Legislative Summary **LS-523E**

BILL C-5: PUBLIC HEALTH AGENCY OF CANADA ACT

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LEGISLATIVE HISTORY OF BILL C-5

HOUSE OF COMMONS		SENATE	
Bill Stage	**Date**	**Bill Stage**	**Date**
First Reading:	24 April 2006	First Reading:	20 June 2006
Second Reading:	8 May 2006	Second Reading:	
Committee Report:	18 May 2006	Committee Report:	
Report Stage:	13 June 2006	Report Stage:	
Third Reading:	20 June 2006	Third Reading:	

Royal Assent:

Statutes of Canada

N.B. Any substantive changes in this Legislative Summary which have been made since the preceding issue are indicated in **bold print.**

Legislative history by Peter Niemczak

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BILL C-5: PUBLIC HEALTH AGENCY OF CANADA ACT*

Bill C-75, An Act respecting the establishment of the Public Health Agency of Canada and amending certain Acts (the Public Health Agency of Canada Act), was introduced in the House of Commons on 16 November 2005. That bill died on the *Order Paper* when Parliament was dissolved on 29 November 2005. It was subsequently reintroduced in the 39th Parliament as Bill C-5, on 24 April 2006.

As its title suggests, the bill provides the legislative basis for the Public Health Agency of Canada. The control and supervision of the Population and Public Health Branch of Health Canada was transferred to the Public Health Agency of Canada by Order in Council pursuant to the *Public Service Rearrangement and Transfer of Duties Act*, effective 24 September 2004. On that same day, Dr. David Butler-Jones was appointed Chief Public Health Officer of Canada pursuant to the *Special Appointments Regulations, No. 2004-15*.

BACKGROUND

A. Context

"Public health" is population-focused and includes disease surveillance, disease and injury prevention, health protection, health emergency preparedness and response, health promotion, and relevant research undertakings.(1) As the Auditor General of Canada noted in his November 1999 Report, responsibility for public health is shared between the federal government and the provinces and territories: provinces and territories provide many public health services, and Health Canada "is responsible for protecting Canadians against risks to

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* Notice: For clarity of exposition, the legislative proposals set out in the bill described in this Legislative Summary are stated as if they had already been adopted or were in force. It is important to note, however, that bills may be amended during their consideration by the House of Commons and Senate, and have no force or effect unless and until they are passed by both Houses of Parliament, receive Royal Assent, and come into force.

(1) Standing Senate Committee on Social Affairs, Science and Technology, *Reforming Health Protection and Promotion in Canada: Time to Act*, Fourteenth Report, 37th Parliament, 2nd Session, November 2003.

health and the spread of diseases."[2] Over the last number of years, there have been calls for the federal government to take a leadership role in coordinating federal, provincial and territorial approaches to public health issues, including improving federal public health legislation. For example, the Auditor General of Canada recommended that Health Canada initiate discussions with the provinces and territories on developing a national framework that would link public health components at various levels of government.[3] That same report also emphasized the need for roles and responsibilities to be clarified with respect to public health, in particular with respect to health surveillance.[4] A 2002 follow-up found that while there was still no federal public health legislation, the department had made progress with respect to establishing a national framework for health surveillance.[5]

The need to improve and strengthen coordination in the arena of public health was highlighted by the inadequacies of the public health response to the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). Several reports examined how the outbreak was handled, including *Learning from SARS – A Renewal of Public Health in Canada, A Report of the National Advisory Committee on SARS and Public Health* (frequently referred to as the Naylor Report, after Dr. David Naylor, Chair of the Committee) and *Reforming Health Protection and Promotion in Canada: Time to Act*, a report of the Standing Senate Committee on Social Affairs, Science and Technology.

B. Jurisdiction Over Public Health

While there is no explicit reference to legislative power over health generally in the *Constitution Act, 1867*, there are references to certain aspects of health**.** Parliament, for example, was granted exclusive jurisdiction over quarantine and marine hospitals (section 91(11)), and provincial legislatures were granted exclusive jurisdiction over the "Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals" (section 92(7)). Other constitutional

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(2) *Report of the Auditor General of Canada to the House of Commons*, November 1999, Ch. 14, "National Health Surveillance: Diseases and Injuries," para. 14.21.

(3) *Ibid.*, para. 14.25.

(4) *Ibid.*, para. 14.44.

(5) *Status Report of the Auditor General of Canada to the House of Commons*, September 2002, Ch. 2, "Health Canada – National Health Surveillance," para. 2.23.

powers have been used to further assign health-related subjects to either Parliament (the spending power, the criminal law power, and the "peace, order and good government" power) or the provincial legislatures (property and civil rights, and matters of a merely local or private nature).(6) As a result, Parliament and the legislatures have shared jurisdiction over health.

Jurisdiction over public health is also shared between Canada and the provinces. The federal jurisdiction is clear with respect to quarantine at its borders, while provinces govern local public health matters under the provincial power to regulate with respect to "property and civil rights," which courts have interpreted as including common law tort, contract and property rights.(7) One of the ways in which provinces have exercised their jurisdiction over public health is by enacting public health legislation that grants medical health officers and other provincial health authorities the power to deal with the prevention, treatment and control of communicable diseases.(8) In addition, as a result of section 92(8) of the *Constitution Act, 1867*, provinces have jurisdiction over municipalities, and historically, municipal governments were largely responsible for government health interventions, due to health being recognized as a "matter of private or local concern."(9) Municipalities remain active in community health. For example, many public health programs are overseen by municipal health officers, and some larger cities have municipal councils that focus on public health-related issues.(10)

The federal criminal law power is the basis for federal management of infectious disease outbreaks. As was articulated in the *Reference re Validity of Section 5(1) of the Dairy Industry Act* (the *Margarine Reference*), a prohibition is validly a criminal law if it is "enacted with a view to a public purpose … [such as] public peace, order, security, health, morality."(11)

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(6) For more information on the federal role in health, see Margaret Young, *The Federal Role in Health and Health Care*, TIPS-59E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 13 December 2000.

(7) National Advisory Committee on SARS and Public Health, *Learning from SARS – A Renewal of Public Health in Canada, A Report of the National Advisory Committee on SARS and Public Health*, October 2003, p. 166, http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf.

(8) Martha Jackman, "Constitutional Jurisdiction Over Health in Canada," *Health Law Journal*, Vol. 8, 2000, p. 112.

(9) *Ibid.*, p. 115.

(10) *Ibid.*

(11) [1949] S.C.R. 1, pp. 49-50.

Federal jurisdiction over the management of infectious disease outbreaks could also arguably be based on the peace, order and good government power.(12) That power has two branches: an emergency branch, which, in times of emergency, allows Parliament to enact laws that would normally lie within the jurisdiction of provincial legislatures; and a national dimensions branch, which allows Parliament to make laws in areas that concern Canada as a whole.

C. Recommendations Relating to the Public Health Agency of Canada and the Chief Public Health Officer

Both the National Advisory Committee on SARS and Public Health, and the Standing Senate Committee on Social Affairs, Science and Technology, recommended creating a federal Public Health Agency and appointing a Chief Public Health Officer. In April 2004, the Working Group on a Public Health Agency for Canada (established by the former federal Minister of Health Anne MacLellan) released its final report relating to the creation of such an agency.

1. *Learning from SARS – A Renewal of Public Health in Canada, A Report of the National Advisory Committee on SARS and Public Health* (the Naylor Report)

The National Advisory Committee on SARS and Public Health was given the mandate of providing "a third party assessment of current public health efforts and lessons learned for ongoing and future infectious disease control."(13) One of the many issues the Committee examined was how a federal public health agency could contribute to the renewal of public health, as well as how such an agency should be structured.

At the time, the majority of public health issues were handled by Health Canada's Population and Public Health Branch (PPHB), which had headquarters in Ottawa and regional offices across Canada. Components of the PPHB included Centres for Infectious Disease Prevention and Control, Chronic Disease Prevention and Control, Emergency Preparedness and Response, Surveillance Coordination and Health Human Development. The Committee observed that this placement within a government department was problematic as it "puts public

(12) National Advisory Committee on SARS and Public Health (2003), p. 166.

(13) *Ibid.*

health professionals inside a very large organization and a highly process-oriented culture with a particular orientation to the political issues of the day."(14) It recommended that placing the PPHB's responsibilities outside of a department in the form of an agency would yield a number of benefits, including:

- attracting scientists and professionals not comfortable in a departmental setting;
- reducing jurisdictional disagreements that might negatively affect the health of Canadians;
- "find[ing] new ways to engage public health professionals in the provinces and the territories"; and
- bringing the delivery of public health services more in line with how public health services are delivered elsewhere.(15)

The Committee recommended that the agency be a federal agency, as opposed to a federal/provincial/territorial (F/P/T) agency like the Canadian Institute for Health Information or Canadian Blood Services, because creating an F/P/T agency "would involve difficult and time-consuming negotiations that could exacerbate existing tensions at F/P/T tables."(16)

With respect to how the proposed entity should be structured, the Committee examined whether it should operate as a Crown corporation, a Special Operating Agency (SOA) (e.g., Technology Partnerships Canada and the Canadian Heritage Information Network), a Departmental Service Organization (e.g., Environment Canada's Meteorological Service), or a Legislated Service Agency (LSA) (e.g., Canadian Food Inspection Agency, Canadian Institutes of Health Research, Statistics Canada). The Committee was of the opinion that having public health handled by a Crown corporation was not desirable as it would be too far removed from Parliament and government.(17) It also rejected the option of its functioning as an SOA (which is not an independent legal entity, but is rather established by Treasury Board approval), because SOAs are part of the home department. The third option of creating a Departmental Service Organization, which would be a unit within the department that delivers services to the

(14) *Ibid.*, p. 73.

(15) *Ibid.*

(16) *Ibid.*

(17) *Ibid.*, p. 74.

department's clients, was rejected on the basis that it would not be sufficiently independent, nor would it be able to integrate activities across multiple departments.

Based on its characteristics, the LSA option proved to be the most desirable.(18) LSAs are:

- headed by a CEO that reports to the Minister;
- supported by a "Board" whose members are Governor-in-Council appointees;
- subject to ministerial discretion;
- separate employers under the *Public Service Staff Relations Act* (which increases the staffing authority and flexibility of the agency);
- focused on performance;
- provided with greater financial and administrative authorities than traditional departments; and
- overseen by the Auditor General of Canada.

Having determined that the new entity should be a LSA, the Committee made a number of other recommendations. For example, the legislation relating to the Agency should include appropriate and consolidated authorities necessary to provide leadership as well as provide for the delegation of powers from ministerial authorities to officials. The Committee also made recommendations relating to privacy and the use of personal information, and noted that the legislation could be "relatively skeletal" to allow it to be passed quickly into law.

With respect to the CEO of the Agency, the Committee determined that it should be a Chief Public Health Officer (CPHO):

> The Chief Public Health Officer of Canada would be a leading national voice for public health, particularly in outbreaks and other health emergencies, and a highly visible symbol of a federal commitment to protecting and improving Canadians' health.(19)

(18) *Ibid.*, p. 75.

(19) *Ibid.*, p. 77.

The CPHO would be required to report annually to Parliament on the state of public health. Other CPHO duties could include:

- advocating for effective disease prevention and health promotion programs and activities;
- providing science-based health policy analysis and advice to the federal Minister of Health and, when requested, to the provincial and territorial ministers of health;
- providing leadership in promoting special health initiatives; and
- improving the quality of public health practice.(20)

2. *Reforming Health Protection and Promotion in Canada*: *Time to Act*

The November 2003 Report of the Standing Senate Committee on Social Affairs, Science and Technology strongly echoed the opinions expressed in the Naylor Report. The Committee agreed with the creation of the Agency, noting that the agency:

> would enhance the federal government's ability to support local work in disease control and prevention … would help bring a more collaborative culture among health protection and promotion professionals in different levels of government … [and] would provide a clear focal point for Canada to manage health protection and promotion issues at its borders and to interact with its international partners.(21)

Witnesses who appeared before the Committee suggested a number of advantages to establishing such an agency. For example, it would:

- concentrate and focus federal resources;
- enhance collaboration between different levels of government and providers of public health services;
- allow for faster and more flexible responses to emergencies;
- improve and focus communication;

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(20) *Ibid.*

(21) Standing Senate Committee on Social Affairs, Science and Technology (2003), p. 11.

- allow for the making of longer-range plans because it would not be limited by the "annual planning cycle of government"; and
- have greater success in attracting and retaining health professionals.(22)

The Committee stressed the need to take immediate steps to create the Agency, even though that might mean that the Agency would not be initially equipped to handle all areas of its eventual mandate.(23) From the outset, however, the Agency should be responsible for the following:

- disease surveillance and control;
- emergency preparedness;
- immunization; and
- chronic disease prevention.(24)

3. Working Group on a Public Health Agency for Canada, April 2004

The Working Group started from the premise that the creation of a federal public health agency had merit.(25) Both the Naylor Report and the Standing Senate Committee's report were the basis for the review by the Working Group. The Working Group also looked at public health models in other jurisdictions, heard presentations from senior Health Canada officials, and consulted with provincial and territorial health officials through the F/P/T Task Force on Public Health.

The Working Group agreed that the Agency should be headed by a CPHO, noting that the position should be a Governor-in-Council appointment. The Working Group also emphasized that the Agency must recognize that public health is an area of shared responsibility between the federal, provincial and territorial governments, and that municipal governments play key roles in the delivery of public health services. The Working Group agreed with the core

(22) *Ibid.*, p. 19.

(23) *Ibid.*, p. 26.

(24) *Ibid.*, p. 28.

(25) Working Group on a Public Health Agency for Canada, *Report: A Public Health Agency for Canada*, April 2004, http://www.phac-aspc.gc.ca/publicat/phawg-aspgt-noseworthy/index.html.

mandate of the Agency as set out in the Naylor and Standing Senate Committee reports. It also agreed that new legislation that provided "a clear and solid legislative foundation for the Agency" was desirable, and noted that until such legislation came into force, the Agency could be established by Order in Council.

DESCRIPTION AND ANALYSIS

Bill C-5 contains a preamble and 24 clauses.

A. Preamble

The five-paragraph preamble states that the Government of Canada wishes to: take a number of measures relating to public health; foster collaboration and coordination in the field of public health; promote cooperation and consultation with the provinces and territories; foster international cooperation; and create a public health agency and appoint a Chief Public Health Officer to "contribute to federal efforts to identify and reduce public health risk factors and to support national readiness for public health threats."

B. Public Health Agency of Canada (Clauses 3 to 5)

Clause 4 establishes that the Minister of Health presides over the Agency. The Minister may delegate his or her powers, duties and functions in relation to public health to any officer or employee of the agency (clause 4), but may not delegate the power to make regulations nor the power to delegate (clause 5).

C. Chief Public Health Officer (Clauses 6 to 12)

Clause 6 provides that the Governor in Council shall appoint a Chief Public Health Officer as the deputy head of the Agency. The CPHO is to be a public health professional (clause 6(2)) and has the rank and status of a deputy head of a department (clause 9). Clause 7 provides that the CPHO is the lead public health professional of the Government of Canada, and that he or she may communicate widely with respect to public health issues.

The CPHO holds office during pleasure for a term not exceeding five years (clause 8(1)) and may be reappointed for one or more additional terms (clause 8(2)). His or her remuneration shall be fixed by the Governor in Council (clause (10(1)) and he or she shall be paid reasonable expenses (clause 10(2)). The CPHO may delegate any of his or her powers, duties or functions to any officer or employee of the Agency, except the power to delegate (clause 11).

Clause 12 establishes the CPHO's reporting duties. He or she is required to report annually to the Minister on the state of public health in Canada (clause 12(1)), and the Minister must lay that report before Parliament within 15 sitting days of receiving it (clause 12(2)). The CPHO may also prepare and publish reports on any public health issues (clause 12(3)).

D. General Provisions (Clauses 13 to 15)

Officers and employees of the Agency are to be appointed in accordance with the *Public Service Employment Act* (clause 13). Clause 14 provides that the Minister may establish public health committees (clause 14(1)), and the remuneration of committee members shall be fixed by the Governor in Council (clause 14(2)). In addition, members of committees are entitled to reasonable expenses (clause 14(3)).

Clause 15 sets out the regulation-making power of the Governor in Council, who may make regulations relating to "the collection, analysis, interpretation, publication and distribution of information relating to public health, for the purpose of paragraph 4(2)(*h*)[(26)] of the *Department of Health Act*" (clause 15(1)(*a*)) and the protection of confidential information (clause 15(1)(*b*)).

E. Transitional Provisions (Clauses 16 to 20)

Clauses 17 to 19 relate to the transition from the Public Health Agency of Canada as it existed prior to the bill to the Public Health Agency of Canada established by clause 3 of the

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(26) Paragraph 4(2)(*h*) of the *Department of Health Act*, S.C. 1996, c. 8, states:

> (2) Without restricting the generality of subsection (1), the Minister's powers, duties and functions relating to health include the following matters:
>
> …
>
> (*h*) subject to the *Statistics Act*, the collection, analysis, interpretation, publication and distribution of information relating to public health.

bill. For example, clause 17(1) provides that the existing CPHO remains in office and is deemed to have been appointed under clause 6(1) of the bill.

F. Related and Consequential Amendments (Clauses 21 to 23)

Clauses 21 and 22 make consequential amendments to the *Department of Health Act* and the *Quarantine Act*. Clause 23 makes a coordinating amendment to the *Quarantine Act*.

G. Coming Into Force (Clause 24)

Clause 24 establishes that the bill, other than clause 23, comes into force on a day to be fixed by order of the Governor in Council.

COMMENTARY

Bill C-5's predecessor, the short-lived Bill C-75, received virtually no media attention; media attention to Bill C-5 has also been non-existent. There was, however, some academic commentary prior to Bill C-75's introduction that pointed out issues raised by the creation of a federal Public Health Agency. For example, it was noted that a federal public health agency would have to be cognizant of privacy and confidentiality issues (i.e., the need to balance the privacy rights of individuals with the need to protect public health). Another issue that was highlighted was the need for such a federal agency to take a collaborative approach with the provinces and territories when addressing potential jurisdictional conflicts.(27)

(27) Nola M. Ries and Timothy Caulfield, "Legal Foundations for a National Public Health Agency in Canada," *Canadian Journal of Public Health*, Vol. 96, No. 4, July/August 2005, p. 281.