health will never win. When prevention works, the results are not visible. Many of its primary tools have been known for centuries, and are rarely high-profile.

The shift to health promotion, led by the federal Liberal government beginning in the 1970s and embraced by the provinces, created two consequential trends that, ironically, served to further

---

---

weaken public health. In 1974, *A New Perspective on the Health of Canadians* (known as the Lalonde Report) challenged the primacy of medical and hospital care by suggesting that biology, environment, and lifestyle choices were more important than health care in determining an individual's health and longevity. The Lalonde Report, and later, *Achieving Health for All* (1986), while utilizing a discourse of prevention and community engagement, reflected a shift towards individual self-education and responsibility (to eat better, exercise, stop smoking, drink moderately), and away from collective responsibility for society's health.

What some called the "new public health," which was supposed to make health care more cost-effective, emerged from a larger context of fiscal austerity and budget cuts. In 1977, barely more than a decade after the passage of the Medical Care Act, the federal government ended open 50-50 cost-sharing with the provinces. Inflation and the economic fall-out of the oil crisis (1973-74) heralded what would become a very long period of fiscal tightening and subsequent changes in health and social welfare policy by governments at all levels.

Despite the outward-facing policy emphasis on health promotion and prevention, in reality even basic public health programs such as vaccination had to compete for restricted resources. The larger goal of addressing the inequities giving rise to disease vulnerability failed to gain traction.

Concern about epidemic outbreaks was dampened by the childhood vaccination campaigns of the post-WWII period. After the clear success of a state-driven fight against polio, vaccines contained many formerly common diseases such as measles, mumps, and rubella. At least for a time.

The overall decline in these diseases, however, masked persistent problems with our approach to public health. For example, a vaccine for measles was commercially available in Canada from 1963. But access to vaccination and parental acceptance was challenged by political, social and economic factors. Inadequate government funding for vaccination programs, the lack of national standards for childhood immunization schedules, lack of vaccinology training for doctors, and parental concerns based partly on societal critiques of biomedicine, declining trust in experts, and a lack of health education – all contributed to periodic outbreaks of infectious diseases such as measles. Declining vaccination rates now pose a significant challenge to controlling Covid-19, assuming effective vaccines become available.

The re-emergence of viral diseases since the advent of HIV/AIDS in the early 1980s has revealed the flaws in our thinking. Infectious disease and pandemics are not a problem of the past. Both HIV/AIDS and SARS were warning signs that Canada's public health system needed greater attention. These signs were not taken seriously enough.

We now appear destined to repeat an old pattern of crisis-driven debate, limited improvements, later followed by retrenchment in government support for public health.

---

To achieve a more effective and multi-pronged public health approach, the Canadian public and policymakers must envision disease prevention based on collective responsibility. A collective response requires sustained and stable increases in investment in public health, and greater recognition of its indispensable role in planning for our new health reality -- what some social scientists call a “syndemic” in which chronic health inequities and infectious diseases combine to greatly increase our vulnerabilities at both the individual and the societal levels. COVID is our opportunity to transform our system for the better.

*This article initially appeared in the Globe and Mail on October 29, 2020.*