Breaking the Deadlock: Public Health Policy Coordination as the Next Step

Sortir de l'impasse : la coordination des politiques de santé publique comme prochaine étape

by NICOLE F. BERNIER, PHD
The Léa-Roback Research Center on Social Inequalities in Health of Montréal
University of Montreal
Montreal, QC

NATHALIE BURLONE, PHD
School of Political Studies
University of Ottawa
Ottawa, ON

Abstract

Recent public health crises have revealed the extent to which coordinated government activity is crucial for ensuring the efficacy of public policies aimed at protecting, maintaining and improving the health of the population. The need for coherent and effective interventions in many areas of human activity always comes up against the challenges related to the division of responsibilities, power and jurisdictions inherent in public administration. The recently initiated renewal of public health structures in Canada opens up new possibilities for public health and could foster better coordination of public health efforts. This paper shows, however, that the eventual broadening

of the traditional mandate of Canadian public health to include the social (non-medical) aspects of health and the articulation of healthy public policies requires intervention at the central policy level. We offer practical observations about the need to foster better policy coordination across sectors of governments, with a view to contributing to the emergence of a comprehensive public health policy in Canada.

Résumé

Les récentes crises en santé publique ont révélé l'importance cruciale d'une activité gouvernementale coordonnée pour assurer l'efficacité des politiques publiques visant à protéger, maintenir et améliorer la santé de la population. Le besoin d'interventions cohérentes et efficaces dans de nombreux domaines d'activité humaine fait toujours face au défi lancé par le partage des responsabilités, des attributions et des compétences inhérentes à l'administration publique. Le renouvellement récemment amorcé des structures de santé publique au Canada ouvre de nouvelles possibilités en matière de santé publique et pourrait favoriser une meilleure coordination des efforts en santé publique. Cet article montre cependant que l'élargissement futur du mandat traditionnel de la santé publique, au Canada, pour inclure les aspects sociaux (non médicaux) de la santé et la formulation de politiques favorables à la santé en matière de santé publique, nécessite une intervention au niveau des politiques centrales. Des observations pratiques concernant le besoin de mieux coordonner les politiques d'un secteur gouvernemental à l'autre sont présentées dans le but de contribuer à l'émergence véritable d'une politique globale de santé publique au Canada.

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SINCE THE BEGINNING OF THE CURRENT DECADE, A NUMBER OF PUBLIC health emergencies have sent shock waves throughout the Canadian public health system and underlined the importance of coordinating public health actions. In the aftermath of the *E. coli* contamination of drinking water in Walkerton, Ontario, the outbreak of SARS in Toronto and possible threats of bioterrorism following the September 11, 2001, attacks on the World Trade Center, federal and provincial committees mandated to study the functioning of public health emergency responses have exposed redundancies, gaps and incoherencies in the public health administrative apparatus. These committees have drawn our attention to coordination problems related to administrative fragmentation.

A number of governmental initiatives have followed, such as the creation in 2004 of the Public Health Agency of Canada (PHAC), which is focused for the most part on improving the coordination of interventions in infectious disease outbreaks and preventing chronic diseases and injuries. The renewal of Canada's public health policy

has also seen the creation of administrative instruments that reflect a vision of public health agencies as concerned not only with crises and risk prevention, but also as seeking to protect, maintain and improve population health more generally. However, in examining recent public health policy initiatives at the federal level that seek to address the social determinants of health (SDOHs) by developing healthy public policies (policies that have a favourable impact on health), we have observed a lack of policy coordination mechanisms at the central level of government. This situation is likely to prevent the development of a comprehensive public health strategy in Canada.

This paper presents evidence of inadequate policy coordination mechanisms among sectors responsible for public health programs that do not deal with emergency responses, risk prevention or specific areas of intervention. Based upon public administration and political science literature, we argue that two conditions are essential for the federal government to develop a comprehensive approach to public health in the years to come: involving central agencies and setting up coordination mechanisms dealing with the substance of policy.

The following section sets the stage with a brief discussion of the basic concepts we use and the context of our study. We then proceed to analyze recent initiatives in Canadian public health policy, showing existing deficiencies. The final sections open points for debate, describing and discussing two propositions for breaking the deadlock in the pursuit of a comprehensive national strategy.

A New Public Health Policy

Public health is an administratively diffuse domain of governmental intervention seeking to protect, maintain and improve population health. A public health policy seeks to ensure provision of adequate healthcare services, to deal with outbreaks of infectious disease and to prevent chronic diseases and injuries. A "new" public health policy comprises the above but is more comprehensive. It also reflects the growing recognition that the many factors known as the social (non-medical) determinants of health, such as income inequality and educational status, affect the population's health. In the spirit of the 1986 Ottawa Charter for Health Promotion adopted by 27 countries worldwide including Canada, a new public health policy seeks to modify the SDOHs via the adoption of healthy public policies (Kickbush 2003; Marmor et al. 1994).

There are variations in the literature and in policy circles as to how SDOHs are named and defined, but they generally comprise income inequality, social inclusion and exclusion, employment and job security, working conditions, contribution of the social economy, early childhood care, education, food security and housing. Healthy public policies seek to "improve the conditions under which people live: secure, safe, adequate, and sustainable livelihoods, lifestyles, and environments, including housing, education, nutrition, information exchange, child care, transportation, and necessary

community, personal, social and health services" (Milio 2001).

Developing a new public health policy is a challenging task. Such policy is meant to be holistic and coherent, whereas public administration divides responsibilities, powers and jurisdictions. In principle, the action radius of a new public health policy extends to all spheres of human activity, whereas public administration is organized into parallel intervention sectors (departments) and distinct levels (local, regional, provincial, federal and international). For instance, the instruments to reduce income inequality – a core determinant of the population's health – are diversified, including such tools as taxation, redistributive programs (e.g., old age pensions, employment insurance, medicare), work legislation and several others that, for the most part, do not fall under the purview of the health sector. Even though Canadian health ministers and provincial leaders might agree on prioritizing a reduction of income inequality for Canada, agreement on the set of instruments most conducive to achieving set goals would not necessarily follow.

This challenge was made clear over three decades ago, when the first federal document to introduce a broader vision of health policy, the 1974 Lalonde Report, called attention to the existing administrative fragmentation of responsibility for health and recognized that interventions from several sectors are needed to address the determinants of health (Glouberman and Millar 2003: 388). In the same vein, the 1986 Epp Report, while identifying health challenges, mechanisms and implementation strategies for better health in Canada, insisted on the importance of coordination among sectors. The same year, the highly influential 1986 Ottawa Charter for Health Promotion directed policy makers from all sectors and at all levels of government to be aware of the health consequences of their decisions and to accept their responsibilities for health. In a nutshell, it has been obvious for decades that policy instruments to achieve healthy public policies are not primarily under the purview of the federal health sector. Policy coordination among sectors and governmental levels is thus an essential condition if deadlock is to be avoided in moving to a new conception of public health in the coming years.

The Need for Coordinated Policy

Over the past 20 years, the work of several public administration experts and scholars has contributed to a body of literature that sheds considerable light on the issue of policy coordination, both in Canada and abroad, at a time when several advanced industrialized countries have undergone a neo-liberal shift involving the review of all their management methods (Peters 2006; Bakvis and Juillet 2004; Bourgault 2002). This literature clearly shows how major policies, such as health, environmental or education policy, are enacted in various programs with different goals, priorities and funding sources. It is the interrelation of these policies, as opposed to individual governmental

programs, that ensures a global response to problems (Peters 1998; Chisolm 1996).

To ensure coherent public actions, formal mechanisms to coordinate governmental initiatives must be implemented to compensate for the division of tasks, powers and responsibilities. Policy coordination is mainly concerned with interrelationships among various aspects of policies. It can be described as a process facilitated by a set of administrative mechanisms seeking to deal with the substance of public policy or, in other words, to harmonize the nature, objectives and instruments of public policy.

Policy coordination highlights the objectives to be reached as well as the means to be used. It seeks to resolve conflicts arising from duplication of programs, to search for common priorities and to introduce an overarching, as opposed to a sectoral, perspective. Policy coordination implies that when a new policy is developed or existing programs are reviewed, ways are sought to integrate the new policy or programs within the existing programs of various organizations and to adjust or abolish related and redundant policies and programs. Policy coordination includes the division of responsibilities and the management of activities by two or more organizations that are hierarchically independent of each other (Bakvis and Juillet 2004). It is distinct from collaboration (less formal) and the exchange of resources (more limited). It is needed in a system in which actors depend on one another to deal efficiently with common problems.

Policy coordination requires a significant investment of resources of all kinds and may reduce the autonomy of organizations that, since they can no longer seek unilateral solutions within the limits of their own spheres of activity, have to work together to find solutions that are common and coherent (Rogers and Whetten 1982). Though requiring significant investment, policy coordination helps reduce unnecessary governmental spending on redundant programs and fills gaps in some program areas or in incoherent policies (Peters 1998, 2006). In addition, organizations that take into account the interactions among their policies and those of other sectors, and that participate in a coordination process when establishing or reviewing their programs, foster improvements in the performance of their own programs and policies (Burlone 2001).

Given the intersectoral and multilevel nature of health policy, policy coordination is an essential condition for achieving a new public health policy in Canada. Both vertical and horizontal forms of coordination are needed among different levels of government and among different sectors. Our discussion focuses on horizontal coordination among federal departments.

Recent Policy Developments:
Confronting Practice with Theory

There have been interesting developments in public health policy in recent years. But has Canada been progressing towards a new public health policy concerned with

policy coordination? The Public Health Agency of Canada, which was created in 2004, is now the main instrument for coordinating governmental interventions in public health. Its areas of intervention are health surveillance, threat identification, disease and injury prevention and control programs. The areas in which PHAC can coordinate are therefore limited to dealing with public health risks and threats within and among jurisdictions, and supporting national readiness to respond to health crises. This purview does not correspond to the broader public health mandate called for by the Ottawa Charter.

PHAC was established at arm's length from government in the hope of de-politicizing the public health policy making process (Fooks and Maslove 2003). This hope has been fulfilled; all provinces, including Alberta and Quebec, supported the creation of PHAC. However, PHAC was originally intended to be more than an emergency response organization, to have a comprehensive mandate that included promoting health and addressing the SDOHs (McIntosh 2005). These aspects of public health could not be de-politicized with the creation of the agency, and some provinces opposed giving PHAC a mandate that was not focused on emergency response and risk prevention. Their perspective was that a broader mandate would mean the federal agency would get directly involved in health and social programs under provincial jurisdiction; this was turf they were not willing to yield to others (interview data).

A compromise has been the creation of six specialized national collaborating centres funded by PHAC. One of these six centres is located in Nova Scotia and focuses on the SDOHs. Another centre, located in Quebec, seeks to contribute to the promotion of healthy public policies across Canada. Whereas these two centres in particular seem to reflect the existence of a new Canadian public health policy, their mandate consists of fostering links among researchers, the health community and other stakeholders in order to facilitate the sharing of knowledge and to help apply it in Canada. These centres can certainly contribute to facilitating dialogue and information exchange about comprehensive public health issues, but they cannot be accurately described as instruments designed to coordinate health policies for addressing the SDOHs.

In the same vein, the Pan-Canadian Public Health Network was created in 2005 to serve as a forum for multilateral intergovernmental collaboration across the spectrum of public health, and to support "developing coordinated responses to infectious disease outbreaks and other public health emergencies." The network's mandate is to facilitate information sharing. It also fosters loose forms of collaboration "while respecting jurisdictional responsibilities in public health" (PHAC 2005). This network is focused on emergencies and information sharing but is not a coordinating tool.

The 2005 Integrated Pan-Canadian Healthy Living Strategy, which was released after a three-year consultation process, was conceived as a "means to ensure greater alignment, coordination and direction for all sectors" in health (PHAC 2005). This time, coordination was a priority. However, the limitation is that this strategy targets

specific, mostly behavioural, issues with programs such as ParticipAction, Dialogue on Drinking, the Canada Food Guide, the National Strategy to Decrease Tobacco Use in Canada and the Canadian Task Force on Preventive Health Care. The strategy emphasizes common preventable risk factors such as physical inactivity and unhealthy eating, targets certain groups such as children and the elderly and adopts a settings approach; that is, it designs interventions for specific settings such as workplaces or schools (Pinder 2006). The strategy brings together health professionals from several sectors and levels to work on specific issues. Its mandate has little to do with coordinating interventions directly addressing the SDOHs by promoting the development of broad healthy public policies – such as, for instance, those required to reduce poverty.

Finally, the 2005 consultation process throughout Canada that led to the establishment of public health goals has resulted in producing broad goal statements that are intended "to be guideposts indicating a path to improve the health and quality of life of Canadians" (PHAC 2007). The goal statements are neither legally binding nor directly enforceable, and no map exists detailing how to attain the goals. This initiative has been put into place as a way to circumvent the lack of consensus on policy design among Canadian health ministers and points to significant deficiencies in how the health ministers' efforts are presently coordinated.

In summary, recent years have seen the implementation of coordination mechanisms mainly for emergency response and risk prevention. Efforts to coordinate policy have also been made in specific areas of health promotion such as nutrition or tobacco use, areas in which, traditionally, policy has been focused on health education and modifications of individual behaviour as opposed to the creation of social conditions favourable to population health. Mechanisms for coordinating policies to address the SDOHs as such are weak or do not exist. Evidence suggests that the closer Canadian public health policy gets to dealing with the SDOHs, the more emphasis is placed on avoiding contentious issues and respecting jurisdictional sovereignty. As a result, little attention is paid to policy coordination, and therefore little is done.

Breaking the Deadlock: The Next Step

The policy making dynamic that governs prevention and promotion activities differs from the one that oversees the response to emergency situations and, as such, requires particular attention. Emergencies are such that agencies seek to resolve concrete or imminent problems. They call for a concerted effort during a (presumably) circumscribed period of time, such that the necessary resources are fairly easy to mobilize. A broad population health agenda that includes the establishment of healthy public policies and factors the social aspects of health into government policy does not readily receive this kind of support or collaboration. On the contrary, there can be important reservations on the part of other administrative sectors and levels owing to historic

tensions in the Canadian policy making process, such as federal–provincial competition. Specific mechanisms must therefore be conceived and implemented to break the existing deadlock. We argue below that two conditions must be met if a new public health policy is to emerge in Canada in the years to come.

Involving central agencies

As shown in a study on horizontal practices and structures (Bakvis and Juillet 2004: 64), central agencies (that is, the Privy Council Office and the Treasury Board) could take greater responsibility for implementing major horizontal initiatives, especially as far as mandate, authority, reporting and support are concerned. For public health, this means that central agencies have the responsibility to detail what is expected of line departments, to instill reporting mechanisms and to support horizontal initiatives in public health dealing with policy substance, financial resources, managerial procedures and accountability issues.

A precondition for involving central agencies is, of course, a strong commitment from the governing party. Upon coming into power in 2006, the Harper government abolished the position of Minister of State for Public Health, sending the message that public health is not a government priority. Unless governmental priorities are changed, it may be necessary to wait at least until the next federal election to see this precondition met.

Setting up specific mechanisms dealing with policy substance

The Canadian public health sector has collaborated for several years with other sectors in specific areas of common interest above and beyond essential functions and emergencies, such as children's welfare, poverty, the environment, education and agriculture. But making a genuine impact on the SDOHs will require effective policy coordination to be established in the federal government.

While central agencies can play an important role in setting up such mechanisms, people who work informally to develop links among interests, professions and organizations and who create or use existing networks can be important catalysts in public policy coordination (Webb 1991; Mandell and Steelman 2003). Professionals and health policy makers could therefore be catalysts in fostering the creation of a formal process of horizontal policy coordination. In practice, this entails the creation of advisory or inter-ministerial committees specifically dedicated to coordinating policy relevant to population health among federal departments. While it is true that Canadian provinces are mostly responsible for health and social policy, the significance of the federal government for the well-being of Canadians cannot be dismissed: it controls important tools for developing healthy public policies, including taxation, fiscal and

monetary policy, income security programs and federal transfers to the provinces. New coordination mechanisms organized along principles relevant to the SDOHs could ensure progression towards healthier public policies.

Importantly, health policy representatives in the new structures need to be involved at every step of a program's (re-)formulation, from program design to implementation, evaluation and revision, as opposed to pursuing a narrower focus on the ultimate "decision-making" stage surrounding laws and regulations. Current efforts focusing on evidence-based information and ensuring knowledge transfer to decision-making arenas are insufficient tools and must be transcended if the goals of policy coordination are to be achieved and the means to achieving them put in place at every step in the policy making process.

Conclusion

Pursuing the renewal of Canadian public health policy requires a review of some existing parameters. We are in no way suggesting that what we advocate will be easy; we are aware that there are major obstacles on the path to achieving coordinated public health policies. All Canadian initiatives have to cope with a horizontally and vertically fragmented public administration. Not only are several administrative levels involved in public health actions, but administration also varies from province to province (Bernier 2007; National Advisory Committee on SARS 2003). In addition, decision-makers have to cope with diverging interests, economic or democratic, in different sectors of activities that may impede the will to coordinate policies.

In spite of foreseeable difficulties, the federal government can pursue the objective of horizontal policy coordination in a realistic way. A necessary condition is that policy coordination be envisioned as a process rather than, primarily, as a final outcome. As Painter (1981) remarks, "the coordination principle is not an objective of striving towards a perfect harmony of policy, but a procedural value concerned with managing conflict." Mechanisms can be set up to enable people in organizations to identify the tensions that can arise from program and policy duplications and incoherencies as they occur in the policy making process and to anticipate solutions to attenuate these tensions. This approach contrasts sharply with that of behaving as if, in the pursuit of a noble goal such as improving population health, such tensions were of negligible importance, or that of completely avoiding dealing with them, as was done in the recent establishment of public health goals for Canada. In a nutshell, policy coordination must be conceived of as a process concerned with identifying and managing tensions and conflicts in the path of harmonizing policy goals and instruments.

In addition, a number of facilitating factors are worth considering. At the central level of government, political will, an overall strategy, sound analysis of the problems and the capacity for synthesis can all contribute to efficient policy coordination.

Facilitating factors also include the capacity to prevent, detect and resolve conflicts, to reconcile policy priorities and budget imperatives, and to adjust policies as a function of the administrative context and culture (OCDE 1996; Anderson 1997). Coordination among and within various bodies can be facilitated as well by parallel planning when such bodies have the same goals (Anderson 1997). Finally, detriments such as a potential lack of resources, unforeseen events and potential crises can also motivate better policy coordination (Rogers and Whetten 1982). Of these negative factors, crisis prevention is especially interesting as a catalyst in coordinating public health policy.

Meeting the two conditions discussed in this paper – involving central agencies and setting up policy coordination mechanisms dealing with policy substance in the federal government – would clearly shift attention from the current focus on end-stage decisions about adopting laws or regulations relevant to population health. Meeting these conditions is an absolute necessity if a public health mandate that includes more than just emergency response is to be fulfilled. Only efforts to coordinate policy at every step in the policy making process can make it possible to identify and meet the challenges of sharing sectoral powers with a view to developing healthy public policies in the coming years.

Correspondence may be directed to: Mme Nicole F. Bernier, Groupe de recherche interdisciplinaire en santé, Faculté de Médecine, Université de Montréal, CP 6128, Succ. Centre-Ville, Montréal, H3C 3J7. Email : nf.bernier@umontreal.ca.

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