RSC SRC

EXECUTIVE SUMMARY

Beyond the COVID-19 Crisis: Building on Lost Opportunities in the History of Public Health

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An RSC Policy Briefing

The influenza pandemic of 1918-1920, which killed 50,000 Canadians, spurred the creation of a federal department of public health. But in the intervening century, public health at all levels has remained, as Marc Lalonde put it in 1988, the "poor cousin" in the health care system. (Lalonde 1988, p.77) Punctuated by sporadic investment during infectious disease crises, such as polio in the early 1950s, public health is less of a priority as the cost of tertiary health interventions rises. While public health potentially involves a broad range of interventions, this paper focuses on the history of public health interventions around infectious disease.

COVID-19 has forced us to re-learn the importance of maintaining basic infectious/communicable disease control capacity, and revealed the cost of our failure to do so. It has also drawn our attention to the intersection between social inequality, racism and colonialism, and vulnerability to disease. In addition to investing in our capacity to contain disease outbreaks as they occur, we must plan now for how to achieve greater health equity in the future, by addressing underlying economic and social conditions, and providing meaningful access to preventive care for all. This is how we build a truly resilient society.

Governments at all levels have recognized the importance of social factors in shaping health and illness for decades. But greater health equity will result only from genuine action on this knowledge. Action will arise from public advocacy in support of prevention, and a new level of engagement and collaboration between affected individuals and communities, public health experts, and governments.

Policy Recommendations

1. Invest in prevention through a dual approach:

- allocate more resources at all levels of government to enhance accessible preventive services;
- increase efficiency in public health by empowering nurses and other health professionals aside from physicians to play a key role in its delivery;
- reduce social inequalities in order to improve the health status and resilience of those differentially impacted by disease.

2. Enhance health equity and social determinants accountability:

- assess relevant areas of public policy at all levels of government (housing, income support, the justice system, health care services, etc) using a health equity lens;
- establish a federally funded health equity auditor's office, with Parliamentary reporting mechanisms, and encourage other levels of government to do the same.

3. Engage the public to address historic inequities and gaps in public health:

- Fund world-class public health advocacy organizations. These would provide input into public health decision making; highlight patients' rights; document and propose solutions for intersectional inequality and racism; and advocate for important public health interventions and more balanced funding;
- Gather better data and make it publicly accessible. We require better information about the social differentials in disease vulnerabilities, and routinely collected data that helps us to trace patterns of race, income, location, etc. When we have that information, public health leadership must acknowledge social differentials and inequities, and plan to support the most vulnerable;

4. Create an equitable public health culture through education:

- encourage a horizontal, not vertical (top-down, one disease at a time), approach to public health. Recognize that technological 'fixes' will never fully protect society, and that human work in various aspects of care, non-medical measures and education will always be essential to resilience and preparedness;
- increase public health education to health care professionals, and to the general public. This must be done routinely, not only during a time of crisis;
- establish multidisciplinary training programs for public health personnel that are attractive to students from marginalized and racialized communities. Breaking down barriers and building trust will not occur unless the hidden assumptions, beliefs and practices that currently exist are eliminated. The history of attention to under-serviced communities and the recognition of the inequities of the capitalist system displayed by previous generations of professional and amateur public health activists can be used as a foundation.
- promote an inclusive and sustainable public health that would build upon various forms of health activism and advocacy and have communities and non-medical/healthcare actors participate in debates and decisions regarding public health.