New Public Health Legislation for the Northwest Territories

A Discussion Paper

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Introduction

Creating and maintaining healthy conditions in which to live, work and play are the responsibilities of every resident of the Northwest Territories (NWT). Individuals, families, communities, and government must work together to positively affect their surroundings.

The Government of the Northwest Territories (GNWT) plays its part by enacting public health legislation. The legislation provides the GNWT with the legal authority to protect the health of NWT residents from a broad range of health risks in several areas including day cares, landfills, restaurants, immunization, disease reporting, drinking water and sanitation.

Public health cannot be taken for granted. The experience with the AIDS epidemic, the water crisis in Walkerton, Ontario and concerns over the spread of Severe Acute Respiratory Syndrome (SARS), West Nile Virus (WNV) and Bovine Spongiform Encephalopathy (Mad Cow Disease) have reminded the general public and policy-makers of the ongoing importance of vigilance in public health protection. Public health legislation must therefore provide a solid framework, yet be flexible enough to adapt to new approaches and new threats to public health.

The current NWT *Public Health Act* was established in 1957. Since that time, the Act has changed very little, except to increase the number of regulations. Today's *Public Health Act* is fragmented and not adequate to deal with emerging public health issues and models. Aside from being outdated, the Act is not consistent with the current administrative arrangements for delivering public health services and has not been reviewed for compliance with the *Access to Information and the Protection of Privacy Act*, the *Charter of Rights and Freedoms*, or the basic principles of fair practice.

This discussion paper defines public health, its principles and its functions, and describes how public health services are currently provided in the NWT. It then outlines the best practices for public health legislation across Canada, and demonstrates where the NWT *Public Health Act* must be changed in order to meet them. Finally, a legislative framework is presented to illustrate the various approaches to public health legislation across Canada. One of these approaches is proposed for the NWT.

The intention is that this paper will serve as a guide to stakeholder discussion around new public health legislation in the NWT. To this end, specific discussion questions appear in the final section. Note that this paper does not review the *Public Health Act* regulations other than to identify the role regulations play. It is anticipated that existing regulations would be recognized in new public health legislation until such time as they can be updated by the Department of Health and Social Services through its regular review process.

Background

The need for new public health legislation in the NWT has been long recognized. In 1993, the then Department of Health commissioned a study of the underlying needs. The resulting document identified a number of issues and discrepancies with the *Public Health Act* and recommended, among other things, that the Act be amalgamated with other health-related legislation to create an integrated approach. Preliminary reviews in 1998 and again in 2001 confirmed the initial issues and found additional areas of concern yet did not echo the integrated approach. Unfortunately, none of these efforts progressed toward development of a legislative proposal due to competing legislative priorities at the time.

A number of recent events have moved the need for new public health legislation to the forefront. The water quality crisis in Walkerton, recent outbreaks of SARS and the heightened fear of bio-terrorism and chemical warfare have intensified the need for strong and relevant public health legislation. In some provinces, the concepts of safe drinking water and health emergencies have even been developed into separate pieces of legislation to provide more emphasis to these issues. Some argue that creating separate legislation for new

and emerging issues is not required, yet strengthening the ability of existing legislation to deal with these developments is essential. Whatever the case, strong parameters to protect public health are required in an environment of constant change.

In November 2002, the Department of Health and Social Services commissioned this discussion paper to research best practices in public health legislation across Canada, to outline the shortcomings with the current *Public Health Act*, and to identify a workable approach for new legislation. To meet these goals, several tasks were undertaken. First, a summarized list of issues was developed based on past studies and concerns raised over the years. Second, a comparison of public health legislation across Canada was conducted, and a list of best practices created. This information was circulated with an accompanying questionnaire to internal informants. These were individuals and groups chosen by the Department of Health and Social Services because they work directly with or have a particular interest in public health. Based on the circulated information and their own experience, each informant was asked to confirm or describe the strengths and weaknesses of the current *Public Health Act*, identify workable practices and approaches, and comment on possible options. Finally, several Canadian jurisdictions participated in an open-ended survey on the strengths and weaknesses of their own public health legislation and were asked to provide advice to the NWT as it seeks to amend the *Public Health Act*. Appendices A through C provide the results of these tasks.

Public Health

Definitions

Public health is what we, as a society, do collectively to assure the necessary conditions in which people can be healthy[1]. Public health considers the health of residents collectively as opposed to health care which looks after the health of one patient at a time[2]. Likewise, it involves many partners at various levels from individuals, families, and communities to businesses, charities and governments. To keep the discussion of public health manageable, this paper will focus on public health services funded by the GNWT, unless otherwise stated.

Over the years, the concept of public health has expanded from basic sanitation and the prevention of infections to a broader focus based on the determinants of health. The determinants of health are the many factors that influence a person's health such as genetics, income, early childhood development, education, environment, social networks, personal practices, social status, employment, and health services[3]. This broader view underscores the general principles of public health:

1. The needs of the population as a whole should be the focus.[4]
2. Emphasis should be more on prevention than treatment.
3. The benefits of protection of the public should clearly outweigh the costs to any one individual.
4. Government should facilitate individuals and communities in their efforts to comply with public health practices.

These principles are the foundation for the six functions of public health, including:

Health Status Assessment: includes identifying a set of health indicators based on the determinants of health, analyzing data, and identifying health trends, challenges, and strengths in a community or population[5]. An example is the *NWT Health Status Report 1999*[6] which reported on the overall health of NWT residents.

Disease Surveillance: includes the detailed study of any health event or disease through collecting and analyzing data and passing the findings on to those who can intervene to prevent the health event or disease from continuing or spreading[7]. An example is the current surveillance of the West Nile Virus being conducted to monitor this disease's impact and its movement throughout Canada.

Health Promotion: is the process of enabling people to increase control over and to improve their health[8]. Example activities include nutrition education, prenatal programs, and active living campaigns.

Disease and Injury Prevention: consists of interventions which have been shown to significantly reduce the likelihood that a disease or disorder will affect an individual or a population[9]. Example activities include vaccinations and laws requiring seat belt use in vehicles.

Health Protection: is the process of identifying factors which create risks to public health and then monitoring compliance to standards or intervening if necessary to ensure that these risks are minimized or eliminated. Because of the enforcement nature of health protection, this function is generally carried out by government through legislation. Examples include inspection of restaurants, monitoring drinking water quality, and the quarantine of people with dangerous infectious diseases.

Public Health Policy: involves setting standards and rules for the protection of the public's health. Public health policy can take various forms and can be set at the community, regional, and territorial levels. Communities enact by-laws to protect their residents. Regional Authorities develop guidelines to provide public health services. The GNWT establishes legislation which outlines standards to protect the public's health in law. Examples are the *Environmental Protection Act* and the *Motor Vehicles Act*. Other examples are listed in Appendix D. The purpose of this type of legislation is to create enforceable standards and to describe boundaries. A failure by government, agencies, or individuals to stay within the parameters of legislation could result in legal or financial sanction.

Because much of what government does could be described as protecting the health of the public, it could be argued that before any new policy or law comes into effect, its potential impact on the health of the public should be carefully assessed. Also, since there are many pieces of legislation related to maintaining the public's health, there is a need to distinguish between these and the *Public Health Act* itself. Therefore, for the purposes of this paper, the term 'public health legislation' will be used to refer specifically to the *Public Health Act* or a similar enactment in another jurisdiction.

Public Health in the NWT

There are many players involved with the provision of public health services in the NWT. At the community level Public Health Nurses provide disease prevention services such as immunizations, health promotion services and injury prevention such as patient education, and they are involved with the control of communicable diseases. Community Health Representatives provide health promotion and injury prevention services including education on healthy personal practices. These functions are also the focus of many non-government organizations and aboriginal initiatives. Band and hamlet councils pass by-laws and resolutions that promote healthy conditions in the community, and municipal Water Treatment Plant Operators provide health protection services by ensuring water quality procedures are regularly completed. Other community personnel such as teachers, peace officers, and recreation leaders also have a role in public health, although less direct.

At the regional level, Environmental Health Officers (EHOs) provide health protection services by monitoring conditions and intervening when public health is at risk. EHOs also have a role in educating others on healthy practices, mostly for organizations and businesses. EHOs, which are called Health Officers in the *Public Health Act*, report administratively to the Regional Health and Social Services Authorities (Regional Authorities) but are territorially appointed. Some EHOs serve several regions. Regional Authorities also employ staff with skills in community health, health promotion, and nutrition, to name a few, who are responsible for planning and implementing strategies to protect and promote public health. Regional personnel of other organizations like aboriginal associations or other GNWT Departments also play a role in reducing risk to the public health of their region.

Public Health services provided at the territorial level are generally more focussed on the NWT population as a whole than on any one particular group of residents. The Chief Medical Health Officer (CMHO) works with several staff in health protection, health promotion and disease registry to carry out the functions of health status assessment, disease surveillance, and development of public health policy and standards. These personnel are also involved with health promotion, disease prevention, and health protection but more in an

advisory or policy role than in direct intervention. The exception is the CMHO who plays a very public and direct role, particularly concerning communicable diseases at all levels. There are also two positions for Medical Health Officers (MHOs) to take on functions similar to the CMHO at a more regional level. These positions are currently vacant.

It is important to recognize that public health services in the NWT are provided in a context that is different from other jurisdictions. Many factors impact on the approach to public health and how services are provided. For example, human resource issues such as recruitment, retention, and capacity significantly impact the NWT's ability to provide a full range of public health services. Self-government is a northern reality, as is rapidly expanding industrial development. The NWT also has a large geographic area which does not lend itself to quick movement of personnel should intervention be required. Other characteristics include a transient population, limited housing capacity in some communities, and the existence of various languages and cultures. Not only do these factors impact current public health services, but each must be considered with the development of new public health legislation.

Elements of Public Health Legislation

Canadian Best Practices

A review of public health legislation across Canada and open-ended surveys with some jurisdictions has resulted in a list of best practices being identified. Essentially, these can be considered in two categories: 1) best practices for public health legislation; and 2) best practices for legislation in general. Both are recommended.

Good public health legislation:

-has precedent over other legislation where a conflict exists

-recognizes partnerships and linkages in public health service provision

-allows for the setting of standards in key areas of public health such as restaurants, reportable diseases, sewer and water, sanitary conditions, etc.

-describes clear roles for the Minister, his/her Department, Regional Authorities, Municipalities, and public health officials

-allows the Minister to enter into agreements with other provinces, the federal government, aboriginal groups, or the United States to provide services.
-contains measures for public health emergencies, including exemptions in extraordinary circumstances

Good legislation:

-is flexible to encompass new issues and models as they emerge

-sets out a framework and puts detail in the regulations

-describes the purpose of the Act and guiding principles.

-is consistent with the *Charter of Rights and Freedoms*

-outlines roles, powers, accountabilities and qualifications of officers named in the Act

-ensures due process (appeals, rights, legal requirements, etc)

-contains Regulation-making authority
-has clear and useful definitions

Recommended Changes for NWT Public Health Legislation

Aside from being outdated, the NWT *Public Health Act* does not measure up to the best practices for public health legislation across Canada. In order to do so, several changes are required.

Flexibility

The *Public Health Act* uses language that is restrictive and prescriptive, leaving little room to deal with emerging issues and circumstances such as AIDS/HIV or chemical warfare. Best practices from across Canada and interview results from some provinces suggest that flexibility of language without sacrifice of standards and parameters is highly desirable in legislation. Not only does this provide a strong framework to decipher emerging issues in changing times, it provides stability in light of the fact that updates and legislative amendments are not quickly made. Changes to legislation rightly require a lengthy review process and investigation before becoming law.

A good example of this is the Nova Scotia *Health Act* which provides the ability to create regulations respecting "any…matter relevant to the public health". Ontario's *Health Protection and Promotion Act* allows the Minister the option to "publish guidelines for the provision of mandatory health programs" thereby providing flexibility as to how the Act and its regulations are to be interpreted. Such open wording would maintain the structure of public health in the NWT while providing room for new models such as the draft "Integrated Service Delivery Model", or another model in the future.

Paramountcy

The term 'paramountcy' in legislation refers to the ability of one Act to supersede or take precedence over another Act or a law at another level of government. There is nothing in the current *Public Health Act* to suggest that it takes precedence over other legislation in order to protect the public, yet this is important. Even in the event of an emergency situation, the parameters of public health must remain in force. Some believe the only legislation paramount to the *Public Health Act* is the *Civil Emergency Measures Act*. Others argue that even in the most severe emergency situation, the standards of public health should remain.

Considering the need for quick intervention in the event of a serious health threat, including the disclosure of medical information in some cases, the *Public Health Act* should also have paramountcy over or be exempted from the *Access to Information and Protection of Privacy Act* where there are inconsistencies between the two. This is not to say that confidentiality, privacy, and protection of health information will not be intact. It means that in certain circumstances these requirements may be waived only to the degree necessary to protect public health.

Recent outbreaks of Severe Acute Respiratory Syndrome (SARS) and the West Nile Virus (WNV) illustrate how communicable diseases cross oceans and borders. The current wording of the *Public Health Act* does not allow for or recognize the reality of self-government and land claims negotiations but it is expected that the *Public Health Act* will have paramountcy over laws created by self-government groups.

Municipalities

The legislation's focus on tax-based municipalities as the governing agencies for the public health system is impractical and inappropriate. This presumes a larger role for municipalities than is actually the case. Under Section 9 of the Act, municipal councils may set up health boards. Currently, there are no such boards in the NWT and in practice, the work which would be carried out by such boards is carried out by the CMHO or the Regional Authorities.

Given that there are only 5 tax-based municipalities in the NWT, the usefulness and sustainability of this model is questionable. Few municipalities or communities currently have the capacity to govern and

administer the public health system, let alone the mechanisms in place to collaborate with other municipalities and other players in the health and social services system. While municipalities are certainly partners in the provision of public health services through their bylaws, their role is not one of public health governance, at least not at this time. This should be clarified in new public health legislation.

Regional Authorities

The current *Public Health Act* does not recognize the existence or role of the Regional Authorities. These Authorities are responsible for the provision of health and social services in the various regions of the NWT, including primary health care and many of the public health functions not currently governed by the *Public Health Act* such as health promotion. As mentioned, the Regional Authorities work administratively with the MHOs and EHOs and employ the Public Health Nurses. Regional Authorities have a manager or director who oversees public health services in the broad sense and these individuals have a role to play in the interdisciplinary nature of public health service.

Some legislation, like that in Saskatchewan refers simply to an authority through which public health services are administered. It defines 'authority' broadly as potentially pertaining to municipalities, regional authorities, self-government groups, or the Minister. This type of wording is useful since it is applicable to the current system, yet is adaptable should the system change.

Partnerships

In the NWT, there are other pieces of legislation which are related to or work in partnership with the *Public Health Act*. Examples include the *Environmental Protection Act*, the *Civil Emergency Measures Act*, and the *Mine Health and Safety Act*. Other examples are listed in Appendix D. The provision of public health services is a multidisciplinary undertaking, involving partnerships within government Ministries, between levels of government, and involving non-government organizations, aboriginal groups, communities and individuals. Water Engineers from the Department of Public Works and Services test drinking water quality, industry is required to reduce toxic emissions, Community Health Representatives in the communities promote healthy practices, and non-government groups run day cares, to name a few. The *Public Health Act* does little to recognize the partnerships required for effective public health protection. There are very few examples across Canada of public health legislation reflecting these partnerships, except in Newfoundland's *Health and Community Services Act* where reference is made to related legislation in that province.

Accountability of Personnel

The current *Public Health Act* is not clear about the accountability, relationships or the powers of the various personnel within it. The current wording enables both municipalities and the Minister to appoint MHOs and EHOs. Municipalities are also responsible for hiring public health nurses under the current Act. In practice, MHOs and EHOs are appointed by the Minister of Health and Social Services, yet they report administratively to the Regional Authorities. Some feel strongly that even the current practice is inappropriate and that MHOs and EHOs should be appointed by and report to the CMHO. This would remove them from potential conflict of interest situations should a public health order be required against a Regional Authority. As well, this would allow these officers to be full advocates of public health without the perceived requirement for regional loyalty. Public Health Nurses currently report to the Regional Authorities. Some argue that Public Health Nurses should also report directly through their Manager or Director to the MHO of CMHO, with administrative relationships still existing with the Regional Authority. While it is not advocated that organizational structure and reporting relationships be addressed in legislation, decisions should be made about the parameters of the appointment, duties, and powers of personnel, and these should be clear in legislation.

Qualifications of Personnel

There are currently no requirements in the current Act for public health officials to hold particular qualifications. While the specifics of the qualifications would more appropriately be detailed in regulations or policy, the recognition that officers require a particular knowledge base is critical. The Canadian Institute of Public Health Inspectors is the recognized body to certify EHOs. Many feel the CMHO should not only be a physician but have additional public health training in the fields of epidemiology and population health. Likewise there is general agreement that MHOs must also be qualified through education or experience in addition to their clinical training. Across Canada, MHOs are normally physicians but some argue that other health professionals with additional training could fit this role. Decisions about the appropriate qualifications for various officers will be required to be placed in regulations.

Delegation, Portability and Authority

The wording of the current *Public Health Act* does not allow the CMHO, MHO, or EHO to delegate their powers to other duly qualified persons in their absence or in the event of their inability to perform their duties. Delegation clauses are also essential in the event of a public health emergency when public health officials from other jurisdictions may be required to act as MHOs for a time. Absence of delegation powers in the current Act means present officials, especially the CMHO, are unable to be on leave or be outside the NWT without first working through a lengthy and complicated appointment and reappointment process. It is important to recognize that delegation powers in legislation do not necessarily allow for delegation to occur practically. Human resource capacity restricts delegation. While the ability to delegate is recommended in legislation, expectations on implementation of this ability must be coupled with the existence of properly qualified personnel to take on public health duties.

Associated with this is the need for portability of public health officers. MHOs and EHOs, once appointed, should be able to perform their duties and maintain their powers throughout the NWT and not in one particular region or area. New Brunswick and Nova Scotia have portability clauses built into their legislation. Given the challenges with recruiting and retaining qualified and experienced personnel in the north, the ability to have public health officials work where needed in the NWT is critical.

Also, the current Act requires most approvals and decisions to be made by the Minister or the Chief Medical Health Officer. Some decisions, like closing unsanitary premises and other items could be made at the MHO or EHO level, provided these officers are properly qualified. Many Canadian jurisdictions include a general clause for health hazards or health nuisances in their legislation. Such a clause enables the public health official to act where the health of the public is at risk, without requiring each and every circumstance under which a risk could occur to be outlined in the legislation. The inclusion of a general health hazard clause in legislation, which also includes provisions for due process and public rights, provides a good balance for protecting public health while doing so in a professional and diligent manner.

Security and Emergencies

Canadians expect their governments to be ready to deal with the possible health risks from natural events and disasters such as floods, earthquakes, fires and highly dangerous infectious diseases; and accidents or criminal and terrorist acts involving explosives, chemicals, radioactive substances or biological threats[10]. These expectations have intensified after the events of September 11, 2001. The current *Public Health Act* sets out restrictions for disease outbreaks and epidemics, yet does not go beyond that to discuss the role of public health in other emergency situations.

In Manitoba, for example, recent amendments were made to their *Public Health Act* to define the parameters around serious health hazards, dangerous diseases, public health emergencies, and circumstances requiring immediate action. As well, Quebec's legislation outlines who may declare a public health emergency and the requirements surrounding this. Many provinces have good examples of exemption clauses which allow the Commissioner or Minister to exempt or waive portions of the public health legislation in the event of an

emergency. That said, there is general agreement that the term emergency needs to be clearly defined, and that strong working relationships through an emergency response plan are key.

Protection of Health Information

In the last twenty years, governments have increased their focus on the balance between protecting the common good and maintaining individual rights. Clearly defining how information is collected, the purpose for its collection and the conditions under which it can be shared are of utmost importance. Many of these issues are addressed under the *Access to Information and the Protection of Privacy Act,* as well as the federal *Charter of Rights and Freedoms*. The Canadian Medical Association has also adopted a *Health Information Privacy Code*[11] which provides guiding principles for patient information collection, use, disclosure and access, including health information technology.

Solid parameters for confidentiality and information release will be required in new public health legislation. While public health officials are well-aware of their responsibilities regarding confidentiality, the Act does not formalize these responsibilities or provide parameters for the use of information, access to information, or definitions to distinguish private information from confidential information. As well, there are no provisions for the sharing of information between jurisdictions and agencies. There are good examples of confidentiality and release of information clauses in the public health legislation of Saskatchewan, Quebec, and Alberta which could be easily adopted.

Also related to information are reporting requirements. In cases of communicable diseases or serious threats to public health, specific information will be required from a variety of individuals in a timely fashion. New public health legislation should include provisions requiring the reporting of information. The scope of information involved and the parameters of this duty could be outlined in regulations.

Disease Reporting

The NWT *Disease Registry Act* was established in 1990 to provide a legal mechanism for the collection of disease-specific information, particularly the NWT Cancer Registry. This Act lists communicable and non-communicable diseases, cases of which must reported be health practitioners.

Because the purpose of disease reporting and the requirement to protect the public from the spread of disease are closely linked to public health, many Canadian jurisdictions include disease reporting under their public health legislation. In most cases this covers communicable diseases and in some instances non-communicable diseases, due to their impact on the health status of residents. Folding the requirements of the *Disease Registry Act* into new public health legislation would reduce the lengthy number of NWT Acts administered by the Minister of Health and Social Services, and bring disease surveillance and control activities together for a more seamless approach.

Due Process

Where serious threats to public health exist, public health officials must often intervene in a manner that may not be perceived by some individuals as in their personal best interest. While this action is legitimized by the powers invested in public health officials, the current *Public Health Act* does not specify that these actions must be subject to the legal system. Restriction of liberty must be legal, legitimate, and necessary, using no discrimination in application and using the least restrictive but effective means. Safeguards such as court orders, warrants, show of identification, and appeal mechanisms must be in place. There are no such safeguards in the current Act.

There needs to be a balance between protection of public rights and ability to act expeditiously. There have been many changes in the legal environment since the *Public Health Act's* inception. The new Act will have to be consistent with the developments in administrative law and the Canadian *Charter of Rights and Freedoms*. Likewise, it will have to be flexible enough to allow quick intervention in certain circumstances, recognizing the

practicalities of living in the North. Workable procedures will be required at the policy level to ensure that due process does not become a hindrance to public protection.

Penalties

The penalties for offences under the *Public Health Act* are too low to be effective for deterring infractions. The current maximum fine is $500 or 6 months jail time. Other Canadian legislation contains a sliding scale of penalties, separating individuals and corporations, and allowing for penalties each day the offence continues, up to $250,000. Many have suggested that public health offences should be in line with those for environmental or employee safety offences, which in the NWT can be as high as $500,000. There is also precedence that, for offences committed by corporations, all officers and board members of that corporation would be liable. Whatever penalties are adopted in new legislation, they should be outlined in regulations so that they can be easily revised over time.

Camps

Sections 14 to 18 of the *Public Health Act* refer to the acute or emergency care of camp employees. These sections are redundant since camp safety and medical care are outlined in the *Mine Safety Act* and the *Workers Compensation Board Act*. In addition, the standards outlined in sections 14 to 18 are outdated and inappropriate. These sections should be removed.

Legislative Framework

In the past, only the functions of health protection and disease prevention have been legislated under public health legislation. Now, the legislation in some Canadian jurisdictions has broadened its scope to embrace the broader definition of public health including the full spectrum of public health functions. This legislation could be considered as having a public health scope.

Other jurisdictions have concentrated their legislation only on the functions of health protection, disease surveillance and disease prevention since these functions are considered enforceable. This latter school of thought believes that the broader public health functions such as health promotion and health status assessment are not appropriate for legislation since they deal with personal lifestyle choice and process, respectively. This type of public health legislation is considered to have a health protection scope.

Another factor to consider with the approach to legislation is the focus or the goal of public health standards. Many jurisdictions have public health legislation that is method focused. A method focus provides standards and detail about how a public health function should be carried out, by whom, and to what degree. The NWT *Public Health Act* is a good example of the method focus. It outlines particular methods and processes that must be followed in order to achieve the desired outcomes of, say, clean drinking water. For example, how often water should be sampled, etc.

A focus which is becoming more prevalent in newer public health legislation is an outcome focus which describes less the particulars of how public health procedures are done, and more the end results which are to be achieved. For example, Quebec's *Public Health Act* requires the Minister to develop a public health program and assess the outcomes of that program regularly. Using the same example of clean drinking water, the standards in outcome focused legislation would describe what characteristics are required for drinking water to be considered safe, and then refer to best practices, such as the 'Guidelines for Canadian Drinking Water Quality' for the methods to achieve this outcome.

Public health legislation generally takes on one of four approaches that combine the following scopes and focuses:

1. Public Health Method-Focused Legislation

2. Health Protection Method-Focused Legislation
3. Public Health Outcome-Focused Legislation
4. Health Protection Outcome-Focused Legislation

Canadian Approaches

The legislative framework provided above describes a variety of approaches to public health legislation across Canada. Table 1 below provides a visual approximation of how some jurisdictions' legislation fits into the framework. The degree to which a jurisdiction falls within one category or another has not been assessed, yet it should be noted that variances do exist and no one jurisdiction falls squarely within the definitions provided.

Table 1: Canadian Approaches to Public Health Legislation

	Public Health Scope	**Health Protection Scope**
Method Focused	Alberta Ontario	Nova Scotia Yukon
Outcome Focused	Quebec	Prince Edward Island

Recommended Approach for NWT Public Health Legislation

Given the many factors at play in the NWT, it is proposed that new public health legislation have a health protection scope and a more outcome focus than what currently exists. This approach involves a conscious decision to focus legislation on the more enforceable and regulative aspects of public health, namely health protection, disease surveillance, disease prevention. The remaining functions of public health would be covered by policy, not legislation. This builds on the strengths and focus of the current NWT *Public Health Act*, with the addition of a disease surveillance function. This approach may also lend itself to the renaming of the legislation to the 'Health Protection Act' or a similar title to more accurately reflect its focus.

The proposed outcome approach would not do away with methodology guidelines. A few methods would remain in legislation while most others would be outlined in policy-type documents. This is in contrast to a full outcome focus which removes procedural and method requirements from legislation altogether and relies solely on the accountability and outcome reporting of public health personnel. A full outcome focus is not advocated as it would require a significant increase in administrative workload and would not be realistic with the limited human resource capacity in the NWT. That said, a move toward outcome standards with heavier reliance on best practices for methodology would provide the necessary flexibility to deal with emerging issues, such as those surrounding the rapid growth of the diamond industry, for example.

With this approach, accountability reporting would remain the responsibility of CMHO, with any reports required by other public health personnel funnelled through the CMHO Office. Also, there is expected to be an increase in administrative workload at the territorial level to research best practices, approve methodology guidelines, and to monitor outcomes. Various policy instruments will be required to support these efforts. An element of this work will also be necessary at the regional levels where human resource capacity may be an issue.

While a health protection scope would not be new to the NWT, the move toward an outcome focus and a stronger emphasis on disease surveillance will require resources to orient personnel at all levels to the

changes. This is not to say that disease surveillance does not already occur. However, placing this function solidly in new public health legislation will bring it to the forefront, and may require strengthened epidemiology capacity and stronger information technology and systems at the territorial level.

Conclusion

The current NWT *Public Health Act* requires significant change if it is to be effective in protecting the health of Northerners. New public health legislation needs to ensure public health services are provided in a professional and fair manner, to be easily administered, and to be applicable to the current health and social services system yet flexible enough to withstand changing models and emerging issues. A health protection scope and a focus which is based more on outcomes than procedure would provide a practical approach to making these changes work together to protect the health of NWT residents in law.

Next Steps

Using this discussion paper as a guide, the next step will be to ensure that NWT residents have a chance to provide their input into the scope and practical direction for new public health legislation. The first and best way to become involved is to consider the questions posed in the next section and to submit responses as indicated.

Once public input is received, a proposal for new public health act legislation will be developed and forwarded through appropriate channels to the Legislative Assembly.

Discussion Questions

1. Are there additional elements that you would consider best practices in public health legislation?

2. Are there concerns or issues with the current *Public Health Act* that this paper has missed?

3. Do you agree with the changes proposed in the following sections?

    a) Flexibility
    b) Paramountcy
    c) Municipalities
    d) Regional Authorities
    e) Partnerships
    f) Accountability of Personnel
    g) Qualifications of Personnel
    h) Delegation, Portability and Authority
    i) Security and Emergencies
    j) Protection of Health Information
    k) Disease Reporting
    l) Due Process
    m) Penalties
    n) Camps

4. What additional factors are unique to the North and need to be considered when implementing new public health legislation?

5. Given the realities of the North, do you think a public health approach or a health protection approach is most appropriate for the NWT? Why?

6. Given the realities of the North, do you think a method focus or an outcome focus is most appropriate for the NWT? Why?

7. Do you agree with the proposed health protection outcome approach?

8. If you agree with the proposed approach, do you think the *Public Health Act* should be re-named?

What name would you suggest?

9. Do you agree that the *Public Health Act* should take precedence over other legislation where there are inconsistencies?

10. Should some public health items, like safe drinking water, be developed into their own legislation for emphasis?

11. Should the development of new government initiatives be required to include an assessment of their impact on public health?

12. What role should municipalities play in the public health?

13. To what extent should delegation of powers by public health officials be allowed?

14. What kind of changes could make the *Public Health Act* more responsive to public health emergencies?

15. How can the right to privacy be balanced with the need to share information when public health is at risk?

16. Should the *Disease Registry Act* be amalgamated with the *Public Health Act*?

17. How can 'due process' be balanced with the need to intervene quickly where serious threats to public health exist?

18. Is there a need for a Public Health Appeal Board in the NWT?

Please submit responses and other comments with your name and affiliation by **September 30, 2003** to:

Mr. Doug Ritchie
Policy and Legislation Unit
GNWT Department of Health and Social Services
Box 1320
YELLOWKNIFE, NT X1A 2L9
Fax: 867-873-0484

You can also provide your feedback online at http://www.hlthss.gov.nt.ca by September 30, 2003.

Appendix A

NWT Public Health Act - List of Issues from Past Studies

Camps
Sections 14-18 may be redundant since other legislation covers these requirements.

Municipalities
Municipalities are given specific roles and authorities which are not practiced and may not be appropriate.

Personnel
-Confusion exists regarding who appoints personnel and their various roles.
-Does not allow for seamless delegation in the absence of officers.
-Qualifications for Health Officers (EHOs) are not required.
-Indemnity of Officers is not stated.

Governance
-Little detail on the role of the Minister and government departments
-Role of Regional Health and Social Services Authorities is absent

Enforcement
-Questionable effectiveness of low fines
-Little detail on due process, appeals, court orders, warrants, etc.

Regulation-Making Powers
Lengthy and overlapping list of regulation-making authorities

Regulations
-Several overlapping regulations
-Food premises regulations are currently inconsistent with Food Retail and Food Services Code

Gaps – No mention of the following items:
-Self government
-Environmental health regulations
-Emergencies / bio-terrorism
-Confidentiality / release of Information
-Quarantine of animals
-General health hazards / nuisances
-Non-communicable diseases

Appendix B

List of Persons Interviewed

Canadian Public Health Association, NWT/Nunavut Branch

CEO, Inuvik Regional Health and Social Services Authority

Chief Medical Health Officer, Department of Health and Social Services

Communicable Disease Specialist, Department of Health and Social Services

Communicable Disease Specialist, Department of Health and Social Services

Director, Community Health, Yellowknife Health and Social Services Authority

Director, Emergency Services, Department of Municipal and Community Affairs

Environmental Health Consultant, Department of Health and Social Services

Environmental Health Officer, Hay River Community Health Board

Environmental Health Officer, Inuvik Regional Health and Social Services Authority

Environmental Health Officer, Stanton Territorial Health Authority

Environmental Health Officer, Stanton Territorial Health Authority

Manager, Diagnostic Imaging, Stanton Territorial Health Authority

Manager, Water and Sanitation, Department of Public Works and Services

NWT Medical Association

NWT Registered Nurses Association

Senior Engineer, Department of Municipal and Community Affairs

Senior Engineer, Water and Sanitation, Department of Public Works and Services

Senior Engineer, Water and Sanitation, Department of Public Works and Services

Senior Environmental Health Officer, Inuvik Regional Health and Social Services Board

Senior Environmental Health Officer, Stanton Territorial Health Authority

TB Control Specialist, University of Alberta

Appendix C

Cross-Canada Comments on Public Health Legislation

	What, in your opinion, are the strengths of your province's public health legislation which the NWT should consider?	**What, in your opinion, are the weaknesses or frustrations of your province's public health legislation which the NWT should avoid?**	**How flexible have you found your province's public health legislation in dealing with emerging issues (eg; bio-terrorism) and models (aboriginal self-government)? Explain.**	**Some suggest public health legislation should contain more health promotion components. Others say health promotion cannot be legislated. Still others say public health should not be legislated separately from other health services as this hinders a seamless system. What are your thoughts on the 'big picture' of public health legislation?**	**What other advice would you give the NWT as it plans for new public health legislation?**
NB	The authority to issue orders to mitigate or eliminate health hazards. The ability for health inspectors to issue certain orders. To be able to obtain orders from the court to detain and treat people with certain categories of diseases.	We have a very weak penalty system based on an Act entitled the *Provincial Offences Procedures Act*. Our Act is weak in the area of confidentiality. We are beginning to look at a Health Information Act.	The new flexibilities have not been proclaimed yet as we have been working on 4 sets of regulations to go with the Act. We do have rather broad powers to issue orders of various natures to eliminate hazards.	Public health legislation has to be legislated separately otherwise it would get lost in the hospital system. And promotion is a big part of what public health does. This is not to say that programs offered by public health can not be provided from Regional Health facilities.	Make sure you know where your problems lie with the current Act and where practice and legislation differ. Also be sure to keep the '*Charter*' in mind.
YT		I have not found any particular strengths or weaknesses within the Yukon Act that either facilitated or impeded the various activities that have occupied my time.	The Act seems to be sufficiently flexible o deal with emerging issues.	Public health should definitely be legislated separate from other health services. It is difficult enough already to keep public health issues in front of politicians and the public at large; if public health issues are incorporated into much broader health legislation they run the risk of becoming buried altogether.	

	What, in your opinion, are the strengths of your province's public health legislation which the NWT should consider?	What, in your opinion, are the weaknesses or frustrations of your province's public health legislation which the NWT should avoid?	How flexible have you found your province's public health legislation in dealing with emerging issues (eg; bio-terrorism) and models (aboriginal self-government)? Explain.	Some suggest public health legislation should contain more health promotion components. Others say health promotion cannot be legislated. Still others say public health should not be legislated separately from other health services as this hinders a seamless system. What are your thoughts on the 'big picture' of public health legislation?	What other advice would you give the NWT as it plans for new public health legislation?
MB	There are not many strengths. The Act is over 30yrs old and has 3 pages of regulation-making powers.	It is inconsistent with the '*Charter*' for entry, apprehension, inspection, etc. It does not include surveillance. It contains a frustrating limitation: to abate an unsanitary condition – permission is needed first.	The new *Securities Management Act* dealt with bio-terrorism and 'serious' PH threats. If self-government groups develop own legal and bylaw structure, the PHA has paramountcy (eg; MHO under native legislation has no powers under PHA).	PH would be lost if placed under same legislation as insured benefits and Regional Health Authorities. Can't legislate health promotion, but guidelines for RHA's will emphasize health promotion. See the Ontario Act, it deals with the health promotion piece.	Link PHA to ATIPP. A new PHA should authorize the CMHO to obtain info as needed. Work with legal advisor to determine what forms and procedures are needed to implement new clauses in the Act. Also, increase the powers of the PH Inspectors.
SK	The responsibility to administer the Act is at the regional level. Concerns about consistency in interpretation arise, but generally this works well. Also, MHOs are given general powers (with an appeal mechanism in place). Prior to this the Act listed each circumstance under which the MHOs had authority. The broader wording works well. Also, the broad definition of 'the authority' allows flexibility as models or circumstances change.	Some of the Com Disease section of the Act is too specific. Also, issues of bio-terrorism not specifically covered.	Powers for security management will be increased shortly. See AB & MB. Use of the term 'local authority' and several possible definitions for this gives lots of flexibility.	Keep public health legislation separate.	Keep wording flexible, general, and enabling. There may be pressure to include specifics for issues that need political profile, but avoid this. Strong policies to support the interpretation of the Act & Regs are important.

	What, in your opinion, are the strengths of your province's public health legislation which the NWT should consider?	What, in your opinion, are the weaknesses or frustrations of your province's public health legislation which the NWT should avoid?	How flexible have you found your province's public health legislation in dealing with emerging issues (eg; bio-terrorism) and models (aboriginal self-government)? Explain.	Some suggest public health legislation should contain more health promotion components. Others say health promotion cannot be legislated. Still others say public health should not be legislated separately from other health services as this hinders a seamless system. What are your thoughts on the 'big picture' of public health legislation?	What other advice would you give the NWT as it plans for new public health legislation?
NF	The HCSA is not prescriptive or overly detailed. The reason that it has stood the test of time is perhaps related to the all encompassing regulation making powers. Regulations currently in place are quite modern and reflective of today's policy directions. This also applies to the governance provisions for Health and Community Services Boards which are detailed in the various constitution orders. Regulations of course can be updated or modified by Government much easier than amending the parent statute.	The HCSA contains a lot of legal language that is quite dated which creates difficulties, particularly as it relates to interpretation. There is some suggestion that having one statute to deal with governance for all health boards may be more appropriate. Some sections of the HCSA (eg: restricted areas) are essentially redundant. A restricted area hasn't existed in our province since the mid-70's.	The HCSA is one of 42 statutes administered by our Department. Other pieces of legislation may impact on emerging issues (eg: bio-terrorism - Communicable Diseases Act). However, in general I can't recall of a situation where the HCSA has provided any barrier to evolving issues. The HCSA does not reflect the language of emerging themes but its general construct, especially the regulation making powers, have been able to adapt.	We need to have legislation to support basic public health and health protection programs (eg: environmental health, communicable disease, etc). What are we hoping to accomplish by supporting health promotion in law? If it is merely for optics, then legislation is inappropriate. Legislation should not form the basis of policy decisions but act as a support tool where mandatory and uniform compliance is necessary and in the public interest. There is often concern with public health being "swallowed up" by the institutional side of health. However, one statute does not necessarily mean one governance arrangement. Many of the powers and authorities of community and institutional boards are the same. There is some operational and technical utility in having only one statute govern both institutional and community based services.	Keep it simple.

Appendix D

NWT Legislation Related to the Public Health Act

The following are a few examples of NWT legislation that are related to the protection of public health or to the broad determinants of health:

All Terrain Vehicles Act
Civil Emergency Measures Act
Disease Registry Act
Environmental Protection Act
Fire Prevention Act
Flood Damage Reduction Act
Hospital Insurance and Health and Social Services Administration Act
Mine Health and Safety Act
Motor Vehicles Act
Public Highways Act
Safety Act
Transportation of Dangerous Goods Act

References

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2. Minnesota Department of Health, Community Health Division. 2002. *What is Public Health?* http://www.health.state.mn.us/divs/chs/what.html.

3. Federal, Provincial and Territorial Advisory Committee on Population Health. 1994. *Strategies for Population Health: Investing in the Health of Canadians*. Minister of Supply and Services Canada. Ottawa.

4. See reference 2.

5. Department of Health. 2002. *Public Health Services: Who We Are, What We Do*. Government of Nova Scotia. Halifax.

6. Department of Health and Social Services. 1999. *Health Status Report 1999*. Government of the Northwest Territories. Yellowknife.

7. Population Health and Public Health Branch, Centre for Surveillance Coordination. Website: http://www.hc-sc.gc.ca/pphb-dgspsp/csc-ccs/faq_e.html#healthsurveillance. Health Canada. Ottawa.

8. See reference 5.

9. See reference 5.

10. Centre for Emergency Preparedness and Response. 2002. Website: http://www.hc-sc.gc.ca/pphb-dgspsp/cepr-cmiu/. Health Canada. Ottawa.

11. Canadian Medical Association Board of Directors. 1998. *CMA Health Information Privacy Code*. Canadian Medical Association. Ottawa.