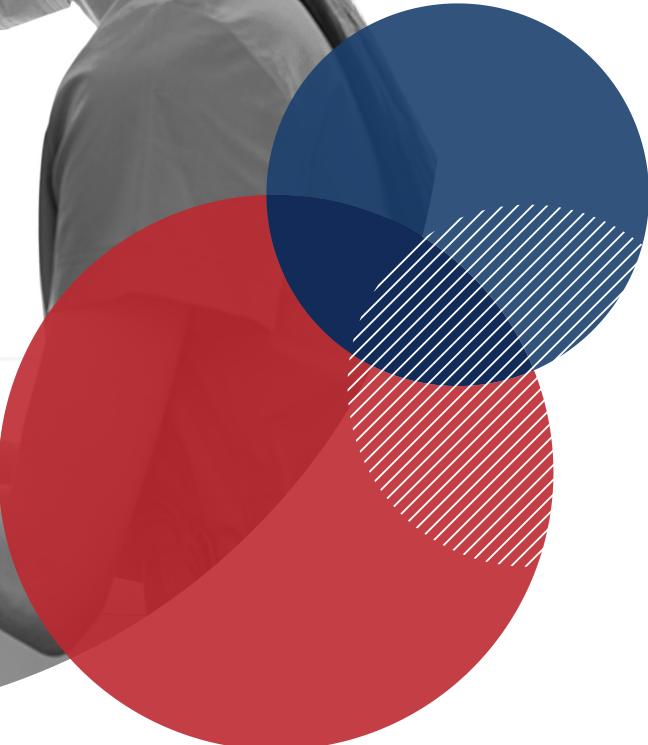




**WHO
DOES
WHAT**
SERIES



The Municipal Role In **PUBLIC HEALTH**

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About IMFG

The Institute on Municipal Finance and Governance (IMFG) is an academic research hub and non-partisan think tank based in the School of Cities at the University of Toronto.

IMFG focuses on the fiscal health and governance challenges facing large cities and city-regions. Its objective is to spark and inform public debate, and to engage the academic and policy communities around important issues of municipal finance and governance. The Institute conducts original research on issues facing cities in Canada and around the world; promotes high-level discussion among Canada's government, academic, corporate, and community leaders through conferences and roundtables; and supports graduate and postgraduate students to build Canada's cadre of municipal finance and governance experts. It is the only institute in Canada that focuses solely on municipal finance issues in large cities and city-regions.

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About the Urban Policy Lab

The Urban Policy Lab is the Munk School of Global Affairs and Public Policy's training ground for urban policy professionals, offering students career development and experiential learning opportunities through graduate fellowships, skills workshops, networking and mentorship programs, collaborative research, and civic education projects.

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Executive Summary

Public health is a rich and broad concept. It includes the direct provision of programs and services, but also encompasses expansive notions of a healthy society. In this sense, a wide range of government functions intersect with public health. In fact, 90 percent of municipal operational expenditures in Ontario contribute directly or indirectly to the social determinants of health.

The formal public health system cuts across federal, provincial, regional, and municipal jurisdictions. The COVID-19 pandemic serves as a case in point: the federal government was responsible for certain quarantine requirements and the Public Health Agency of Canada, which served as the face of the national response; provincial governments set in place province-wide mandates; and local governments played a key role in implementing, or even going beyond, the measures required by higher levels of government.

As public health is both a complex concept and a shared responsibility, coordination and cooperation between levels of government take on special importance.

Municipalities

Katherine Fierlbeck and Gaynor Watson-Creed set out the broad scope of municipal engagement in public health, noting that the urban context can have a direct impact on the health of individuals. They stress the important role of municipalities in tailoring public health interventions to the local context.

Similarly, Lawrence Loh highlights how municipalities sometimes act as first movers, setting precedents later adopted at the provincial level, and sometimes play the opposite role, adjusting provincial policies to fit the local context. He cites the examples of the *Smoke-Free Ontario Act*, which the province introduced only after many cities had already banned smoking in public spaces, and the COVID-19 pandemic response, where municipalities adapted provincial decisions to fit local needs.

Lindsay McLaren and Jason Cabaj put forward a vision of public health in which municipal governments have a more clearly defined role, and which, in turn, supports a broader well-being agenda as a path to population health and health equity.

Provincial governments

Fierlbeck and Watson-Creed note that while the role of the formal public health system is enshrined in provincial legislation, some provincially led reorganizations have undermined the system's effectiveness. Provinces must collaborate and share data with municipalities to achieve better outcomes.

Loh recognizes the provincial government's role in putting in place overall frameworks which local authorities can adapt, or exceed, as necessary. In this context, Loh emphasizes the need for the provinces to adequately and equitably resource local public health units.

McLaren and Cabaj call for legislative changes at the provincial level to facilitate coordination with municipalities. However, they also point out that a well-being approach to public health applies to provincial governments as well as municipal governments, since it hinges on a broader, coherent societal vision of health rather than the actions of a single level of government.

Federal government

Fierlbeck and Watson-Creed argue that failure to coordinate across levels of government, including at the federal level, characterized the handling of the SARS outbreak in 2003. But improved coordination does not necessarily mean centralization: information and data-sharing at the national level should strengthen local governance of public health.

McLaren and Cabaj also emphasize the federal government's role in coordination, as well as in funding and establishing accountability mechanisms. To this end, they explore the possibility of a national *Public Health Act*. Such legislation would enhance public understanding that formal public health involves all levels of government.

Intergovernmental cooperation

Cooperation between levels of government underpins the recommendations in all three papers. For example, Fierlbeck and Watson-Creed describe how a national framework for health data collection could bolster public health surveillance. Loh concludes that Ontario's balance between local and provincial policy-making can lead to complicated dialogue but achieve

good results. McLaren and Cabaj frame intergovernmental cooperation in two contexts: first, as the cornerstone of incremental efforts to strengthen the formal public health system, and second, as a means to implement a bolder well-being agenda, which will require action on the part of all levels of government.

About the Who Does What Series

Canadian municipalities play increasingly important roles in addressing the policy challenges at the centre of political debate, including addressing climate change, increasing housing affordability, reforming policing, and confronting public health crises. The growing prominence of municipalities, however, has also led to tensions over overlapping responsibilities with provinces and the federal government. Such “entanglement” between orders of government can result in poor coordination and opaque accountability. At the same time, combining the strengths and capabilities of different orders of government – whether in setting policy, convening, funding, or delivering services – can lead to more effective action.

The Who Does What series gathers academics and practitioners to examine the role municipalities should play in key policy areas, the reforms required to ensure municipalities can deliver on their responsibilities, and the collaboration required among governments to meet the country’s challenges. It is produced by the Institute on Municipal Finance and Governance and the Urban Policy Lab.



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Who Does What: The Municipal Role in Public Health

Backgrounder: Municipalities and Public Health

By Tomas Hachard, Gabriel Eidelman, and Ruth Rosalle

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Local and regional bodies are integral parts of the public health infrastructure in many parts of the country, offering services related to communicable diseases, vaccinations, substance use, mental health, sexual health, and more.

Municipalities contribute to public health policy both through their relationships to these bodies and their own policy-making. This backgrounder examines the role Canadian municipalities play in public health, where they face constraints, and how they work with other orders of government.

How municipalities work independently within legal and fiscal constraints

The structure of regional or local public health units varies considerably across the country, as does the role municipalities play in relation to them. In Ontario, local public health units have direct relationships with municipalities. The 34 units are established in the *Health Protection and Promotion Act* (1990), the *Municipal Act* (2001), and the *City of Toronto Act* (2006), either as local boards of health or regional boards with representation from multiple municipalities, each led by its own chief medical officer of health.¹ Provincial governments fund 70 percent of public health units, with the remainder paid for by municipal governments.²

Most provinces have regional or local public health units without municipal involvement. In British Columbia, five provincially funded Regional Health Authorities are

responsible for the provision of health services that range from acute care to public health services, and complement the services provided and funded by the province.³ In Québec, the Ministry of Health and Social Services (Ministère de la Santé et des Services sociaux) shares responsibility for protecting community health with 18 regional public health departments across the province.⁴ Similar systems operate in Manitoba (five regions), New Brunswick (seven), Nova Scotia (four), and Newfoundland and Labrador (four).⁵

Some provinces have experimented with eliminating or amalgamating regional and local public health units. In 2009, the province of Alberta integrated its 12 health units, which were responsible for public health and more, to create a single-tier model, overseen by Alberta Health Services.⁶ Saskatchewan implemented a similar integration in 2017.⁷ More recently, Alberta Health Services once again reorganized to create five regional “zones” that help deliver care, including related public health programs. Prince Edward Island remains the only province that operates a single public health unit for the entire province.

In some cases, provincial legislation grants municipalities the authority to make public health decisions on their own. For example, at different times, the City of Calgary has eliminated or reinstated fluoridation of its drinking water by a vote of council. In Toronto, food safety regulations and restaurant inspections are overseen by municipal bylaw enforcement. And in response to the COVID-19 pandemic, many municipalities closed playgrounds, limited access to parks, and used ticketing to manage group sizes and physical distancing requirements in public spaces.⁸

To some observers, these differences create confusion and blurred lines of accountability. In March 2022, for example, the Alberta government passed legislation requiring Ministerial approval for any municipal bylaws related to masking or proof of vaccination.⁹

Ultimately, though, the breadth of public health initiatives led by municipalities is constrained by limited funding. In a 2013 survey of senior-level staff and local politicians from 17 municipalities in Metro Vancouver, respondents indicated that municipalities have limited capacity to address health inequities in comparison with other orders of government, reflecting “concerns within municipalities across Canada about fiscal imbalance and downloading of responsibilities from senior governments to the municipal level.”¹⁰

Municipal coordination with other orders of government

Municipalities and local health units are part of a larger public health structure that was significantly restructured following recommendations from the 2003 National Advisory Committee on SARS and Public Health (commonly referred to as the Naylor Report).¹¹ The report argued that the largest impediment to addressing SARS was a lack of collaboration between orders of government. The report spurred the creation of the Public Health Agency of Canada, which includes the Pan-Canadian Public Health Network, a table that includes representatives of each province, co-chaired by a federal and provincial representative.¹²

Despite this change, public health policy remains largely a provincial responsibility. While the level of local or regional delivery varies from province to province, as noted earlier, most provinces have legislation that establishes a

Chief Medical Officer of Health (CMOH) to implement province-wide public health orders and policies.¹³ CMOHs and their offices complement the public health unit structure by overseeing public health

policies and programs. Their role expanded and became more visible during the COVID-19 pandemic.¹⁴

Where municipalities are not directly involved in setting public health policy through local health units, there is case-by-case cooperation between provinces and municipalities. In 2018, for instance, the government of Québec announced a public health plan that included support for municipalities in analyzing the health effects of land-use planning and development.¹⁵

In British Columbia, the Vancouver Coastal Health Authority and the City of Vancouver co-led the creation of a healthy city strategy to collaboratively *design* policies related to community safety; healthy childhood development; food, income and employment security; and more. The strategy is run by the Healthy City for All Leadership Table, co-chaired by the CMHO and Vancouver’s City Manager. The Table comprises 30 individuals representing municipal, provincial, and federal government departments, public- and private-sector agencies, and foundations.¹⁶

In other cases, municipalities work collaboratively to *complement* provincial plans. The City of Vancouver’s “Four Pillars” drug strategy, which provides supervised injection sites,¹⁷ worked in tandem with a three-year, \$322-million provincial investment to support community-based overdose prevention, as well as mental health and addictions services.¹⁸

Conclusion

Municipalities play varied roles in the public health infrastructure across the country. Municipal decisions impact public health directly, as in the case of fluoridation, and indirectly, when areas of municipal responsibility such as housing and transportation interact with the social determinants of health. In some cases, municipalities also directly oversee and fund local public health units.

Public health policy is also collaborative in nature, as the COVID-19 crisis has illustrated. Before the pandemic, some municipalities already coordinated with regional health authorities and provinces on public health strategies. And while the pandemic brought intergovernmental tensions to the fore, it also highlighted the role of municipalities as central players in responding to public health crises.

Municipal governance and public health

By Katherine Fierlbeck and Gaynor Watson-Creed

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The precise relationship between public health and municipalities, as Hachard, Eidelman, and Rosalle note in their backgrounder, varies considerably across Canada. Some features are relatively consistent across jurisdictions, however. One is that the municipal role in public health connects to the broader health care system in its focus on the social determinants of health. A second is that the municipal role in public health has, over the past decade, been affected by health system reforms at the provincial level in a way that makes them less able to fulfil this role effectively.

The consolidation of public health units under provincial centralization strategies has undermined the capacity of public health to address these larger health issues in a targeted and effective manner.

Municipal health and the social determinants of health

While the legislative basis of much public health rests at the provincial level, municipalities can often address the social determinants of health in a nimbler and more focused manner than the province can. Many aspects of residents' physical environment are the direct product of a particular urban context, such as drinking water quality, garbage collection, noise pollution, and land use policies (which affect, for example, the availability of green space or recreational facilities). Other municipal policies and services, such as local transportation, affordable housing, workplace safety, and food security, can also affect the health of urban populations.¹⁹ And because social isolation and marginalization can contribute to diminished health status, support for social networks, social capital initiatives, and other forms of social integration are important municipal initiatives.²⁰

The Association of Municipalities Ontario notes that 90 percent of municipal operational expenditures in Ontario (\$42.5 billion) contribute directly or indirectly to the social determinants of health.²¹ The urban context is also useful in understanding and addressing the distribution of health and disease in the population. As Patricia Collins and Michael Hayes argue, "Social gradients in health can be created and exacerbated when municipal governments (or comparable

government bodies operating locally) are unable to plan, deliver, and manage equitable and viable spaces to live amidst rapid population growth.”²²

While many actors are involved in the achievement of public health goals, the *formal* public health system is mandated under provincial legislation. All provinces have chief medical officers (or chief public health officers) who are directly accountable to Ministers of Health. Why, then, is a public health presence important at a municipal level?

One advantage to having a local public health capacity is that municipal officials can more effectively form relationships with local stakeholder groups. This is especially the case where relationships of trust must be built within a context that is relevant to populations of interest. Often that context includes neighbourhoods, which are recognizable within municipal governance models. Relationships with marginalized communities can most constructively be built around their particular “neighbourhood” dynamic.²³

As with other models of decentralized governance, where

authority rests nearer to local populations, the specific needs of discrete communities can be identified and addressed more effectively. A more granular focus on smaller groups who can engage in the discussion of health-related issues can also nurture a greater sense of ownership in the programs that are developed.

This fine-tuning of programs geared to overarching public health objectives can make a difference: a general obesity-prevention program that focuses solely on individual diet and exercise information, for example, may be irrelevant in a neighbourhood where the underlying issue is access to fresh and nutritious food. Defining problems locally can also support more innovative kinds of policy or program development, whereby partners can identify unanticipated barriers and potential opportunities in policy development.

At a more localized level, as well, there are often fewer competing priorities diverting personnel and resources away from public health objectives to clinical ones. Finally, problem-solving for public health issues can be nimbler at a local level. Where the protocol for decision-making at a provincial level can be slow and cumbersome (especially in a centralized system, where decision-making has to be approved at several levels before any action can be taken), public health officials working with municipal officials can often address

unexpected issues more quickly, responsively, and creatively.²⁴ Finally, as Evelyne de Leeuw argues, public health policy learning can be more effectively applied horizontally across jurisdictions (city to city) than in a top-down manner from central governmental authorities to municipalities.²⁵

Municipal public health and health system reform

The interface of public health and municipal governance varies across Canada. In Québec, for example, 2004 reforms led to a more formal integration of public health into local governance structures through Health and Social Services Centres (CSSSs), which were charged with the improvement of geographically defined populations.²⁶ In Ontario, some municipal public health units are “autonomous,” existing at a local level, but independent of municipalities, while others are “integrated,” operating within the administrative structure of municipalities.²⁷ And, in Nova Scotia, key municipal public health functions do not reside within the public health domain at all: in 1994, health inspectors were moved out of public health units altogether and into the Department of Environment due to perceived overlap

between municipal and provincial functions.²⁸ Similar reorganizations have taken place in New Brunswick and Newfoundland and Labrador.

Notwithstanding these historical differences across provinces, the larger trend toward centralization in health governance has had a considerable impact on the municipal role of public health in most jurisdictions. Following a period of decentralization in provincial health governance, and the establishment of regional health authorities in many provinces, the centralization of health authorities began in Alberta in 2008, a move repeated in several other provinces.²⁹ The reasons cited for this move included cost efficiency, greater political control, and greater uniformity across jurisdictions.³⁰ At the same time, public health emergencies (such as SARS and H1N1) showed the difficulty of mounting a coordinated response in a highly decentralized system of provincial health care governance.

The SARS outbreak in 2003 was a highly visible case study of the failure of provincial and federal jurisdictions to work effectively in both policy coordination and data-sharing. Turf wars between institutions, differing practices across public health units, problems with data-sharing, and unclear protocols led to the shock and embarrassment of the WTO’s imposition of a travel advisory for Toronto in April 2003.³¹

While a concerted effort was made to establish better communications and modes of collaboration in the wake of SARS, the 2009 H1N1 pandemic, which manifested itself more widely across the country, exposed both novel and ongoing problems of coordination. Within provinces, the prevalence of highly decentralized Regional Health Authorities complicated attempts to inventory essential medical supplies, establish who was in charge of which operations, and shift goods and personnel where they were needed.³² Across provinces, messaging differed, and the numerous bodies set up after SARS to support and coordinate government activity across federal and provincial jurisdictions led to the duplication of efforts and confusion regarding roles and responsibilities.³³

While much of the reamalgamation of health authorities across Canadian provinces was due to larger organizational and financial concerns, the difficulty of organizing pandemic responses also played a role in the move to greater centralization in the following decade.

This reorganization of health care governance across provinces has clearly had a detrimental effect on the municipal-public health interface. The most notable consequence in some provinces has been the reduction in funding for public health as a discrete function.³⁴ In Québec, for example, Bill 10, introduced in 2015, led to a 30 percent reduction of public health funding.³⁵ Similarly, Ontario announced plans in 2019 to reduce the number of local public health units, with a funding reduction of 27 percent for public health.³⁶

Less obvious, but just as significant, has been the transfer of analytic capacity from public health units to other provincial health offices. In Nova Scotia, for example, epidemiological capacity was moved from regional (local) public health agencies in 2016 to a more centralized analytics unit serving departmental functions beyond public health. Detailed local analyses (of food security or child development, for example) were, after this move, largely discontinued.

The consolidation of data functions within one agency may have been more “efficient” from a strictly economic perspective, but it also meant that local public health bodies now have no direct control over the epidemiological infrastructure necessary to perform key functions, such

as the collection of data necessary to identify health disparities across populations. As data analytics are now the responsibility of the provincial health authority, the immediate operational and evaluation priorities of that body may take precedence over surveillance functions typically used to identify the health disparities that local public health was once charged with discovering.

The capacity for data analytics, quite simply, is a limited resource, and a centralized data unit will respond to the direction of the provincial executive. Public health, especially for localized concerns, gets edged out. Similarly, collaboration in data access across federal and provincial units remains extremely difficult to achieve, although the justification for refusing to share data efficiently in this case is a concern with data privacy (as the privacy of provincial health data is a mandated responsibility). A related issue is the trend to move public health officials out of public health units to other departments. For example, in 2017 in New Brunswick, inspectors were moved out of public health to Justice and Public Safety, while others were sent to Social Development or to Environment and Local Government.³⁷

In a slightly more complicated manner, the restructuring of health system governance in many provinces has

constrained the formal authority of public health officers – Medical Officers of Health (MOHs) or Medical Health Officers (MHOs) – working with local communities. In Nova Scotia, for example, when eight health authorities were amalgamated into one, MOHs were reassigned to four provincial “zones.” However, decision-making capacity in this new organizational structure rested formally with the new provincial health authority, which appointed medical directors in each of the four zones. At the same time, the MOHs assigned to each zone formally remained under the aegis of the provincial Department of Health and Wellness. As MOHs are not formally part of the *health authority*, they now have no formal decision-making capacity, and must negotiate informally with health authority officials at the zone level to support public health initiatives in municipalities within these zones. (Interestingly, while MOHs remain under the authority of the Department of Health and Wellness, public health *nurses* are under the jurisdiction of the provincial health authority.) The restructuring of Nova Scotia’s health care system, in sum, means that public health officers have less clear authority at the local level.

The restructuring of health system governance in many provinces has constrained the formal authority of public health officers – Medical Officers of Health or Medical Health Officers – working with local communities.

Facilitating relationships; improving collaboration

The nature of “public health” is, within the sphere of health policy, quite distinct. While public health does involve some direct provision of services, its key functions involve measuring, monitoring, and evaluating trends. Specifically, the formal public health system is the only arm of Canada’s health system required to systematically identify and expose disparities in health outcomes so that they may be resolved. The steps taken to address these disparities often require the legislative or fiscal support of non-health-related departments and agencies.

By its very nature, public health is a collaborative and outward-looking enterprise, seeking to make connections within and between social and political actors. At best, it consolidates networks of communication and collaboration for effective policy-making. An effective system of public health is not facilitated by governance reforms seeking to centralize and rationalize all functions. The centralization of governance functions tends to consolidate public health units away from the local level, where they can be most effective.

Public health expertise is often “supportive” – it can facilitate municipal efforts to achieve a better and more equitable standard of living at a local level, but it also requires the existence of a vision of such a standard of living in the first place.³⁸ Municipalities willing to use the expertise of public health officials can best develop this capacity in two ways.

The first is to facilitate integrated relationships of support and good faith between public health and community organizations. The strategy must be a stable and organic process; the kinds of relationships that work effectively cannot simply be brought into being at the whim of policy-makers when required.

The second, as with many municipal responsibilities, requires the collaboration of provincial governments. Modern public health surveillance can be bolstered through the availability of new technologies and forms of data collection,³⁹ but surveillance requires a provincial or national infrastructure that not only accommodates the collection of granular data, but also provides unobstructed access to these data by those at a local level who have been trained to use them. Such access could involve legislative changes to the *Canada Health Act*, but would require closer operational collaboration between provinces and bodies such as the Public Health Agency of Canada and Health Data Research Network Canada. And, as Andrew MacRae et al. have argued, most provincial legislation does not actually *preclude* interprovincial sharing of patient-level data, which (in the

case of COVID-19 vaccine research) could be facilitated with a waiver of consent.⁴⁰

Conclusion

What sets “public health” apart from most other medical disciplines is its focus on wider populations rather than on individuals and on how the environment within which individuals are situated influences their health outcomes. If, as the Standing Senate Committee on Social Affairs, Science and Technology argues, “Fully 50 percent of the health of the population can be explained by socio-economic factors,”⁴¹ then these variables must be identified, measured, monitored, and addressed. And because so many people come into contact with these variables through municipalities, effective public health management must have a robust presence at the local level.

Health reforms that try to centralize governance structures for the sake of efficiency tend to lose sight of this important fact. Technological innovations such as cloud computing and algorithmic calculation may have an increasing role to play in public health, and will require full engagement at both the provincial and national level, but technologies will never replace the fundamental importance of governance strategies that carefully cultivate relationships of trust and respect within local communities.

Between provincial direction and local placemaking: A careful balance for optimal health

By Lawrence C. Loh

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Many people conflate the concept of “health” with the provision of health care services.

To be fair, health care systems do play some part in maintaining health through the delivery of certain preventive programs. Beyond those, however, the reality is that most people access acute health care services only when their health has been compromised. In that sense, the health care system is in fact much like the legal system – nobody wants to be involved with the system unless it is absolutely necessary.

As the “social determinants of health” become better understood, it has become clear that what determines health is how society, rather than the health care system alone, is organized.⁴² Health is endowed at the start of life and subsequently nurtured, maintained, or lost over time. Community context and disparities drive the critical barriers and opportunities that people face in optimizing and maintaining their health and well-being.

This fact puts health squarely within government’s role in shaping policy and places. Through creating the appropriate context and addressing disparities in policy and programming, various levels of governments can help their populations stay healthier for longer – and out of the health care system – just as a rational statutory environment allows people to live freely without running afoul of the legal system.

As the level of government closest to the day-to-day life of citizens, local public health agencies and municipal governments have an important impact on health directly and indirectly through, among other functions, policing and community safety, transit and transportation, zoning, housing and the environment, and social services.⁴³

Local decisions and policies can and should be designed to meet the specific health needs of each community. This is important, as the particular health issues and the potential interventions that can mitigate them may well differ between

different communities in priority, form, and magnitude. Perspectives on issues held in common may also vary between local and higher orders of government, which can result in different opinions on what needs to be addressed to safeguard population health.

In this context, natural tensions and opportunities arise. In local public health practice in Ontario, provincial policy has on occasion been driven by municipal decisions. Conversely, municipalities have sometimes tailored provincial decisions to better fit the relevant community context.

The examples that follow demonstrate how, at its heart, the foundation of this complex system supports a rich discourse that allows a better balance of central and local considerations in tailoring public health programming and policy to the diverse community contexts across a vast province.

The path to a smoke-free Ontario: Local action driving provincial policy

The 2006 passage of the *Smoke-Free Ontario Act* (SFOA) marked a major change in policy after decades of scientific study and advocacy. Its passage shifted the societal context such that many young adults today will likely not remember having to decide between the smoking or non-smoking

section when visiting a restaurant. By prohibiting smoking in public places like restaurants, bars, and nightclubs, the SFOA pushed further than previous legislation, notably Ontario’s 1994 *Tobacco Control Act*.

To date, SFOA remains one of the most

successful health policy interventions in Canadian history, improving health by mitigating the harms of tobacco through preventing youth from starting to smoke, reducing the harms of secondhand smoke, and encouraging smokers to quit.⁴⁴ It was, however, municipal efforts that first began to shift the nature of tobacco consumption in public spaces between 1994 and 2006.

In 1996–97 the pre-amalgamation City of Toronto was first in Ontario with its controversial decision to ban smoking in restaurants, bars, pubs, and nightclubs.⁴⁵ At the time, surrounding municipalities like North York, Scarborough, and Etobicoke looked on, but the change had begun. Ten years later, when SFOA was implemented in 2006, nearly 90 percent of Ontario’s population was covered by a local policy measure banning smoking, either through municipal bylaw or section orders made by local Medical

Officers of Health under the *Health Protection and Promotion Act*.⁴⁶

Benefits accrue to stakeholders in two areas of municipal jurisdiction: residents (public health) and businesses (economic development). As it pertains to Ottawa's implementation, for example, studies demonstrated widespread public support and found no impact on sales at restaurants and bars.⁴⁷ These local policies also provided a platform for municipalities to advocate for a consistent provincial approach and also a legal precedent to support the eventual SFOA statute.⁴⁸

It's not surprising, perhaps, that urban municipalities like Ottawa and Toronto were the first to move. Their urban local context likely saw more secondhand smoke in crowded restaurants and bars. Those local decisions, however, were each a chapter in the SFOA story, demonstrating how Ontario's decentralized balance facilitates local health policy, relevant to context, that in turn drives central policy decisions.

Vaccination exemptions: provincial policy tailored by local approaches

Ontario's decentralized balance also moves the other way, whereby provincial decisions on health policy allow for local interpretation.

One example is the provincial government's 2017 decision to require parents to complete a Ministry-developed vaccine education module in order to obtain a philosophic exemption to vaccination reporting requirements for school attendance.⁴⁹

Different local authorities tailored the completion of this requirement according to their local context. Remote completion of the module via Internet or telephone was a common approach taken by many rural, northern, and remote health units.⁵⁰ In contrast, more populous local health agencies like Peel and Toronto provided for group completion, rather than individual outreach.⁵¹

In this instance, a centrally taken provincial decision on health programming was tailored to local context to achieve the directed goal. Initial evaluations of these diverse approaches identified, however, that the program presented a significant resource burden that did not result in greater vaccination uptake. Current dialogue, coordinated among some local health agencies, now calls for an end to philosophic exemptions to vaccinations altogether.⁵²

The COVID-19 pandemic response in Ontario

The dual dynamics arising from this provincial-local balance quickly became clear during the COVID-19 pandemic. Through the earliest waves, the province's message was clear that it would respect local autonomy, enshrined in statute, to institute local measures that were more stringent than those directed by provincial policy, as necessary.⁵³

The adoption of mask mandates between the first and second wave presented an expedited version of the SFOA story, with a patchwork of Section 22 orders and municipal bylaws eventually mandating masking in public places in most municipalities in Ontario.⁵⁴ These initiatives led the province to mandate masking in October 2020 as the second wave started to take off, bringing consistency to the measure across Ontario.⁵⁵ Conversely, the vaccination roll-out reflected provincial policy interpreted at the local level. Notably, at the beginning of the campaign, limited vaccine supplies were directed using a provincially determined priority list of high-risk groups. The autonomy of local health units, however, resulted in different delivery models with respect to how this was interpreted and implemented.⁵⁶ This meant that 34 different health units implemented programs appropriate to their community that considered factors such as population and demographics, resourcing and technology, vaccine supply, and delivery models.⁵⁷

Most striking throughout the pandemic response, however, was the evolution of local autonomy in the use of public health measures to address immediate threats to health and safety. In the earliest days of the pandemic,

before vaccines or treatments were available, limiting the transmission and spread of a novel virus within a widely susceptible population was critical to preventing severe outcomes and preserving health care capacity at a population level.⁵⁸

Like other large, disparate jurisdictions, Ontario saw a similar pattern of COVID-19 introduction. Well-populated, internationally connected centres saw community transmission first, followed by regional population centres, and finally, rural and remote areas. After the first and most stringent province-wide closure and curtailment in March 2020, the Greater Toronto Area (GTA) bore the brunt of the first three waves of COVID-19 through the end of 2020 and into spring 2021.

With the province's recognition that local Medical Officers of Health could go above and beyond the provincial

framework as necessary, targeted local measures saw the curtailment of social gatherings in Peel in November 2020, and the closure of schools in both Peel and Toronto in April 2021.⁵⁹ In both instances, local circumstances and data differed from trends at the provincial level, dictating the need for additional protective measures on top of those provided for in the provincial framework.

Through the fall and winter, these local measures throttled the spread of the virus in the GTA and saved lives, while buying time for other local jurisdictions in Ontario to forestall more significant transmission until later in the winter.⁶⁰ They also bought time to reach widespread population vaccination that would disrupt the infectious cascade from spread to severity. This meant that by late 2022, high vaccination rates across Ontario allowed the suppression of the Delta variant and mitigated the impacts of the Omicron variant on the health care system, despite higher levels of community transmission.

Taken together, masking, vaccinations, and other measures represent a great success from Ontario's careful central-local balance. Throughout the COVID-19 pandemic, local decisions combined with provincial actions succeeded in implementing policies and programming that largely limited the worst of the pandemic to the most populous parts of Ontario until widespread vaccination was achieved.

Considerations for advancing public health locally

Whether tobacco policy, vaccine education modules, or the COVID-19 response, it is clear that Ontario's balance between local and provincial policymaking can lead to complicated dialogue but achieves good results. With the transition from the COVID-19 pandemic's acute phase, there will likely be many questions about how local public health agencies and governments continue to work with the province in advancing the health of Ontarians. In my view, any discussion aiming to optimize the system should consider the following:

1. Keep public health separate from health care. While they are partners that share some goals, health care and public health do not always share a single common goal. Keeping public health separate from health care allows the former to accomplish its vital work of creating healthy

community contexts that keep people out of the health care system.

2. Keep the “local” in public health. Any consolidation of local public health units should carefully consider the value and effort that has gone into developing existing relationships and knowledge at the local level. Input from local public health agencies will be critical in identifying potential jurisdictions that could come closer together. The literature has found that the optimal population size served by a single public health unit ranges from 50,000 to 100,000 residents, with diminishing returns observed in agencies serving populations of more than 500,000 residents.⁶¹

3. Enshrine the unique role and expertise of Medical Officers of Health. Given the unique, community-wide mandate overseen by MOHs with their local public health agency team, it is crucial to ensure that any physician who assumes the role – either through appointment or on an acting basis – possesses specific training and expertise in public health. This requirement would ideally be recognized through the completion of a Royal College of Physicians and Surgeons of Canada residency in Public Health and Preventive Medicine. This could be accomplished by a new hiring convention respected by Boards

of Health, or changes to legislation to enshrine the requirements for this unique role that serves the health of the community.

4. Resource public health now and into the future. Investment in public health is the ounce of prevention that replaces a pound of cure, reducing impacts on hospitals and the acute care system.⁶² One-time investments in recovery after this unprecedented, historic emergency response is crucial, but there is also work to be done in addressing existing resource deficits, training more public health professionals, and providing funding that maintains the existing mix of provincial and local cost-sharing for public health budgets at the historic 75:25 level.

5. Address disparities in resourcing. As local action helps support and tailor health policy and programming to the diverse communities of Ontario, disparities in resourcing and support for various health units, particularly in the provincial contribution, should be addressed to ensure that all health units can provide optimal service for their unique communities while meeting centralized requirements.

Conclusion

In Ontario, the unique perspectives that local governments and health agencies bring to dialogues on health make for a richer, if more complex, system to navigate. The benefits, however, are undeniable – allowing residents to enjoy consistency on matters of higher-order policy while ensuring that specific needs and inequities are addressed through locally informed interventions.

As Winston Churchill once said: “We shape our communities and thereafter they shape us.” Through the examples of tobacco control, vaccination exemption education, and the COVID-19 pandemic, we remember that health, far from health care alone, relies very much on the placemaking leadership jointly shared by local and provincial governments.

Protecting, optimizing, and enhancing the role of local government in shaping healthy contexts in an optimal balance with centralized decision-making is critical to driving equity, bringing local knowledge to bear in programming and policy, and ensuring that Ontario’s residents benefit from better health status, no matter where they live.

What is public health? Reflections on the role of local government in strengthening population well-being and health equity in Alberta

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In this essay we reflect on current and ideal roles for municipal governments in the domain of public health, drawing from our respective experiences working independently and collaboratively as a public health scholar and a practitioner in Alberta.

The discussion of local government role(s) in public health is complicated by different views on what public health is. They can range from a narrow version focused on legislated duties, programs, and services carried out by health (care) systems (i.e., the formal public health system or sector), to a broader version focused on creating circumstances to support well-being for all, which requires robust intersectoral action, sustained attention to root causes of poor health and health inequities, and leadership with a bold vision.

These different views about the scope and mandate of public health can manifest as tension and fractures within the field,⁶³ and misunderstanding among those outside the field.⁶⁴ Addressing these challenges, including the embedded power dynamics, is integral to a robust vision of intergovernmental arrangements for public health, and we offer two recommendations in this regard.

What is public health, and where does municipal government fit?

A well-known,⁶⁵ and longstanding,⁶⁶ definition of public health is the art and science of preventing illness and injury and promoting health through the organized efforts of society. This definition conveys several key elements.

First, public health is about the health of populations or communities rather than individuals,⁶⁷ with health understood (in theory if not always in practice) in a holistic way that includes physical, social, mental, and ecological dimensions of well-being.⁶⁸

Second, public health is about keeping people healthy in the first place, which has the important co-benefit of reducing pressure on medical services. Some prevention and promotion services are delivered within the formal public health sector through provincial, regional, or municipal jurisdictions,

depending on context; examples include immunization, cancer screening, and well-child visits. However, most of the factors that shape the health of populations, including health inequities (that is, differences in health between social groups that are unfair and avoidable) lie outside the health sector. These include policies and practices – and their ideological underpinnings – that shape the circumstances in which we are born, grow, live, work, and age. These are known as the social and ecological determinants of health.⁶⁹

With public health defined in this way, it may seem obvious that municipal governments, which affect peoples' lives very directly, have an important role to play. Examples such as land use planning, which – combined with activities by other levels of government – significantly impact peoples' lives and thus health through housing affordability, transportation options, and opportunities for meaningful and dignified participation, demonstrate the potential health impacts of such municipal policies. While these domains are not usually considered "public health" initiatives, they are integral to achieving public health goals

through broad impacts on chronic disease, injury, and mental and physical health and well-being.

Unfortunately, the contribution of municipal government activities to public health goals is under-appreciated (and thus under-mobilized) because of a widespread tendency to conflate public health and medical care, with the latter largely falling under provincial jurisdiction in Canada. This tendency can be illustrated by a local example. Community water fluoridation is a public health intervention to prevent tooth decay; decisions about fluoridation are made by municipal governments in Canada because of their responsibility for local water systems. Although there are good reasons for local responsibility (decisions about local drinking water should engage those served by the local system), deliberations on this issue in Calgary almost always include a plea for responsibility to be shifted to the provincial government because it is responsible for "health" – meaning health care.⁷⁰

This example illustrates how the language of "health" and "public health" seems to automatically trigger an association with provincial governments and health care. This conflation makes it harder to mobilize the considerable value of municipalities in contributing to public health.

Based on these challenges, we identify two sets of recommendations to strengthen the role of municipal governments in the domain of public health – one incremental, which aligns with the narrower, formal version of public health; and one bold, which aligns with the broader vision.

An incremental step: Strengthen mechanisms for intersectoral and intergovernmental collaboration and coordination for formal public health structures

The incremental recommendation aligns with the narrower view of public health, focused on the formal public health system, which in Alberta (and most other Canadian jurisdictions, with Ontario and Québec being the main exceptions) is not a municipal function. Rather, core public health responsibilities are carried out by the provincial government (including the provincial Ministry of Health and the Chief Medical Officer of Health), the First Nations and Inuit Health Branch of Indigenous Services Canada,

and the provincial health services authority, Alberta Health Services (AHS). At AHS in particular and at a national level more broadly, public health constitutes a very small proportion of funding and capacity within health care services.

It is helpful to situate this arrangement in historical context.⁷¹ For much of Alberta's

history, formal public health activities were local, and boards of health were responsible for carrying out provisions under the provincial *Public Health Act* (1907). Membership of these local boards included members of municipal councils (including, for much of this time, the mayor or commissioner), thus facilitating strong connections between formal public health and local government.

This arrangement remained largely intact until the late 20th century, when a flurry of changes (regionalization) occurred, including a transition from more than 140 local health units to 17 regional health authorities in 1994, to nine health regions in 2003, and finally to a single, province-wide health services authority (Alberta Health Services) in 2008, with five administrative zones that encompass, but do not necessarily align with, municipal boundaries.

Regionalization in Alberta has had both benefits and drawbacks for formal public health. Although rigorous evaluation of different public health structures has been

limited, some perceived advantages – based on professional experience in this system – include the potential for more consistent service provision, enhanced information systems and data-sharing, and improved coordination, particularly with respect to health emergencies. Notably, these benefits of scale have the potential to benefit smaller communities, which may face greater resourcing challenges under a local structure.

Conversely, a key challenge with the integration of public health into health care service-focused organizations is the fragmentation of public health systems. For example, in Alberta, nutrition and prevention-oriented mental health and addiction services have been separated structurally from other population and public health teams, which are further siloed by organization into provincial and zone-based structures with distinct reporting and governance. These impacts have not occurred evenly across public health activities: the historically dominant and medically based health protection activities (such as communicable disease control) have generally fared better than the non-legislated functions such as health promotion. These dynamics have been felt to compromise the capacity, visibility, and impact of public health in Alberta.⁷²

Centralization in Alberta has reinforced a narrow version of public health by solidifying its position as part of the health care system, thereby weakening a vision of public health as a broad intersectoral endeavour. For example, community and intersectoral engagement, which are central to public health,⁷³ have been more difficult under this broader regionalized health services structure. The shift in Alberta away from an embedded role for public health within municipal governments has contributed to these challenges.

Therefore, a key recommendation is to strengthen mechanisms for intergovernmental collaboration and coordination on public health.⁷⁴ One example concerns the modernization of provincial and territorial public health acts to clarify the municipal role in jurisdictions where that does not exist at present in a substantive form (such as Alberta). This strengthening could occur within the broader context of a national Public Health Act (the development of which is currently being discussed), which could define core public health functions, detail the federal mandate for supporting public health at the national level and in collaboration with provinces and territories, and provide new funding transfers and accountability mechanisms.⁷⁵

A federal Public Health Act has precedent in other federal public health-related legislation (such as food safety legislation, the *Quarantine Act*, and the *Public Health Agency of Canada Act*), and could enhance public understanding that formal public health involves all levels of government. Other possibilities include the development and resourcing of municipal health-focused frameworks, such as the Vancouver Healthy City Strategy. These recommendations should be coupled with efforts to clarify and improve public understanding and appreciation of what public health is and does.

A bold step: Establish a coherent, cross-policy agenda for population well-being and health equity

Strengthening mechanisms for collaboration and coordination around formal public health activities, including between Alberta Health Services, the provincial Ministry of Health, and Alberta municipalities, would undoubtedly have merit. However, there is abundant scholarship on the pernicious influence of medicalization on public health.⁷⁶ The individualistic orientation of medical care, coupled with its hegemonic

status, is likely to detract from the broad vision of public health embodied in the well-known definition with which we opened this essay (*the art and science of preventing disease and promoting health through the organized efforts of society*).

From this point of view, a key recommendation involves (1) taking a step back and remembering the ultimate goals of public health – population well-being and health equity; (2) figuring out how to achieve those goals; and (3) structuring and orienting our society (including different levels of governments) accordingly.

We know that population well-being and health equity require a coordinated, whole-of-government approach anchored in principles of equity and ecological integrity. Such an approach is evident in the idea of a *well-being economy*, whereby the health (well-being) of all people, and of our ecosystems, is the purpose of all our institutions, including governments.

A well-being economy, an idea that is gaining international momentum,⁷⁷ goes to the root causes of poor health and health inequities. It does so by pursuing a significant departure from our current economic model of neoliberal capitalism, which, through its pursuit of a narrow vision of economic growth, does not support the well-being of people and the planet. The benefits of economic growth

accrue mostly to those who already have high levels of income and wealth, while incomes, along with public supports and services for the rest of the population, have been eroded.⁷⁸ Our historical and ongoing focus on economic growth has also led to ecological degradation on a massive scale, which compromises the health and well-being of all species and is experienced in an unjust manner.⁷⁹ Equity and ecological integrity are key concerns of a broad public health vision, which remain unrealized (and even obstructed) under our current structures and systems.

A well-being economy represents a way to achieve the ultimate goals of public health within a broader, coherent, societal vision of health (well-being) for all and a healthy planet. Initiatives and examples of what this could look like can be found at different levels of government, including national⁸⁰ and provincial⁸¹ governments in Canada. At the level of municipal governments, a well-being agenda represents an important way to strengthen the health-promoting activities they are already doing, but using different language. Because a well-being approach represents an entirely different path

to pursuing population well-being and health equity, it is independent of how formal public health is currently structured. In other words, the approach could equally well be applied in jurisdictions where formal public health activities are currently situated primarily in provincial, or in municipal, jurisdictions. It would, however, require efforts to figure out how and where existing formal public health structures fit within a well-being model.

There are many frameworks to guide efforts towards a well-being economy at the municipal level. One is *doughnut economics*, developed by Kate Raworth, an idea anchored in the recognition that humanity's greatest challenge (including threats to health and well-being) is to meet the needs of everyone within the means of the planet (see Figure 1).⁸²

The “doughnut” illustrates the dual imperatives of ensuring that no one is left behind when it comes to the essentials of life (that is, *the social determinants of health*, including food, housing, high-quality health and social care, political voice; this is the inner ring of the doughnut); while not exceeding the planet’s life-supporting systems on which we collectively depend (that is, *the ecological determinants of health*; the outer ring of the doughnut). The “shortfall” and “overshoot” arrows indicate a current imbalance, including failure to provide the social foundations while simultaneously exceeding the ecological ceiling. These arrows provide

guidance for policy in that policies should aim to resolve the shortfalls and fix the overshoots.

The city of Nanaimo in British Columbia adapted the doughnut model for its municipal government, where it now provides “a cohesive vision for all City initiatives and planning processes.” The city created a customized doughnut along with a city portrait (a holistic snapshot of the city through four lenses: social, ecological, local, global) as a way of adapting the framework to its unique environmental, sociocultural, economic, and political contexts. Under its Strategic Plan Vision “to be a community that is livable, environmentally sustainable and full of opportunity for all generations and walks of life,” the model is guiding local policy such as land use decisions, which are focused on increasing walking, cycling, and transit; building walkable, dense neighbourhoods, reducing sprawl, and thereby reducing transportation-related carbon emissions; and reducing homelessness by increasing rental housing and diverse housing options for different living arrangements and life stages.⁸³ In other words, the plan privileges social and ecological determinants of health, which are the key drivers of population well-being and health equity.

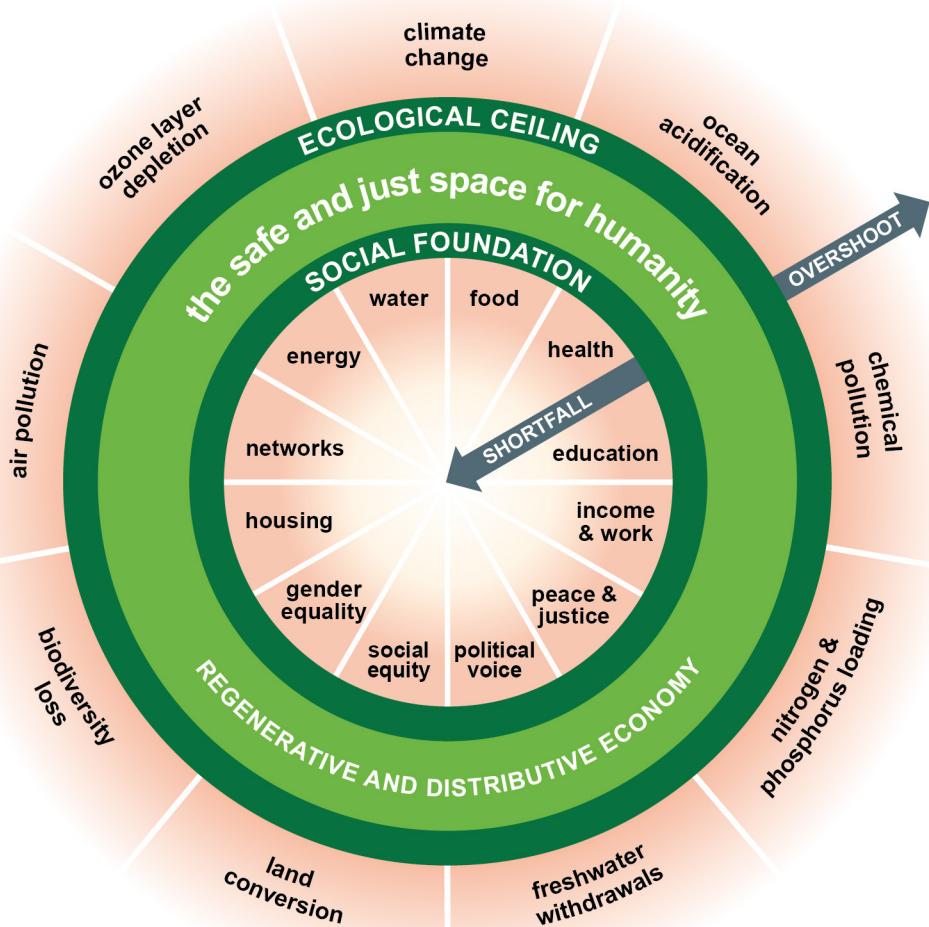
For readers who may feel that we have strayed from public health, we reiterate at this point that, if we focus on the ultimate goals of public health (population well-being and health equity),

then public health and a well-being economy are one and the same.

With respect to formal public health systems and structures, the question then becomes: how and where do these systems fit into a well-being agenda? Answering the question is a task for public health communities. The task needs to be approached from a position of disciplinary, epistemic, and professional humility, in collaboration with other knowers and actors when it comes to health and well-being. It will require foregrounding efforts to avoid the pernicious “downstream drift” of focus on individual illness and risk factors,⁸⁴ which reflect broader social forces and political choices (aptly described by the World Health Organization Commission on Social Determinants of Health as the “toxic combination of poor social policies and programs, unfair economic arrangements and bad politics” which constitute the root causes of health inequities.⁸⁵)

To advance this vision outside public health communities will require leadership that transcends policy domains to orient governments towards a bold vision of well-being.⁸⁶ An example exists at the sub-central level, from Wales, which in 2015 passed a *Well-Being of Future Generations Act*.⁸⁷ The

Figure 1. Doughnut economics (Kate Raworth)



Source: Kate Raworth and Christian Guthier. CC-BY-SA 4.0. <http://bit.ly/3g8MnzK>

Act requires public bodies, with the guidance and support of the *Future Generations Commissioner* (who is independent of government) to think about the long-term impacts of their decisions and to prevent persistent problems such as economic inequality and climate change, which constitute upstream determinants of health. The Act specifically outlines roles for local governments, including structures (a public services board is established for each local authority area) and processes (for example, each board must prepare and publish a local well-being plan). It thus offers potential guidance for the role of municipal government in the Canadian context in a well-being agenda.

A well-being agenda as a path to population health and health equity will hinge on large-scale decoupling of health from medical care, thus enabling people to connect the dots between health and its broader social and ecological determinants. This would require, among

other things, major, sustained efforts to reframe and shift public discourse around health,⁸⁸ and curriculum change in our education systems so that learning about social and ecological determinants of health occurs at the primary and secondary education levels. Currently these ideas are not introduced until the undergraduate or even graduate level of education, which is too late (and, in fact, their treatment is incomplete even at that stage).⁸⁹

This bold vision requires stretching our imaginations. Within the context of a seemingly unending global pandemic, the increasingly rapid destruction of our ecosystems, and the erosion of our democracies, there has never been a more important time for bold leadership across all orders of government to advance a broad public health agenda and well-being economy.

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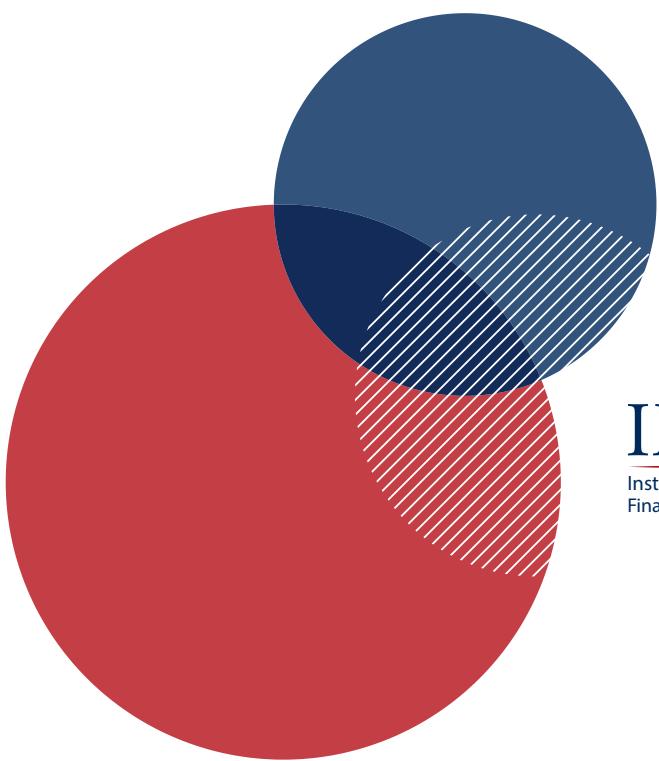
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