Partners in Public Health

Final Report of the Federal/Provincial/Territorial Special Task Force on Public Health
To: Federal/Provincial/Territorial (F/P/T) Ministers and Deputy Ministers of Health

In the immediate aftermath of the 2003 SARS event, Ministers of Health met to discuss the challenges and impact posed by this transmittable disease, and to chart a course for greater collaboration in public health. The overall goal, as expressed by Ministers in Halifax in September 2003, was to build on public health strengths and successes across the country to enable governments to respond effectively to public health threats, respecting federal, provincial and territorial jurisdictions.

This report is the culmination of efforts of the F/P/T Special Task Force on Public Health to meet the goals set out by Ministers. As it’s centrepiece, we recommend the creation of the Pan-Canadian Public Health Network, to enable governments to work together on the day-to-day business of public health and to anticipate, prepare for, and respond to public health events and threats.

And second, the development and implementation of principles for an Agreement for Mutual Aid During an Emergency.

We present Partners in Public Health for your consideration. In doing so, we wish to acknowledge and thank our colleagues from every province and territory, with whom we have worked closely in developing the contents and recommendations in this report.

Sincerely,

Dr. Perry Kendall, MBBS, MSc, FRCPC
Co-Chair
Provincial Health Officer,
Ministry of Health Planning,
Government of British Columbia

Ian Shugart
Co-Chair
Senior Assistant Deputy Minister,
Health Canada,
Government of Canada
### Contents

1. Introduction................................................................................................................................................................1
2. Overview of Public Health Organization in Canada ...........................................................................................5
4. The Public Health Network .................................................................................................................................17
5. Instruments of the Public Health Network .........................................................................................................29
6. Mutual Aid During an Emergency .......................................................................................................................35
7. Review of Existing Public Health Groups / Networks .........................................................................................39
8. Conclusion...........................................................................................................................................................43

### Appendices

A. Development of an Agreement on Mutual Aid During an Emergency ...............................................................45
B. Terms of Reference of the Council of the Pan-Canadian Public Health Network – Proposed .......................47
C. Organization of Existing Public Health Groups / Networks ...........................................................................51
D. Preliminary Terms of Reference – Six Expert Groups .....................................................................................53
E. Strengthening Public Health Infrastructure Task Group – Highlights .............................................................73
F. F/P/T Ministers of Health Communiqué – September 2003 ............................................................................75
G. First Ministers’ Communiqués – Public Health Network .................................................................................77
H. Terms of Reference of the Task Force ................................................................................................................79
I. Members of the Task Force .................................................................................................................................83
Section One
Introduction

Over the past few years, concerns have grown as to the capacity of Canada’s public health system to anticipate and respond effectively to public health events and threats. The SARS outbreak in 2003, the continuing challenges posed by the incidence and spread of the West Nile Virus, the mad cow disease (BSE) crisis, the arrival of the Avian Flu Virus, and other public health issues including the growth of obesity and other non-communicable diseases have underscored the urgency for decisive and coherent action.

While Canada has a proud history of policy leadership in the area of health promotion articulated through the Lalonde Report in 1974 and the Ottawa Charter of 1987, current public health policy initiatives can be linked to more recent intergovernmental studies. These include the report on Public Health Capacity in Canada prepared by the Advisory Committee on Population Health in 2002 as well as several high-profile reports, by Dr. David Naylor (October 2003), Senator Michael Kirby (November 2003), Dr. David Walker (April 2004) and Mr. Justice Archie Campbell (June 2004). All of these studies have helped clarify the major challenges confronting Canada’s public health system, have provided thoughtful analysis, and have proposed solutions for improving Canada’s ability to manage outbreaks of infectious diseases and the day-to-day business of public health. In addition, a strong consensus exists among all governments on the need to move forward to strengthen public health infrastructures and capacity at the local, provincial/territorial and federal levels.

1 Defining public health is essential. In Canada, it is widely accepted that public health is the system responsible for helping and protecting Canadians from injury and disease and for helping them stay healthy. There is also agreement that the five core functional areas of a public health system are: 1) population health assessment; 2) health surveillance; 3) disease and injury prevention; 4) health promotion; and 5) health protection.
At their September 2003 Conference, federal, provincial and territorial Ministers of Health acknowledged the need to:

“make public health a top priority by improving public health infrastructure, and increasing institutional, provincial, territorial and federal capacity that builds on current strengths and successes across the country.”

They also agreed to work collaboratively on such issues as:

- clarifying the roles and responsibilities for preventing and responding to public health threats, in a manner respectful of federal, provincial and territorial jurisdiction;
- creating a national network of centres of public health science;
- ensuring the adequacy of public health human resources and strengthening the capacity to respond to regional and national public health emergencies; and
- enhancing national surveillance and information infrastructure.

Consequently, F/P/T Deputy Ministers of Health put in place the Special Task Force on Public Health (Task Force) to respond to the Ministers’ direction. Since that time the Task Force has been proceeding to give effect to these charges (see Appendix H for the Terms of Reference of the Task Force and Appendix I for a list of its members).

In undertaking this work, the Task Force has worked closely with the Strengthening Public Health Infrastructure Task Group (SPHITG) of the Advisory Committee on Population Health and Health Security (ACPHHS), which is taking the lead on addressing public health system infrastructure issues, including those identified in the Naylor Report. Their work has focussed on infrastructure initiatives in four key areas:

- development of a plan to enhance public health human resources;
- development of priority areas for building organisational capacity;
- development of information and knowledge systems; and,
- development of strategies to address cross-cutting issues including public health laboratories, Aboriginal health, collaborating centres and the need to better track system resources.

In the implementation of the recommendations contained in this report, there are opportunities also to build on the work and recommendations of SPHITG. A further overview of highlights of the work of the SPHITG is included as Appendix E.

The Task Force also worked with other F/P/T committees related to public health. For example, the Task Force reviewed the Reducing Health Disparities report of the ACPHHS Health Disparities Task Group and agrees that initiatives to reduce health disparities are critical, cross-cutting themes that should be taken into account in any collaborative inter-jurisdictional action on population health. Similarly, the Task Force supports the work of the National Emergency Preparedness and Response Network and the Strategic Framework for Health Emergency Management to facilitate the preparation for and response to public health emergencies.

Action to strengthen public health capacity is also occurring on other fronts. All jurisdictions have organizational structures and health professionals responsible for activities and programs related to public health. Some provinces have recently undertaken their own public health reviews, (i.e., Ontario and Quebec). The federal government is also taking steps to strengthen its responsibilities in public health. For example, since December, 2003 there has been a federal Minister of State for Public Health and a new federal public health agency has been created to ensure Canada is linked both nationally and globally, in a network for disease control and emergency response.

The Public Health Agency of Canada will be developing pan-Canadian strategies for managing infectious diseases as well as chronic diseases, in partnership with provinces, territories and health providers. Provincial/territorial capacity, the establishment of the Public Health Agency of Canada, the appointment of a Chief Public Health Officer for Canada and the creation of the six National Collaborating Centres for Public Health were taken into account as the Task Force went
about its work on intergovernmental issues related to public health.

The Special Task Force on Public Health has approached its task by focusing on the structural relationships between jurisdictions. Specifically, the Task Force has considered ways to respond to the weak links in our public health system identified by Naylor, Kirby, Walker, and others. This report does not address the issue of what resourcing will be required to reinforce the public health infrastructure across Canada. That work will be presented to the Conference of Deputy Ministers of Health by the Strengthening Public Health Systems Infrastructure Task Group. However, the realignments and collaborative structures recommended in this report will allow for a more strategic reinvestment in public health infrastructure. Therefore, while every jurisdiction likely needs additional capacity, both for emergency surge capacity and to address chronic disease prevention, these issues can be more effectively dealt with through a Network structure that has resource sharing agreements in place to proactively commit to mutual assistance.

In a federation such as ours, there is an ability and opportunity for sharing resources, experience and information across jurisdictions for the benefit of all. However, the health sector experience has been one of ad hoc, uncoordinated, collaboration on public health issues, often through numerous one-off committees, task groups and functions. What is needed is a mechanism that considers the entire spectrum of public health and one that enables the sharing of resources between partners as something federal, provincial and territorial governments can support and rely on.

The Task Force has thus worked to identify the mechanisms and tools most appropriate to support intergovernmental cooperation on public health issues and inter-jurisdictional coordination, when necessary, particularly in order to deal with the public health elements of an emergency. In doing so, the Task Force is of the view that governments should build on existing F/P/T bodies (e.g., the proposed Communicable Diseases Control Network; the Canadian Public Health Laboratories Network; the Network for Emergency Preparedness and Response; etc.) that are a success, rather than creating another distinct organization.

In sum, therefore, the Special Task Force is proposing four key measures.

First, the Task Force recommends that a Pan-Canadian Public Health Network (the Network) be established. The mandate; principles; functions and structure; and instruments of the Network are designed to facilitate intergovernmental coherence on public health matters; support the day-to-day business of public health; and facilitate access to mutual aid between governments during emergencies.

The Pan-Canadian Public Health Network is envisioned as the primary vehicle for multilateral sharing and exchange between federal, provincial and territorial public health institutions and professionals.

While it is accepted that there is a need to address environmental and human resource issues, the Task Force proposes that the Network initially focus on collaboration in the following six public health areas:

- communicable disease control;
- planning/preparedness and response/recovery during emergencies;
- linkage between laboratories;
- public health surveillance and information;
- non-communicable diseases and injury prevention; and,
- health promotion.

Second, the Task Force has identified the tools, protocols, agreements and other processes that the Network should put in place to support dialogue and cooperation amongst jurisdictions. In particular, the Task Force has proposed that the Network develop collaborative public health strategies in the short term, and has recommended a number of areas where intergovernmental agreements should be developed and implemented.

Third, the Task Force has developed a “principles” approach to an Agreement for Mutual Aid During an Emergency. Based on a commitment made by Provincial Premiers and Territorial Leaders at their July 2004 Council of the Federation meeting, the multilateral agreement will serve as a basis for sharing resources between provinces, territories
and the federal government. The principles for the agreement are described in Section 6, and included as Appendix A.

And, finally the Task Force has reviewed the existing public health groups and networks, and proposes a rationalization to bring order to existing F/P/T bodies dealing with public health. This is in order to ensure a convergence amongst public health bodies and an efficient and effective use of limited and stretched human resources in all jurisdictions.

In presenting these findings and recommendations, the report is organized as follows. Section two describes the current provincial/territorial and federal public health capacity. This includes three provincial centres (British Columbia, Ontario and Quebec) as well as the newly created Public Health Agency of Canada, its Winnipeg facilities and the six National Collaborating Centres for Public Health being established across the country.

Section three presents an analysis of the need and rationale for the creation of a pan-Canadian Public Health Network to address gaps in readiness and facilitate inter-jurisdictional collaboration in the proposed Network. This includes three scenarios to demonstrate the immediate as well as longer-term value-added of the Network.

Next, in Sections four and five, the report describes the Public Health Network in detail, including its mandate, principles, functions and structure as well as the instruments that should be put in place (e.g., collaborative public health strategies; framework for a common approach to public health legislation / regulations; a secured web site to share information; best practices, etc.) to facilitate collaboration on public health. These sections also address transition issues and identify specific work plan priorities for the Network over its first year. Section six discusses how jurisdictions could manage public health issues during an emergency and outlines the principles for an Agreement for Mutual Aid During an Emergency. Section seven provides the key findings of the review of existing F/P/T structures in the public health domain and proposes that the Network be established with a Council, an initial six Export Groups and a limited number of Issue Groups.

The conclusion of the report (Section eight) summarizes the Task Force's key findings and advice on how to continue to build a strong and effective intergovernmental partnership in public health.
Section Two
Overview of Public Health Organization in Canada

Introduction

In his report “Learning from SARS”, Dr. David Naylor provides a summary of the organization of public health across the country.

Briefly, primary responsibility for public health services is at the municipal or local level, through approximately 140 health units and departments that serve populations ranging in size from 600 to 2.4 million people, with catchment areas from 4 to 800,000 square kilometres. The next level of organization is provincial or territorial. At the provincial/territorial (P/T) level, staff engage in planning, administering budgets, advise on programs, and provide technical assistance to local units as needed. Capacity at the P/T level, for coordination and technical support of local health agencies, varies sharply from one jurisdiction to the next.

Two provinces have already established unique organizations dedicated to public health matters. British Columbia’s Centre for Disease Control is responsible for provincial-level management of infectious disease prevention and control, including laboratories. Québec established the Institut national de santé publique in 1998 by amalgamating staff from existing regional public health departments and the Québec Ministry of Health and Social Services; it oversees the main public health laboratories and centres of expertise. The Québec Institute mandate includes prevention, health promotion, healthy living, workplace health, and chronic disease prevention as well as infectious disease control.

Other provinces are reviewing their provincial capacity and taking various steps to strengthen their public health programs and services. For example, in June, 2004 the Government of Ontario announced “Operation Health Protection,” a three-year action plan to restore and revitalize public health in the province. The action plan establishes a new Ontario Health Protection and Promotion Agency; increases the independence of the Chief
Medical Officer of Health; establishes a Provincial Infectious Disease Advisory Committee; increases the number of medical and scientific personnel; and establishes new surveillance, communications and IT (information technology) capacity.

Federal activity concerning public health was originally concentrated in the Population and Public Health Branch (PPHB) of Health Canada. On September 24, 2004, this branch was transformed to become the Public Health Agency of Canada, within the health sector portfolio. The Agency is pillared in two locations, Winnipeg and Ottawa, and supported by six regional locations across the country. Its responsibilities include Centres for Infectious Disease Prevention, Emergency Preparedness and Response, Surveillance Coordination, and Healthy Human Development. The National Microbiology Laboratory in Winnipeg and the Laboratory for Foodborne Zoonoses in Guelph are also part of Agency. Health Canada and other federal departments and agencies continue to be involved with public health to a variable extent.

With the establishment of the Public Health Agency of Canada, the federal government will now be able to more effectively protect and promote the health of Canadians. The Agency is responsible for leading the federal government’s response on a range of threats to health, such as communicable and non-communicable diseases and injuries, and will also support the six new National Collaborating Centres for Public Health. Dr. David Butler-Jones has been appointed as the first Chief Public Health Officer of Canada, head of the Public Health Agency of Canada.

In summary, some important organizational structure already exists across the country to address the public health needs of the population. The following details illustrate the expertise that already exists or is being implemented. The Special Task Force on Public Health acknowledges this capacity and recognizes it should be part of and linked to any mechanism to enable jurisdictions to work better together. The goal is to enable these various organizations and centres of public health expertise to compliment and support one another in order to enhance the public health system in a pan-Canadian manner.

British Columbia Centre for Disease Control (BC-CDC)

In 1996, the Government of British Columbia established the BC Centre for Disease Control (BC-CDC) to consolidate and coordinate province-wide responses to communicable disease outbreaks. The BC-CDC liaises with a network of senior public health officials across six health authorities who maintain a strong working relationship with the provincial health officer. This network provides a rapid-response capacity of high calibre.

Affiliated with the University of British Columbia, the BC-CDC integrates a number of essential elements of effective disease control: knowledge development and translation, surveillance, disease control, and communication. Public health policy development at the ministry level is connected to front-line public health delivery through the BC-CDC and a network of regional health officers. This network also acts to coordinate, synthesize and disseminate research findings, laboratory and epidemiological analyses – resulting in quality improvement and sustained by day-to-day operational linkages among all of BC’s public health programs and providers.

More recently, environmental health, food safety, radiation protection and poison control have been added to the BC-CDC’s mandate, which already includes the provincial public health laboratory and pharmacy.

National Microbiology (level 4) Lab, Winnipeg

The Canadian Science Centre for Human and Animal Health is the first facility in the world to accommodate both human and animal health facilities at the highest level of biocontainment under one roof. This facility, which houses both the National Microbiology Laboratory and the Canadian Food Inspection Agency’s National Centre for Foreign Animal Diseases, provides a unique environment in which researchers can collaborate as they study established, emerging and re-emerging diseases of both humans and animals.

The National Microbiology Laboratory (NML) is Canada’s main infectious disease public health
laboratory. It has primary responsibility for reference microbiology and quality assurance, laboratory surveillance for infectious diseases, and, bioterrorism and biologic threat preparedness and response. It also supports the epidemiology program, and microbiological research and development.

The NML has in place capacity for rapid molecular diagnostics for all bioterrorist “A list” bacterial and viral agents, and has active research programmes and world class expertise with anthrax, Ebola, Marburg, Crimean Congo Hemorrhagic Fever, Nipah and Hantavirus.

The NML also has a key role in the response to bioterrorism and biologic threats (such as pandemic influenza, importation of viral hemorrhagic fevers, etc.), as follows:

• coordination of a national three tier laboratory network of local, provincial and national (NML and Defence Research Establishment, Suffield) for response to bioterrorism – this is partly in place and functioned well in the aftermath of the US anthrax incidents. This is done through the Canadian Public Health Laboratories Network;
• development of laboratory protocols for testing of potential biologic terrorism agents and the training of members of the laboratories network in their use;
• development of protocols and rapid diagnostic tests for bioterrorist agents and rolling these tests out to other members of the lab network;
• maintenance of deployable level 3 laboratory capacity (as was used once in New Brunswick in connection with an anthrax threat, and was used during the 2002 G8 conference in Kananaskis, Alberta); and
• provision of advice to other components of the emergency response system on infectious agents.

Finally, the Canadian Science Centre for Human and Animal Health contains Canada’s only biosafety Level 4 laboratories. These labs have been designed and built to allow scientists and researchers to work safely with the most serious human and animal pathogens and diseases. The Centre is regarded as the bench-mark for other laboratories in the world to achieve.

Ontario Health Protection and Promotion Agency

Two separate reviews of Ontario’s experience with SARS have been undertaken by the province. The Ontario Expert Panel on SARS and Infectious Disease Control, led by Dr. David Walker, released its final report in April 2004. The SARS Commission, led by Justice Archie Campbell, released its final report in June, 2004. Both these reports were taken into account by the Government in its June 2004 launch of “Operation Health Protection” – a three-year action plan which includes the establishment of a new public health agency for Ontario. Work on this plan is underway, including steps towards establishing the Ontario Health Protection and Promotion Agency, and operationalizing Ontario’s new public health laboratory by 2006-07.

Institut National de Santé Publique du Québec (INSPQ)

The Institut National de Santé Publique du Québec (INSPQ) is a governmental organization founded in 1998 to improve the development and use of expertise in public health. Its creation involved uniting Québec’s public health laboratories and centres of expertise and transferring and assigning staff from a number of regional public health departments and from the provincial Ministry of Health and Social Services.

The primary objectives of the INSPQ are to support the provincial Ministry and the regional agencies in executing public health goals and to manage laboratories and expertise centres in Québec. In particular, the Québec Public Health Laboratory, the Screening Expertise Centre, and the Québec Toxicology Centre offer important expertise in public health.

More specifically, the Institute’s mission is to:

• contribute to the development, up-dating, dissemination and implementation of knowledge in the field of public health;
• develop and promote research in public health, working together with research and funding organizations;
• inform the Minister of the impact of public policies on the population’s state of health;
• inform the population on its state of health and welfare, emerging problems, their determinants and effective means to prevent or solve these problems;
• work together with universities in preparing and up-dating public health training programs and in implementing continued training programs; and,
• promote national and international cooperation and the exchange of knowledge concerning public health.

Public Health Agency of Canada

In response to the recommendations in the 2003 public health reports by Dr. Naylor and Senator Kirby, the Government of Canada has taken steps to address Canada's public health challenges through new mechanisms for coordination. In particular, the need to strengthen federal leadership and better coordinate federal resources in the field of public health were identified as critical challenges.

As a first step, in naming his first cabinet in December 2003, Prime Minister Paul Martin appointed Dr. Carolyn Bennett Minister of State for Public Health. In this capacity, Dr. Bennett has led federal discussions and consultations towards the creation of the new Public Health Agency of Canada.

The creation of the Public Health Agency of Canada and appointment of a Chief Public Health Officer of Canada in September 2004 has resulted in a consolidation of current federal authorities and roles in public health.

Consistent with the recommendations of Naylor and Kirby, the role of the Agency is to focus on the following priorities:

• support national readiness for public health threats, with particular emphasis on the adequacy of, and capacity to deploy, health professionals where and when they are needed in response to public health threats;
• promote excellence in the management of public health in Canada and throughout the world; and,

• oversee federal efforts to:
  • strengthen national capacity to identify and reduce risks to public health; and,
  • develop, implement and assess policies and programs that help enable Canadians to live a healthier life.

Summary

It is clear that each jurisdiction places a priority on developing and maintaining a high quality system of public health. Each jurisdiction is responsible for the administration and organization of their public health system in order to best meet the needs of their residents. There is also a recognition of the opportunity for jurisdictions to learn from each other and tap into experiences and lessons learned.

From a pan-Canadian perspective, it is important that these opportunities to work together and learn from one another be exploited to support an enhanced public health system that builds on the strong foundation already in place. A key role to consider for new intergovernmental partnerships in public health should be to promote stronger linkages to the expertise that the Government of Canada and individual provinces and territories have already built and to enable this capacity to function better.
Section Three
Strengthening Linkages Through a Public Health Network

There is a consensus that there is an urgent need for better inter-jurisdictional public health collaboration and coordination. The F/P/T Special Task Force on Public Health agrees and proposes that a “Network” approach be used to improve public health infrastructure and capacity at the local, provincial/territorial and federal levels. The Special Task Force believes that the Pan-Canadian Public Health Network, as described in the following three sections, responds to the need for a comprehensive, integrated and responsive system for intergovernmental coherence and collaboration in the field of public health.

For some areas, collaboration will best be through previously negotiated agreements that facilitate policy consultation and action on matters of national concern such as during a pan-Canadian communicable disease outbreak. These agreements should be put in place as soon as possible, so as to be prepared for and able to respond to the next crisis. In other areas, different tools and instruments such as information sharing mechanisms and the implementation of common surveillance architecture can serve jurisdictions well.

In order to facilitate this vision of collaboration and consultation, there is a pressing need to establish a more effective means for providing leadership in coordinating and implementing common public health priorities and approaches. Existing F/P/T bodies are structured to provide policy advice to the Conference of F/P/T Deputy Ministers of Health, but lack mandates to implement or follow-up on recommendations. Numerous technical advisory committees also exist that provide technical input to programs. Other structures (e.g., Council of Chief Medical Officers of Health) lack defined reporting relationships. Overall, there is a sense that some structures and memberships are duplicative and that structures are not optimally effective. A simpler, effective intergovernmental structure for public health is desirable.
Thus, the Task Force recommends that governments establish a Pan-Canadian Public Health Network. The different components of the proposed Network, as described in detail in the next section, will best enable the various needs and gaps in public health collaboration to be addressed.

Specifically, the approach and recommendations of the Task Force in this report are intended to enhance public health collaboration across Canada, by creating a Network that will:

- foster cooperative and collaborative approaches on public health matters;
- establish, maintain and implement instruments, initially in the form of collaborative public health strategies, formal inter-jurisdictional arrangements (with the Agreement on Mutual Aid During an Emergency, as identified below, as the first of these), and a framework for a common approach to public health legislation and regulation;
- facilitate collaboration and mutual aid across jurisdictions during public health crises and urgent situations;
- establish consensus-based priorities, helping governments focus and refine their public health investments and resources;
- encourage processes for developing, implementing, maintaining and updating standards, guidelines, and best practices in the public health field;
- negotiate arrangements which will govern intergovernmental collaboration in the day-to-day business of public health;
- facilitate processes whereby applied research can be best translated into policies, programs and practice; and,
- develop strong and robust public health partnerships between governments, academics, researchers, non-governmental organizations and health professionals.

Scenarios

Another way to demonstrate both the need for, and the value of, a pan-Canadian collaborative approach to the day-to-day business of public health is through the use of scenarios. Scenarios that illustrate what the Network could do during a public health crisis or how it could support the development of information and surveillance technologies and programs that enable each jurisdiction’s public health information and surveillance system to exchange information with other jurisdictions are valuable learning tools.

Currently, and on a more frequent basis, public health officials must deal with major public health challenges – communicable disease like SARS or shortages in influenza vaccine – that are causing anxiety among citizens and raising questions about how well governments are organized to implement public health policies, and deliver programs and services that will protect and maintain the health and well-being of citizens. One essential tool for good public health policy development and program delivery is to have robust public health information and surveillance systems that collect, analyze and disseminate pertinent information to public health officers, labs, care providers and others. During communicable disease outbreaks, it is essential to be able to track, analyze and report on the incidence and spread of diseases using comparable indicators and compatible information/surveillance systems.

As the three scenarios in the tables on the following pages demonstrate, the Pan-Canadian Public Health Network would be an effective and efficient mechanism for inter-jurisdictional collaboration and cooperation on such issues. The Network can facilitate aid during a public health crisis (Scenario 1) as well as create the tools and other instruments necessary for each jurisdiction’s public health surveillance programs to “talk” to one another and share appropriate information between public health surveillance systems (Scenario 2). Finally, the Network, and its groups, can respond in a timely and coordinated manner to meet any unprecedented demand for influenza vaccine (Scenario 3). The goal of the Network is to demonstrate to Canadians that governments are working, individually and collectively, to better prepare for and respond to their public health needs, particularly, in an appropriate and coordinated manner during any public health event that could endanger the overall health and well-being of the population.
Scenario 1 – Emergency Preparedness and Response

Background

A Canadian province becomes overwhelmed while trying to cope and respond to the re-emergence of SARS in Canada. The province's health system quickly becomes over-run as laboratory capacity cannot meet need: health care providers become overworked, tired and anxious; epidemiology needs exceed capacity; and surveillance and reporting systems are not able to provide timely and accurate information.

The demands placed on the province's health system far exceed the capacity of the health system to respond resulting in additional pressures on all areas of the health system. For example, emergency rooms close to the general public health, primary health care services are functioning beyond capacity, and there is a lack of health care professionals to meet the challenge. Simultaneously, neighbouring jurisdictions fear that SARS will easily spread to their populations, further propagating the crisis.

Issue

The Pan-Canadian Public Health Network (the Network) would be prepared, at the request of the province, to serve as a linkage to multiple provinces that are able to provide assistance consistent to the Agreement on Mutual Aid During an Emergency. The Network could be called upon to assist in coordinating the provincial request for medical and emergency response personnel.

Process

The Provincial Medical Officer of Health, working through the Network's Council, requests that the Network coordinate and mobilize resources nationally in order to immediately increase the province's capacity to respond to the emergency.

Working through the Network, the Public Health Agency of Canada's Centre for Emergency Preparedness and Response (CEPR) takes the federal lead in acting on the Government of Canada's health security mission of response in accordance to established Federal/Provincial/Territorial emergency operational protocols.

The CEPR would ensure, through its Emergency Operations Centre, that the mobilization of federal government assets, including health assets is achieved in a timely and coordinated manner to provide optimal support to provincial and local authorities.

The steps to be followed in response to the request for supplies and personnel would be as follows:

- laboratory capacity within the stricken province would be enhanced as the Network, through the Canadian Public Health Laboratory Expert Group Secretariat, coordinates support from other provincial public health laboratories, in order to ensure that capacity to meet day-to-day health care needs is not exceeded by the emergency. Samples such as throat swabs are transferred to a neighbouring jurisdiction’s lab for analysis in order to ensure responsiveness;
- the provincial Health Emergency Management Director may request medical supplies from the National Emergency Stockpile System directly from CEPR. Supplies would be accessed from pre-positioned depots within the impacted province or, if unavailable or exhausted, be transported from a neighbouring province or the central depot in Ottawa;
• the request for medical and emergency response professionals would also be placed to the CEPR. The CEPR would implement previously established protocol to coordinate the response of medical and emergency response personnel. Based on the Agreement on Mutual Aid During an Emergency, personnel would be drawn from a data base of Health Emergency Response Teams. Out-of-province medical professionals would be eligible for temporary licensing, as outlined in the Agreement on Mutual Aid During an Emergency;

• to ensure sustainability of this response, the Network through the Emergency Preparedness and Response Expert Group would collaborate on providing technical/scientific support, to assist the province to respond to longer-term recovery needs. This group would seek expert advice and support from other Expert Groups (Communicable Disease Control, Canadian Public Health Laboratories, Surveillance and Information), as well as Public Safety and Emergency Preparedness Canada (PSEPC) officials and provincial and territorial emergency management authorities;

• this consultative process would include, but not be limited to, enhancing timely response to further requests for professionals, goods and supplies; data collection and monitoring of population health needs; emergency transportation of supplies; and public health financial investments; and

• upon completion of this consultation process, including the review and endorsement of key findings, the recommendations and proposed processes for implementation would be submitted the Council of the Network.

Through the emergency, the Network Council would update and inform F/P/T Deputy Ministers of Health on the state of coordinated F/P/T emergency response, as appropriate. Following the emergency, the Network would develop an analysis report on the coordinated response and capacity regarding the emergency, including of recommendations of how to further improve preparedness efforts, to be shared with all jurisdictions through the Conference of F/P/T Deputy Ministers of Health.
Scenario 2 – Surveillance and Information

**Background**

Through consultation with several Expert and Issue Groups such as the Communicable Disease Control Expert Group, The Canadian Nosocomial Infection Surveillance Program, Communicable Disease Surveillance Standards Working Group, The Canadian Laboratory Surveillance Network, or the Canadian Immunization Registry Network, it has been determined that there is a requirement for pan-Canadian surveillance of a number of diseases.

The data for this surveillance is housed in a number of jurisdictional infectious disease registries. To implement this requirement, there is the need to develop F/P/T data sharing agreements and corresponding enabling regulations/legislation.

**Issue**

The F/P/T data sharing agreements require the approval of senior government officials and legislative or regulatory changes. The Network has been asked to facilitate the development of these data sharing agreements.

**Process**

The Network provides the venue for review, endorsement and action. The Network Council assigns this task to a time-limited Special Task Group working with the Surveillance and Information Expert Group.

Through consultation with its membership and that of other Expert Groups, along with legal/policy support, the Special Task Group develops a protocol data sharing agreement and accompanying processes (i.e., approaches to legislation/regulations). The Network may choose to develop model legislative and/or regulatory amendments that participating jurisdictions could utilize.

Once there is consensus among jurisdictions in the Task Group and Expert Group, a recommendation is made to the Network’s Council regarding the adoption of the agreement and subsequent processes for implementation.

Once endorsed by the Network’s Council, a recommendation is made to the Conference of F/P/T Deputy Ministers of Health who would have the final policy approval and endorsement before implementation by participating jurisdictions.

Following endorsement from F/P/T Deputy Ministers, each participating jurisdiction, the Network and associated structures would implement the process to ensure this direction is taken.

On an on-going basis, the Network could make technical-oriented changes to the data sharing agreements (i.e., the types of diseases included) without prior approval from Deputy Ministers. If there are substantive changes to the “body” of the data sharing agreements, these would have to be approved by F/P/T Deputy Ministers.
Scenario 3 – Response to Unprecedented Demand for Influenza Vaccine

Background
A production problem experienced by an influenza vaccine manufacturer has resulted in a significant shortage in the anticipated influenza vaccine supply to the United States. While not impacting directly on supply to Canada, it contributes to an unexpected and unprecedented increase in early demand for influenza vaccine in Canada. As a result, several provinces and territories (P/Ts) report concerns that their requested vaccine supply will not be sufficient to meet overall demand.

Issue
The Canadian Immunization Committee (CIC), which is an existing F/P/T body established to support the National Immunization Strategy and which is a proposed component of the Pan-Canadian Public Health Network, plays an ongoing role in monitoring influenza vaccine supply. The CIC is mobilized to assist in the co-ordination of efforts to manage this issue.

Process
The federal government, through Public Works & Government Services Canada (PWGSC), contracts with two suppliers of influenza vaccine on behalf of all P/Ts.

The possibility that a jurisdiction may have insufficient supply to meet anticipated demand is first communicated to the Vaccine Supply Working Group (VSWG) – a working group of the CIC – by that jurisdiction’s VSWG representative. Upon identification of a possible problem, VSWG attempts to resolve it by identifying any existing surplus supply (i.e., from a jurisdiction that does not require its entire allocated quantity) and then by requesting additional supply from one or both of the contracted suppliers. When it is determined that the problem extends to several jurisdictions and cannot be resolved through the existing contracts, issue resolution is elevated to the CIC. The following steps are taken to resolve the problem:

• individual P/Ts identify vaccine stocks that are surplus to their needs and communicate this to the Public Health Agency of Canada (PHAC). The CIC then reaches a consensus on how best to re-distribute that surplus stock amongst jurisdictions in need;
• the CIC discusses and reaches a consensus on the prioritization of high-risk groups for the receipt of vaccine in limited supply while respecting the individual nature of P/T immunization programs. The National Advisory Committee on Immunization (NACI) is consulted during this process;
• CIC requests that PWGSC investigate the option of purchasing vaccine that is not currently licensed in Canada;
• the PHAC, on behalf of the CIC, requests that Health Canada, Health Products and Food Branch (HPFB) conduct an expedited review of a new drug submission in order to ensure the timely approval of an alternative influenza vaccine for use in Canada;
• the CIC works with Health Canada to implement a protocol that would allow for the sale of the unapproved vaccine under the Special Access Program (SAP) as an interim measure while expedited approval was underway. The PHAC acts as the liaison between the CIC and Health Canada, HPFB; and
• the CIC coordinates communications efforts to ensure that consistent messages are presented by all individual jurisdictions.

Throughout the issues management phase, regular teleconferences are held and updates are provided by PHAC and PWGSC as the federal coordinators. Following issue resolution, an analysis of the activities that were undertaken and the processes that were followed is conducted, and the “lessons learned” are shared with all jurisdictions. Recommendations for improving demand and supply management are agreed to, and implemented by, the CIC.
Summary

As these three scenarios clearly illustrate, there is an important coordinating and collaborating role that the Network can play in facilitating an inter-jurisdictional partnership in public health. First, it can facilitate inter-governmental cooperation and collaboration when a crisis threatens the health of communities and their residents. Second, the Network can assist participating jurisdictions achieve efficiencies and economies in the operation of their public health programs and services by developing tools that enable their public health information and surveillance systems to share information using common definitions and comparable indicators. And third, the Network can support the National Immunization Strategy and assist in the coordination of efforts to access new supplies of influenza vaccine during times of unprecedented demand. These roles could also extend to issues and needs in the areas of chronic disease, injury and the promotion of health.
Section Four

The Public Health Network

Context

The concept of the Public Health Network directly addresses the key recommendation of the Naylor report to enhance F/P/T collaboration through the creation of a separate public health agency, and through networks. As such, through the different components of the Network outlined here, different needs and gaps in public health collaboration are addressed.

It will be important that the Network have leadership capacity. Thus, the proposed Network will include a Council, comprised of representatives of participating F/P/T governments, in order to provide cohesion and coordination between ongoing public health groups to ensure activities are not duplicated, and to serve as a governance forum for developing the key instruments of the Network, including collaborative public health strategies, the implementation of the principles-based Agreement on Mutual Aid During an Emergency, and the preparation, negotiation and implementation of other types of intergovernmental agreements envisioned here. Coordination is critical; in creating the Network, the intention is to better organize existing groups as Expert Groups. These bodies may work very well on their own, but are not fully linked to F/P/T decision-making structures such as the Conference of F/P/T Ministers / Deputy Ministers of Health.

---

1 Quebec participated in the development of this report and agrees with most of its recommendations. However, in accordance with the positions expressed previously on the subject, it does not endorse the recommendations pertaining to the prevention of non-communicable diseases and accidents and health promotion. Furthermore, Quebec does not endorse the recommendation pertaining to the adoption of a common approach with regard to public health legislation and regulation. In addition, in general, Quebec remains available to share information concerning best practices.
The Task Force has also approached this issue as an opportunity to rationalize groups and recommends a number of existing groups be incorporated within the Network structure as either Expert or Issue groups, as expanded on in Section 7. In proposing the Network, it is not the intention of the Task Force to build new structures but to bring about a rationalization and streamlining of existing bodies into an efficient, effective and robust structure.

However, the Task Force is of the view that it is equally important that Expert Groups be empowered to make decisions, where appropriate, in order to reduce the time required for deliberation, to be able to respond quickly, and also in order to reduce the burden of senior officials to needlessly review technical issues already reviewed by experts. But, by being part of the Network, Expert Groups will also have linkages that can be activated as a quick and accessible route for decisions to be raised up to the Council, F/P/T Deputy Ministers or Ministers of Health, as necessary.

The following diagram graphically illustrates these relationships, as outlined above and described in detail below.
While the proposal of the Network can be considered a forum for the convergence of F/P/T public health collaboration, it is certainly not a complete departure from the ways governments currently work together. The Network also presents opportunities for new approaches for intergovernmental collaboration. As well, it is accepted that as the Network evolves it will accommodate in its governance and operating structures a multitude of players necessary for a strong and robust public health partnership between governments, academics, researchers, non-government organizations and health professionals.

Aboriginal Public Health

In reviewing the various challenges to improving the public health for Canadians, the Task Force discussed and agreed it is critical that the public health status of Aboriginal Peoples be a priority. While there are steps each jurisdiction is taking to improve their public health capacity and infrastructure, the building of a new structure for public health partnerships is also an opportunity to determine how best to include Aboriginal Peoples. To that end, the Network will regularly engage Aboriginal leaders to ensure Aboriginal expertise and experiences inform public health policy research and policy development. This will improve the processes of assessing the public health needs of Aboriginal communities and enable the two groups to jointly determine collaborative approaches in meeting those needs.

In addition, the Council will be responsible for ensuring an inclusive approach is taken in all F/P/T activities that involve the development of its public health strategies and initiatives for Aboriginal public health activities. The federal representative, the Chief Public Health Officer of Canada, will be responsible for regular liaisons with others in the federal health portfolio, and invite, as necessary, the First Nations and Inuit Health Branch (FNIHB) of Health Canada to contribute to public health policies and strategies that concern FNIHB’s responsibilities in the provision of public health services to First Nations living on reserves. This inclusive approach will permit a coordinated, integrated and efficient use of F/P/T resources devoted to public health activities dealing with Aboriginal public health matters.

As the Network is proposed as a structure within the purview of the Conference of F/P/T Deputy Ministers of Health, it is suggested that the Network’s approach to Aboriginal public health be consistent with the approach F/P/T Deputy Ministers adopted for the health sector as a whole in 2003. That is, an integrated approach that examines and addresses Aboriginal issues within the context of each specific health policy area. To do so, the Expert Groups and their issue groups should consider including Aboriginal leaders in their work, where appropriate. Public health will also remain among the potential issues to be discussed in regular meetings between the leaders of the five National Aboriginal Organizations and the Co-Chairs of the Conference of F/P/T Ministers of Health. The Task Force believes that Aboriginal leaders need to be engaged to determine the best mechanisms by which the Aboriginal community is involved in the ongoing work of the Network.

Involving Non-Governmental Organizations (NGOs)

The Task Force also agreed that it will be important for the Network to include the participation of non-governmental organizations (NGOs) with public health expertise, capacity and interest. These will include scientific and academic institutions, along with health care professional groups such as the Canadian Medical Association and the Canadian Nurses Association. In several cases, including NGOs as part of Expert Groups is critical to pan-Canadian collaboration, and already takes place within existing structures. The Task Force also notes that, as appropriate, NGOs be invited to participate in Council discussions on issues that are directly relevant to their mandate or expertise.

The following offers an expanded definition of the Network, including detailed recommendations regarding the Network’s mandate, principles, functions, and instruments.
Mandate

The Pan-Canadian Public Health Network (the Network) will function as a mechanism for intergovernmental collaboration and coordination on public health issues.

Through its machinery, the Network will:

• facilitate information sharing among all jurisdictions;
• disseminate information regarding best-practices in public health;
• support the public health challenges jurisdictions face during emergencies;
• provide advice and regular reporting to F/P/T Deputy Ministers of Health on public health matters and the activities of the Network;
• collaborate on the day-to-day operations of public health;
• respect jurisdictional responsibilities in public health; and,
• be accountable to the Conference of federal/provincial/territorial (F/P/T) Deputy Ministers of Health.

In undertaking its work, the Network will:

• respect the authority and jurisdiction of each government to manage public health operations within their own domain;
• embrace the differences in how each jurisdiction exercises its public health responsibilities, establishes priorities and manages its public health infrastructure;
• recognize that there is no “one size fits all” approach to public health; and,
• include as part of the scope of the Network’s activities collaboration with, and participation of, non-governmental organizations, researchers, academics and other public health experts.

Principles

The principles that guide the Network in fulfilling its mandate are collaboration, responsiveness, and where necessary, coordination of the public health activities of F/P/T governments, and other stakeholders, within Canada. This will enhance their effectiveness and serve to better protect and promote the health of Canadians. In particular:

• collaboration and mutual assistance across jurisdictions is necessary for the effective response to public health emergencies;
• attention to the infrastructure of the public health system is necessary, and aspects of this work are best undertaken in a pan-Canadian manner;
• public health activities must be guided by evidence; research and its translation into policies, programs and practice is best affected in a coordinated manner across Canada;
• there is a requirement to improve public health capacity and programs efficiently – this will often call for an inter-jurisdictional coordinated approach; consensus-based priorities will help governments focus and refine their public health investments and priorities; and,
• accountability, transparency and communication with stakeholders and the public will be enhanced by increasing clarity of the roles and responsibilities of the various partners.

Functions and Structure

Over time, success in Canada’s public health system will be measured by both an enhanced public health infrastructure and a Network with the mandate and tools (including intergovernmental agreements) necessary to be effective and responsive.

Reporting Relationships

The Network, through its Council, is accountable to the Conference of F/P/T Deputy Ministers of Health (CDM). The Council will present an annual report of the Network’s activities and future directions to F/P/T Ministers of Health, via the Conference of F/P/T Deputy Ministers of Health.

The Network will collaborate with the Conference of F/P/T Deputy Ministers of Health (CDM) on its public health responsibilities and activities, and others, as appropriate. The Network’s linkage to government decision-makers and others will help ensure a broad synthesis of health policy issues, horizontally linking health policy issues in an integrated and robust fashion.

Furthermore, the Network will provide policy advice to the Conference of F/P/T Deputy Ministers.
of Health on public health matters. The Network will receive its mandate and role from the CDM. It is the CDM who will identify the scope of the mandate of the Network and will hold the members on the Council accountable for the deliverables and performance of the Network.

The Network, through its Council, is accountable to the CDM. The CDM will provide the Network with its initial mandate and will approve all future mandates of the Network. The Network, through its Council, will regularly report on its work to the CDM. The CDM will, in turn, provide strategic direction to the Network through their Council members; identify/approve its policy priorities and direct that the Network and the Advisory Committee on Public Health and Health Security (ACPHHS) do not duplicate work being done elsewhere. The Network’s priority setting activities will be aligned with the annual priority setting exercise of the CDM to ensure ongoing synergy, responsiveness and an appropriate division of labour.

Recent experiences in public health have revealed how collaboration between/across jurisdictions could be beneficial when a jurisdiction is unable to manage by itself. As a F/P/T forum on public health, the Network will bring together existing public health capacities from all jurisdictions to the benefit of all jurisdictions. However, the Network will not have the authority to bind its advice or work to any jurisdiction. That is to say that the Network will not become a mechanism that commits jurisdictions to any particular initiatives or funding obligations. It is a voluntary association and cooperation whose efforts to collaborate are to enhance public health across the country.

The Council

The members of the Council will facilitate the activities of the various parts of the Network. The Council will serve as a central governance body and will represent the Network to the public. The Council will serve as the senior body responsible for taking a strategic, coordinated view of the ongoing conduct and operation of the Network. The initial proposed Terms of Reference of the Council are included as Appendix B.

The membership of the Council will consist of one senior representative from each participating jurisdiction. In addition, those jurisdictions serving as co-chair are also entitled to have a separate member participate on the Council. In selecting their member, jurisdictions may wish to consider senior officials with decision-making authority who have technical knowledge of public health and who exercise leadership in a public health organization within government (i.e., Agency, Centre, Branch, Sector). While provinces and territories can nominate whom ever they choose to represent them on the Council, there are substantial benefits if the Council’s membership mirrors the existing Council of Chief Medical Officers of Health (CCMOH). Participation within the Network is voluntary and participating jurisdictions can exercise as a prerogative as to which Expert Group(s) / Issue Group(s) they choose to participate in or opt out of.

In times of public health emergency, the Council will provide leadership to ensure that resources are accessible in an appropriate and timely manner (as per the pre-established principles of the Agreement on Mutual Aid During an Emergency). The Council will have the capacity to gather quickly in times of emergency, and will be adaptable to meet and ensure the assistance is provided in any location and to any jurisdiction, if requested.

The Council will be co-chaired by its federal member and a P/T member to rotate among provinces and territories.
The Council will be responsible for developing and implementing the tools of the Network, particularly the collaborative public health strategies, and public health agreements. It is recommended that the Council report to F/P/T Deputy Ministers of Health on progress towards development of the initial set of five public health agreements twelve months after the creation of the Network. The Government of Canada’s member of the Council will be the new Chief Public Health Officer of Canada. Having the Government of Canada, through the Chief Public Health Officer of Canada, hold a permanent Co-Chair position, will enable the Network to take advantage of the Public Health Agency of Canada as a focal point among several F/P/T groups of the Network.

**Expert Groups**

The day-to-day business of public health will continue to be conducted by a number of existing bodies (i.e., expert groups, such as Communicable Disease Control, Emergency Preparedness and Response and the Canadian Public Health Laboratories). Each of these Expert Groups will:

- coordinate activities, research and information dissemination in public health program and/or policy areas based on its specific work areas;
- gather and consider all information from its issue groups to ensure an integrated and comprehensive perspective; and,
- have decision making authority insofar as considering work and material from Issue groups.

F/P/T Ministers of Health and officials have already established a variety of working and task groups on specific public health issues. It is intended, where it is appropriate, that such groups will be maintained in the future under the auspices of the Network. Specifically, the Network will encourage and support the development of groups which bring together government officials, academics, stakeholder groups and others, as appropriate, to discuss specific public health issues. Where such groups already exist and/or will have an on-going mandate, the Network will seek to establish formal mandates for such committees, and F/P/T officials will seek to agree on the general operating rules/codes of conduct for such groups.

**Issue Groups**

Issue groups will conduct research and consultation on a variety of specific public health issues. Each Issue Group will reach across Canada to bring together research, resources and expertise in specific areas. Issue groups could be technical and/or operational in nature, such as an issue group on zoonoses, which would be part of the proposed Expert Group on Communicable Disease Control. The Task Force’s review of existing public health groups / committees has streamlined and identified an initial series of 34 issue groups (as well as 10 sub-issue groups), as specified in Appendix C.

**Task Groups**

Task Groups will be struck by the Council as needed to address emerging public health issues. The mandate of Task Groups will be time-limited. Task Groups will report to the Council directly and, while they may link to Expert Groups on issues, they do not report through Expert Groups. Task Groups could be given specific tasks to complete, such as the development of the various instruments of the Network, if the task cannot be dealt with by an existing Expert Group.

Where appropriate, Expert Groups will have the authority to take decisions that promote convergence and collaboration on public health issues in areas of mutual interest where participating jurisdictions voluntarily agree to joint actions. The existing Canadian Public Health Laboratories Network is an excellent example of the form of inter-jurisdictional cooperation that would be maintained and encouraged in the future.

Preliminary Terms of Reference for the six initial Expert Groups have been developed and included as Appendix D. These include common elements related to vertical and horizontal accountability, including reporting requirements to the Council. The Council will work with these Expert Groups to refine and endorse these Terms of Reference as an early priority.
Maintenance of Public Health Agreements

A key role of the Network will be to prepare, implement and maintain intergovernmental agreements on public health issues between jurisdictions. These agreements will be in a number of areas including emergencies, sharing of information, resources, facilities and personnel. In establishing public health agreements, the Network will first prepare and negotiate the agreement within the Council, forward to F/P/T Deputy Ministers of Health for review and comment, and ultimately submit to the Conference of F/P/T Ministers of Health as appropriate for approval prior to implementation.

Public health agreements will encourage the efficient use of resources, particularly in times of emergency. These agreements will respect the authority and limitations of individual jurisdictions and their right to manage public health functions and operations within their own domain. The intention is that all jurisdictions will be provided, through these agreements, access to additional public health resources to draw upon as needed and requested.

Public health agreements will be structured to address existing gaps and areas of fragmentation in the intergovernmental coordination of public health services. Some agreements may also serve to codify existing informal agreements / relationships / practices.

The Network, through the Council will take the lead in developing and negotiating the establishment of public health agreements, to be finalized by each jurisdiction. The Task Force has identified an initial series of five agreements, to be negotiated within twelve months of the creation of the Network. These five areas are outlined in Section 5 of this report. The Council will also be responsible, over time, for ensuring that public health agreements remain appropriate to changing circumstances, and to recommend the revision of agreements and/or development of new agreements, as needed. Some agreements may assign roles and/or delegate authority to components of the Network (i.e., the Council or specific Expert Groups, such as Emergency Preparedness and Response during an emergency).

Role During Public Health Emergencies

The Network will be empowered, through pre-established public health agreements, to act in an orderly and coordinated manner during times of emergency to ensure a functional and timely public health response (see Section 6 and Appendix A for details on the proposed principles on Mutual Aid During an Emergency). The Network will report to the Conference of F/P/T Deputy Ministers of Health, as appropriate, about actions taken.

The Network will support public health collaboration and coordination during emergencies, taking into account jurisdictional authorities and emergency operational responsibilities. Activities may include the sharing of information in real time, and being available to assist the local public health authority through the sharing of resources and expertise, where appropriate and possible.

The sharing of resources through public health agreements will be most effective if centrally accessible. For example, the Network could develop a database of public health resources that could be made available, whether on a regular basis or in a time of emergency.

Administration

The Network will operate as a virtual and functional public health mechanism, without a central headquarters or permanent operations. Rather, the Network’s administration will be adaptable to the public health issues and challenges being faced. By not being bound to a central location, the Network will have the capacity to meet and provide assistance quickly in any location and to any jurisdiction, as necessary. For example, the Network can coordinate many of its functions with the activities of the Public Health Agency of Canada as well as the various National Collaborating Centres for Public Health in an effort to streamline activities and disseminate information.

As the diagram on the following page illustrates, the Public Health Network is anticipated to build a strong working relationship with other public health partners including the Public Health Agency
of Canada and the National Collaborating Centres for Public Health.

**Secretariat and Financial Resources**

A secretariat to support the Network will be provided by the Government of Canada through the Public Health Agency of Canada (PHAC). The Secretariat may be comprised of F/P/T officials, through secondment opportunities, and will be responsible for facilitating information sharing between Network components and other duties assigned by the Council. The federal government has identified financial and human resources to support secretariat capacity and activities. In addition, Health Canada/PHAC will continue to invest current secretariat services, as appropriate, to the various groups being integrated into the Network.

Initially, the majority of the operational costs of the Network will be derived from shifting the resources and support provided to existing F/P/T and Health Canada public health groups/committees that are being incorporated as part of the Network’s structure. This involves a reallocation of their respective budgets and staff support. This reallocation of existing resources will ensure that collaborative F/P/T work in public health is complementary as opposed to duplicative. Moreover, rationalizing existing bodies into a unique structure will achieve economies, efficiencies and enhanced value-for-money public health products and services.

**Transition Issues**

The Network will come into force upon its acceptance by the F/P/T Conference of Ministers of Health. It is envisaged that there will be a twelve-month transition period for the Network to
become a strong and fully functioning body. During this transition period there will be a need to bridge any gaps. To ensure a smooth and seamless integration between the Network and existing structures/committees the leadership of the Network and the Advisory Committee on Population Health and Health Security (ACPHHS) will coordinate their activities and maintain strong linkages with a practical and reasonable division of labour and responsibilities. During the phased-in period all efforts will be taken by the appropriate bodies to ensure that no capacity is lost before the Network is fully operational.

It is proposed that pre-existing public health groups be incorporated into the Network structure, based on the review and advice of the Special Task Force (see Section 7 for a summary of the committees to be aligned within the Network). During the transition period, the Council will review and update each Expert and Issue Group’s Terms of Reference, as appropriate, to reflect the new mandate and structure. The role and responsibilities of the CCMOH will be incorporated as a component of the Network, reporting through the Network’s Council to the Conference of F/P/T Deputy Ministers of Health. This new reporting structure for the CCMOH will be incorporated as part of the review of its role and responsibilities currently being undertaken by the CCMOH in conjunction with the Public Health Agency of Canada. It is envisaged that the ACPHHS will continue to be responsible for providing the Conference of Deputy Ministers of Health with strategic and policy advice related to population health and other health security matters. Current population health matter will continue under the Advisory Committee, such as the implementation of the Healthy Living Strategy.
### Plans and Priorities

The Task Force has proposed work priorities in a number of areas: the creation of the Network including its infrastructure of the Council, Expert Groups, Issue Groups, the Secretariat, etc. (see schematic of the proposed structure). In addition, the work plan priorities would be the development / implementation / operation of inter-jurisdictional agreements and a number of collaborating public health approaches. For the first year the following its creation, the priorities for the Network are proposed as:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Announcement of the Network</td>
<td>Ministers announce the creation of the Network; name of their Council member (and co-chairs); and the principles of the Agreement on Mutual Aid during an Emergency.</td>
<td>Spring 2005 Conference of F/P/T Ministers of Health</td>
</tr>
<tr>
<td>Establishment of the Network</td>
<td>Hold initial Council meeting; set up Network structure (6 Expert Groups, secretariat, etc.). Immediately populate the first 4 Expert Groups with the other 2 to follow</td>
<td>Spring 2005</td>
</tr>
<tr>
<td>Negotiate other agreements in public health</td>
<td>Establish a time-limited Task Group to bring together the appropriate negotiation expertise from all jurisdictions. Direction to be provided by CDM. Suggested 2nd priority is the Agreement on Public Health Information Sharing.</td>
<td>Spring 2005 – Spring 2006</td>
</tr>
<tr>
<td>Reporting to the CDM</td>
<td>Mid-year updates at June CDM and annual report / workplan at December CDM (or more frequently as requested by the CDM and/or during an emergency).</td>
<td>• Update report June 2005&lt;br&gt;• 1st Annual report/work plan December 2005</td>
</tr>
<tr>
<td>Review of related F/P/T public health players and linkages to the Network</td>
<td>Decision with respect to the priorities / projects of ACPHHS to be discussed during the January – March 2005 period by the Conference of Deputy Ministers (CDM) for implementation in the 2005-06 fiscal year.</td>
<td>Jan. – March 2005 CDM</td>
</tr>
</tbody>
</table>
Recommendations

The Task Force acknowledges and supports the work and efforts of all jurisdictions in improving the provision of public health services for their residents, and recommends that:

Creation of the Pan-Canadian Public Health Network

1. Federal, provincial and territorial governments establish a pan-Canadian Public Health Network (the Network) as a mechanism for intergovernmental collaboration and convergence on public health issues.

2. The proposed Pan-Canadian Public Health Network establish strong linkages to existing provincial, territorial and federal public health organizations / capacity to ensure stronger and better functioning capacity.

3. The mandate of the Network be to:
   • collaborate on the business of public health and the sharing of best practices;
   • support the public health challenges jurisdictions face during emergencies (e.g., surge capacity); and,
   • provide advice to the Conference of Deputy Ministers of Health on public health matters.

   The mandate is to be fulfilled in a manner that:
   • respects the authority and jurisdiction of each government to manage public health operations within their own domain;
   • embraces the differences in how each province and territory exercises its public health responsibilities, establishes priorities and manages its public health infrastructure;
   • recognizes that there is no “one size fits all” approach to public health; and,
   • includes as part of the scope of the Network’s activities collaboration with, and participation of, non-governmental organizations.

4. Improving the public health status of Aboriginal peoples be a priority for the Network. In order to accomplish this, Aboriginal leaders need to be engaged to determine the best mechanisms by which the Aboriginal community is involved in the ongoing work of the Network.

Network Structure

5. The Network’s structure consist of the following components:
   • the Council
   • the initial Six Expert Groups on public health, as follows:
     • communicable disease (Communicable Disease Control Network);
     • emergency preparedness and response (EPR Network);
     • laboratories (Canadian Public Health Laboratories Network);
     • surveillance and information;
     • non-communicable disease and injury prevention and control; and
     • health promotion.
   • issue Groups that are specific in scope; and
   • task Groups that are time limited.

The Council

6. The Network’s Council be co-chaired by a P/T member and the federal representative and consist of a representative of each participating jurisdiction, with the co-chair jurisdiction permitted to have a second member.

7. The Network, through its Council, is accountable to the Conference of FIP/T Deputy Ministers of Health and will report on an annual basis. In times of public health emergency the Council will report as appropriate to the situation.

8. That non-governmental organizations, as appropriate, be invited to participate and help inform Council discussions on issues that are directly relevant to their mandate or expertise.

Expert and Issue Groups

9. The day-to-day business of public health collaboration be conducted through Expert Groups, and their issue group.
Section Five
Instruments of the Public Health Network

One of the ways the success of Network will be measured will be by the tools the Network develops and implements to address public health content in a consistent, pan-Canadian approach. Ensuring that the Network has a broad set of tools in its toolbox will ensure that the Network remains functional and responsive. Moreover, these tools will allow the Network to evolve and adapt to changing public health needs and circumstances. The Task Force has identified the following tools as priorities for development by the Network:

- collaborative public health strategies;
- inter-jurisdictional agreements in five areas: mutual aid during an emergency; public health information sharing; labs; international cooperation / coordination; and the inter-change of public health researchers and providers; and
- a framework for a common approach to public health legislation and regulation.

Once developed and implemented, these tools of the Network will provide Canadians with the confidence that their governments have a coherent and comprehensive approach to protect and respond to their public health needs, and in particular, to emergencies.

Developing Collaborative Public Health Strategies

In agreeing to A 10-Year Plan to Strengthen Health Care, First Ministers committed to, accelerate work on a pan-Canadian Public Health Strategy that will set goals and targets for improving the health status of Canadians through a collaborative process. The Network can play a key role in supporting this work and provide advice to F/P/T Minister and Deputy Ministers of Health regarding the implementation of the strategy and the subsequent goals and targets.
The development of collaborative public health strategies is intended to set out overarching frameworks for public health across Canada. The strategies would outline how the federal government, provinces and territories each approach public health and how they collaborate in a coherent and consistent manner. They could be articulated as a set of comprehensive blueprints for governments to plan for and respond to the public health needs of their residents. Collaborative strategies could also accommodate and promote best practices in public health.

However, recognizing that each jurisdiction has different approaches and different public health priorities, the strategies will be flexible to enable each jurisdiction to enhance its public health system, as well as work with others. The strategies should not set out prescriptive steps, but allow for synergy across jurisdictions.

Developing collaborative public health strategies should be one of the first priorities of the Network, to be led by the Council, likely with the assistance of a Task Group devoted to this work.

Development of Public Health Agreements

Public health agreements are envisaged as a tool to establish a common basis for working relationships between F/P/T public health institutions and personnel. These are intended to be framework agreements between F/P/T Ministers of Health that signal a strong measure of political commitment. While not legally binding, these commitments will provide a sufficient basis for jurisdictions to proceed, for example, to be able to count on another jurisdiction to share resources in times of emergency.

Some of these agreements would also be expected to confer a limited, ongoing functional role to the Network. For example, the Network may administratively (through its Secretariat and the Emergency Preparedness and Response Expert Group) maintain a database in order to “match” jurisdictions in need of assistance during an emergency with a jurisdiction with resources it can spare. The Network would also be expected to be the principle venue for the sharing of public health developments beyond Canada’s borders.

As to priority, all issue areas are important and essential to an effective, efficient and coordinated approach to public health issues across jurisdictions. However, given the urgency to act, the Task Force has discussed and developed the principles for the first of these agreements (regarding Mutual Aid During an Emergency). The Task Force would further recommend that an agreement on issue two (Public Health Information Sharing) should proceed on an immediate basis, upon establishment of the Network.

The Task Force also notes that progress is being made in each of these issue areas – and in some cases – such as for laboratory services – less formal inter-jurisdictional “arrangements” have already enabled the sharing of lab capacity and services during past surges related to public health crises (such as SARS, BSE and the West Nile Virus). Converting these existing arrangements to an agreement will be a means to codifying this successful practice, and will serve to demonstrate quick progress in the work of the Network.

Priority Areas for Agreements

1. Agreement on Mutual Aid During an Emergency

While Canada has public health capacity in terms of equipment, facilities, information systems and professions, that capacity is not distributed consistently or equally throughout the country. Current levels of public health capacity vary by region, by jurisdiction, and by regional health authority or community. Rather than duplicate initiatives and efforts to allow for “surge capacity” in a single jurisdiction or area, this agreement will ensure the sharing of resources to ensure an appropriate use and redistribution of existing capacity and resources in times of need and emergency.

Specifically, disease control resources could be shared more broadly across jurisdictions. This agreement will serve to “match” between a jurisdiction in need of public health resources, in times of emergency/crisis, and those with a supply

...
they can spare. The intent is not to absolve a jurisdiction of its responsibility to adequately prepare for emergencies, but to provide access to additional resources as an extra tool upon which a jurisdiction can rely.

A key component of this agreement relates to the inter-jurisdictional practice of public health professionals. Such arrangements will allow for their work in non-resident provinces and ensure more timely and efficient use of these resources in times of crisis.

Any agreement regarding the provision of public health human resources must be based on need. Moreover, all professionals should be used to the full scope of their capability, training and experience. It is clear that an added influx of public health human resources during a public health crisis is needed for many reasons including, ensuring quality patient care, enhancing disease control and containment, and alleviating pressures on existing public health human resources. In addition, this approach of sharing of resources during “surges” caused by public health emergencies would guarantee that jurisdictions would have access to appropriately trained public health professionals that can do the job, and serves to preserve health human resource capacity for use elsewhere in the health system.

Core elements:

• define conditions for access to medical equipment;
• provisions for infrastructure capacity (in the form of additional facilities/rooms/beds within neighbouring jurisdictions);
• increase coordination and dissemination of information in times of emergency;
• inter-jurisdictional recognition of professional licensing during times of emergency;
• consider and resolve potential human resources issues related to indemnity, insurance and compensation; and
• implement transportation policies and procedures for the safe and efficient travel of individuals, equipment and clinical samples.

A further discussion of the steps the Task Force has taken in developing principles for an Agreement on Mutual Aid During an Emergency is presented in Section 6 and Appendix A.

2. Agreements on Public Health Information Sharing

This agreement would define and establish the rules on sharing public health information, including arrangements for timely access to information in times of emergency, best practices in data collection, and protection of privacy. Overall, these systems will facilitate the flow of information across all jurisdictions and ensure that the quality of the information is consistent and capable of being rolled up at the community, regional, provincial/territorial and national level. Disease and condition specific information, such as symptoms and clinical practice guidelines, will be disseminated quickly among health care professionals nationally ensuring early detection and protection against new diseases/conditions.

Core elements:

• protocols for: data collection, data aggregation, custody, access, use, release, interpretation & dissemination, destruction (for communicable disease, these could be worked out through the Communicable Disease Control Expert Group);
• privacy;
• security; and
• standards for: data models, core data sets, list of reportable diseases, expanded data sets, messaging standards, etc.

3. Agreement on Public Health Laboratory Networks

The purpose of this agreement is to enable all jurisdictions to identify their public health laboratory capacity and expertise and to provide access to a comprehensive set of networked pan-Canadian public health laboratories. This reciprocal agreement would codify and amplify existing public health laboratory networks in Canada, such as the Canadian Public Health Laboratories Network. As a reciprocal agreement laboratories in a specific jurisdiction will recognize the needs of other jurisdictions in relation to a particular area of expertise. Likewise, other jurisdictions would recognize the public health laboratory needs of
one another in other areas of expertise. Therefore, all provinces and territories will have access, on uniform terms and conditions, to public health laboratory services across Canada. This is in order to ensure an integrated and effective approach to epidemiologic investigation and control, particularly during public health events.

Core elements:
- regular sharing of public health laboratory facilities (not just in times of emergency);
- reciprocity in access to and use of resources;
- coordinate planning for capacity expansion, when appropriate; and
- standards.

4. Agreement on International Networks

This agreement would ensure the timely dissemination of information on public health issues that are internationally and locally relevant. This agreement will reaffirm the role of the Government of Canada, through the Public Health Agency of Canada, to represent Canada internationally and will commit the Agency to link with provinces and territories via the Network on international public health issues, events and initiatives. This agreement will also require the Agency to link Canadian experts with their international counterparts regularly to facilitate information and research sharing of international public health issues.

Core elements:
- timely and regular information sharing; and
- regular consultations with the Network as to Canada’s participation in international public health initiatives.

5. Agreement for Interchange and Secondment of Public Health Researchers and Providers

This agreement would facilitate the practical training and learning of public health research and care providers within and among various jurisdictions. Public health experts will be seconded among jurisdictions in order to facilitate training and information exchange. Providers will gain additional experience and be exposed to a wider spectrum of public health issues in various jurisdictions. The creation of National Collaborating Centres for Public Health as part of the broader Canadian public health landscape can contribute to this objective.

Core elements:
- mutual exchange of public health researchers and care providers;
- facilitated regulation of provider exchange; and
- relevant and experience-building seconding.

Development of a Framework for a Common Approach to Legislation and Regulation

Currently, public health legislation (including infectious disease control) exists primarily at the provincial/territorial level. A review of public health legislation across jurisdictions by the Public Health System Infrastructure group indicates that a number of issues require collaborative and cooperative action. This includes issues of potential conflict between privacy legislation and public health activities; variation in legislation on: who must report incidents/events; criteria for a reportable disease; scope of report; timing for reporting; reporting to whom, etc. Thus, the intent of this work would be to identify and agree to the key elements of a model public health law approach, which would encourage and assist jurisdictions to proceed with the changes necessary to harmonize public health legislation in each jurisdiction. The framework is intended to facilitate and assist jurisdictions with legislative renewal, it will not prescribe.

Core elements:
- create a framework for a common approach to modern and comprehensive public health legislation;
- provide guidance on legislative provisions (e.g., public health emergencies; duty to report / act; ethical framework; privacy; etc.);
- develop common approaches / solutions (by sharing experiences); and
• develop interlocking legal provisions for control of human pathogens, quarantine, and other disease control actions within Canada’s borders.

Development of additional collaborative public health tools

While collaborative strategies on public health, agreements and the framework for a common approach to legislation outlined above should be the initial priorities for the Network, the Task Force discussed the need for a comprehensive set of tools for the Network. In particular, the Task Force recommends that the Network:

• establish mechanisms for sharing advice, information and expertise;
• provide a mechanism for sharing best practices in public health;
• facilitate the holding of collaborative workshops, conferences, etc.; and,
• develop a secure, collaborative web site for information sharing.

The development, implementation and endorsement by the Council of these additional collaborative public health instruments will be key in establishing the Network as a strong and responsive body and ensuring collaboration between jurisdictions is a regular daily practice of public health professionals.

Recommendations

The Task Force recommends that:

Instruments

10. The Network establish, maintain and implement the following instruments on a priority basis, in order to address public health content in a consistent, pan-Canadian approach:

• collaborative public health strategies;
• inter-jurisdictional agreements in five areas:
  • mutual aid during an emergency;
  • public health information;
  • public health laboratories;
• international cooperation / coordination; and
• interchange of public health researchers and providers.
• a framework for a common approach to public health legislation and regulation.

11. The Council be responsible for developing and maintaining the agreements of the Network, and report to F/P/T Deputy Ministers of Health on progress towards development of the priority tools listed above within one year of its creation.

12. The Network develop additional public health tools as a means to establishing the Network as a strong, collaborative and responsive body.
Section Six
Mutual Aid During an Emergency

Context

Managing public health programs, public health emergencies or the public health implications of disasters such as contaminated water from floods or human negligence, involves a wide range of skill sets, networks and professional domains. In many instances, as the SARS outbreak demonstrated, the need for mutual aid between and across jurisdiction can go beyond the immediate boundaries of the public health domain.

The Task Force notes that there are two critical aspects to managing public health issues. One is related to the day-to-day delivery of programs designed to maintain and enhance the health of populations. These programs include infectious disease prevention and control; research on, and diagnostic of existing, recurrent and emerging infectious diseases; chronic disease prevention and control; and surveillance and monitoring of the health of Canadians. The other critical function is the management of public health emergencies or emergencies with public health implications across the spectrum of infectious diseases, chemical toxic agents, radio-nuclear contamination, and terrorism.

For many emergency situations, the health of the population affected or at risk is a critical component in emergency response and management. The health sector, in the form of federal, provincial and territorial governments’ collaboration, has a primary role to play. However, it is important to note that responding to these health needs that the health sector’s response will and must fit within broader government emergency management procedures, processes and structures.
The broader F/P/T Emergency Preparedness Sector has the overarching lead in intergovernmental coordination during emergency situations. To facilitate this role, governments are in the process of developing a National Emergency Management System, through provincial and territorial government Emergency Management Senior Officials and the Department of Public Safety and Emergency Preparedness Canada (PSEPC).

As such, not only is there a recognition of the need to work closely together within the health sector but also to collaborate more broadly with other F/P/T governmental departments on emergency preparedness and response.

Key Players During a Public Health Emergency

During a public health emergency the Public Health Network has a critical role to play to identify priorities, formulate strategies, and develop the operational mechanisms to ensure that all professional domains and sectors across Canadian jurisdictions work in a coordinated, knowledgeable, and integrated manner.

There are presently three broad fields or networks of interest that must collaborate to achieve a robust, integrated and seamless public health capacity in Canada that could be mobilized during a public health emergency. That is, the Communicable Disease Control Network (CDCN), the National Emergency Preparedness and Response Network (EPRN), and the Canadian Public Health Laboratories Network (CPHLN).

The CDCN is being created to ensure that infectious disease prevention and control across Canada proceeds in a coordinated manner. The impetus for the creation of this particular network was the SARS outbreak in 2003 and the need for collaborative and consistent actions across jurisdictions.

The Emergency Preparedness and Response Network (EPRN) was created in early 2002 to implement the recommendations of the Special Task Force on Emergency Preparedness and Response. It was directed by federal, provincial and territorial Ministers of Health to develop an integrated, coordinated, seamless, and robust capacity to manage public health emergencies or emergencies with public health implications.

The CPHLN, created in 2001 was galvanized in their resolve to be prepared for bioterror attacks after the September 11, 2001 terrorist attacks in the United States and the anthrax attacks in the US. CPHLN ensures that public health laboratory resources, data, analytical protocols, surveillance capability, and diagnostic expertise can come together to tackle public health priorities and laboratory public health issues that include laboratory response to infectious disease outbreaks involving emerging and re-emerging pathogens, as well as bioterror agents.

Much has been achieved in all of these three areas. The Task Force is of the view that the creation of the Public Health Network and its integration of all three of these existing groups, along with a specific mission to facilitate mutual aid and support during an emergency is good public policy and a good use of public resources. It would also ensure that the necessary linkages of the public health system and the provision of health services in times of emergency when Canadians naturally gravitate to their physicians and emergency wards in hospitals.

How Would the Public Health Network Function During an Emergency?

The Network, primarily through the Emergency Preparedness and Response Expert Group, but also through the leadership of the Council, when necessary, would be involved in emergency planning and preparedness as well as emergency response and recovery. This means that it should act as a coordinating resource in setting policy directions for public health emergency programming, linking the policy priorities to cross-jurisdictional and inter-sectoral initiatives, providing the strategic venue to inform the public health ongoing programs, and build, as a unique function across jurisdictions, the program elements to provide the necessary emergency surge capacity, when required.
The Network would ensure that public health imperatives are supported by science, and emergency management expertise and resources. The Network, as the lead body responsible for coordinating action on the principles of an Agreement on Mutual Aid During an Emergency, is able to prepare, respond to, and recover from public health emergencies or emergencies with public health implications (where inter-jurisdictional collaboration is necessary).

It would also provide for a seamless and robust set of resources and expertise to ramp up from the ongoing business of public health to manage complex public health emergencies that challenge provincial or territorial capacities to cope or that require a national focus to resolve. Without the Network’s guidance and coordination, overlap and duplication of efforts will likely occur and raise the possibility of disjointed actions where a consistent, seamless, robust and integrated response approach is preferable to ensure the convergence of capabilities, capacities, expertise and operational mechanisms and instruments.

**Agreement on Mutual Aid**

The ability to respond to emergencies through intergovernmental collaboration and coordination was recognized in the Naylor report. Premiers and territorial leaders at their July 2004 meeting of the Council of the Federation also highlighted the need for coordinated F/P/T work in the area of mutual aid.

In the development of the principles for an Agreement on Mutual Aid During an Emergency, the Task Force has considered the need to encompass the above elements and developed a “modus operandi” that favours collaboration and cooperation and not competition across the public health key functional areas. The Task Force also looked to build upon the International Emergency Management Assistance Memorandum of Understanding (MOU) agreed to by Quebec, New Brunswick, Nova Scotia, Newfoundland and Labrador, Prince Edward Island, and the New England states in July 2000. Similarly, the Task Force’s approach is consistent with the Memorandum of Understanding agreed to by British Columbia and Alberta in the spring of 2004 for providing assistance during an emergency.

As such, the Agreement on Mutual Aid during an Emergency, will be based upon the following principles:

- recognition that F/P/T governments have varying degrees of public health capacity and that collaboration could be beneficial when a jurisdiction is unable to manage by itself during an emergency or public health crisis;
- that sharing existing capacity and resources is a more efficient and effective way to provide surge capacity that results in little to no duplication in resources nor activities;
- that F/P/T governments can support one another, facilitated through the Public Health Network, to assist any jurisdiction(s) dealing with a public health event/crisis that is beyond its capacity;
- that each jurisdiction can establish the procedures necessary to provide assistance to others during public health emergencies, and enable emergency responders from a responding jurisdiction to be treated the same way for legal licensing purposes as emergency responders in the jurisdiction that made the request; and,
- that the provision of assistance will not endanger or severely limit public health capacity in any jurisdiction providing assistance.

The Agreement on Mutual Aid During an Emergency will be a statement of commitment on the part of F/P/T governments to common principles for providing assistance to one another during a public health emergency; the goal being that if a local system is overwhelmed by an event, then there is a strong, seamless and organized response from the provincial, territorial and federal levels that is ready to be initiated. The agreement will signal a common approach governments will take to address roles and responsibilities, liability and health professional certification matters. It will build on the progress made in developing a National Health Emergency Management System; consider the existing Canadian Public Health Laboratories Network achievements; and structure and review the orientation of the Communicable Disease Control Network to ensure that all of these essential elements are integrated in a seamless and coordinated fashion. The principles of the Agreement are included as Appendix A.
Summary

The Special Task Force on Public Health sees a major value in using the Public Health Network to facilitate intergovernmental sharing of capacity and resources during a public health crisis. The Agreement on Mutual Aid During an Emergency will commit governments to a set of principles necessary for facilitating inter-jurisdictional collaboration of the business of public health during all types of emergencies with a potential to impact the health of populations.

Recommendations

The Task Force recommends that:

Agreement on Mutual Aid During an Emergency

13. FiPIT Ministers of Health approve the principles for an Agreement on Mutual Aid During an Emergency.

14. The Network be responsible for monitoring and reporting on the development and implementation of the Agreement on Mutual Aid During an Emergency, within one year of its approval.
Section Seven
Review of Existing Public Health Groups / Networks

Introduction

Currently there are more than eighty-four (84) F/P/T committees with roles and mandates related to public health. The reporting relationships of these groups vary from F/P/T Ministers of Health to Director level within Health Canada or the Public Health Agency of Canada. The scope of activities includes the health sector and other sectors such as education, social services and environment. Funding for these groups varies from formal F/P/T Conference of Deputy Ministers of Health investments to federally funded mechanisms. Membership of these groups also varies from F/P/T officials, non-government organizations, and academic and community public health representatives. Many of the participants are involved in a host of public health related committees.

The time sensitivity of different committees or groups varies from highly sensitive emergency response functions to less sensitive strategic planning functions. The degree of role clarity, formality and information exchange varies. These groups could be described by public health issue, population, public health function and degree of integration (issue-specific to broad strategy).

The Pan-Canadian Public Health Network will need a range of actors to advance public health. Different actors are involved at different points of the policy continuum at different times, with different, complementary and shared roles. Public health expertise is not necessarily distributed equally across the country. There are both barriers and incentives to participate in F/P/T committees and processes. F/P/T groups and committees remain as important links to local, regional and international actors and mechanisms.
Evaluation of F/P/T Committees for Alignment within the Network

In preparation for the establishment of the Public Health Network the Special Task Force has undertaken a review of the outputs and continuing need for existing F/P/T committees/groups dealing with a number of public health issues as well as their alignment to the Expert Groups proposed to be part of the proposed Network. The goal is to streamline and rationalize the number of existing bodies and processes for dealing with public health issues in order to create a strong and effective structure. There are only limited financial and human resources available to perform these essential public health tasks and they must be allocated to priority and essential policy, program and service areas (The evaluation report is a stand alone document titled Evaluation of F/P/T Committees for Appropriate Fit in the Pan-Canadian Public Health Network).

The existing 84 committees and groups have been evaluated against a set of objectives and criteria that include the need to resolve duplication and overlap, and to bring about a convergence of all public health groups. Based on this review, it is recommended that:

- three (3) existing committees should form the basis of Expert Groups:
  - the Communicable Disease Control Network;
  - the Emergency Preparedness and Response Network; and
  - the Canadian Public Health Laboratory Network.

- two (2) committees that should be Issue Groups and take on an umbrella role for specific sub-issue groups dealing with key aspects of the same subject:
  - the Canadian Immunization Committee; and
  - the Communicable Disease Surveillance Standards Working Group.

- five (5) committees that can or have sunset:
  - the Canadian Committee on Standardization of Molecular Methods;
  - the Canadian External quality Assessment Group on Antimicrobial Resistance;
  - the Canadian Heart and Stroke Surveillance System – Pilot Project;
  - National HIV Clinical Lab Testing Working Group; and

- thirty-four (34) committees that should be aligned as Issue Groups to Expert Groups;
- fourteen (14) committees that can be, or have already, merged or which should be sub-issue groups to other committees; and
- twenty-six (26) committees that because of the nature of their work should not be part of the Network at this time. They should be reviewed, at a future date, to assess their linkage to the Network.

The chart on the following page provides an illustration of the Task Force’s recommendation for the Network’s structure. That is, a Council, the initial six Expert Groups, and 34 Issue Groups mandated by the Conference of F/P/T Deputy Ministers of Health to facilitate intergovernmental coherence on public health matters; support the day-to-day business of public health; and facilitate access to mutual aid between governments during emergencies, when required.

Improving Effectiveness and Efficiencies

Formally sun setting unnecessary committees; resolving duplication and overlap of mandates and activities by merging committees or aligning issue groups under broader issue groups; and, sharing information, expertise and best practices through strong communication links between committees can improve the effectiveness of both individual committees and the Network while at the same time improving resource management.
It should be kept in mind that all of the Expert Groups, Issue Groups as well as the time limited Task Groups will need to operate in an effective and efficient manner with maximum use of electronic communications rather than face-to-face meetings. Ensuring formal links to enhance communication, cooperation and collaboration (e.g., representation from one committee sitting on another, meetings of secretariat staff) and informal links (e.g., sharing of minutes) is something that the Council members and Expert Groups should encourage and facilitate.

Details regarding the alignment of the various committees to the Expert Groups, communications within and amongst Expert Groups and managing issues (e.g., terms of references) and further analysis are provided in the detailed evaluation report. Appendix C summarizes the alignment of the proposed 34 Issue Groups under each of the six Expert Groups. There are also 10 sub-issue committees working on priority projects and/or activities (identified in the full evaluation report).

Although there are opportunities now for efficiencies through sun setting, aligning and merging some committees, as one establishes the new Public Health Network, the efficiency opportunities are much greater over the longer term as the Network improves coordination and collaboration between the Issue Groups and the Expert Groups. The sharing of information, lessons learned, and expertise and skills can potentially move Issue Groups and the entire Network forward much faster than under past structures. The Emergency Preparedness and Response Network and the Canadian Public Health Laboratory Network are two committees that have begun the process of adopting the role of an Expert Group and are showing how the new system can work better through inclusion, cooperation and collaboration.

Once the Network is established, the Council should continually review opportunities to expand access to expert advice and support through revisions to the scope of membership of Issue Groups and by including other public health related committees, on an Associate Group basis, in the Network. However, the goal should always remain to a wise and efficient use of the time of limited public health resources.

Summary

It is possible to streamline and rationalize the number of intergovernmental bodies support public health matters across the country. To that end, the Task Force recommends that the initial structure of the Network consist of the Council, the 6 Expert Groups and 34 Issue Groups. This creates a strong and robust foundation for advancing the priority activities and initiatives proposed for the Network – particularly in the areas of mutual aid, dealing with communicable diseases and supporting integrated laboratory networks.

Recommendation

The Task Force recommends that:

15. The Pan-Canadian Public Health Network include an initial set of 6 Expert Groups and 34 Issue Groups, formed by incorporating existing F/P/T groups and committees as identified by the Task Force.
Section Eight
Conclusion

The need for multilateral F/P/T collaboration in public health exists because of the policy interdependence inherent in the provision of public health services. Moreover, the desired outcome of a responsive, efficient and high quality public health system requires collaboration among and between all governments, when and as appropriate.

The Task Force has examined the existing and real barriers to moving forward on improving public health and has developed a concrete set of recommendations that are necessary to renew and strengthen public health across the country. The initiatives, structures and investments proposed will contribute to a strong and robust public health system, ready and able to collaborate on the day-to-day business of public health and respond in times of emergency.

In conclusion, the Special Task Force on Public Health is of the view that the way ahead includes the following key measures:

- the establishment of a pan-Canadian Public Health Network as a means of improving intergovernmental collaboration in the public health sector;
- support for the efforts by all jurisdictions to improve their public health structures and capacity at the local, provincial/territorial and federal level;
- the creation of tools and other instruments such as intergovernmental agreements, secure web sites, surveillance systems/communications protocols, etc. necessary for building consensus and cooperation amongst provincial, territorial and federal public health professions;
- the implementation of the proposed principles for the Agreement on Mutual Aid During an Emergency in order to plan/prepare for and respond/recovery from public health emergencies;
- the development and implementation of collaborative public health strategies by the Network, on a priority basis; and
that a core number of essential F/P/T bodies be brought together within the Public Health Network structure in order to create a robust and effective foundation for F/P/T coordination and cooperation on public health matters.

By taking these steps, provincial, territorial, and federal governments would be signalling that they have learnt important lessons from SARS and other recent public health situations. The establishment of the Pan-Canadian Public Health Network is a concrete and practical step to improve the ability of governments to coordinate and collaborate in preparation and response to future potential public health challenges and crisis.
Appendix A
Development of an Agreement on Mutual Aid During an Emergency

Introduction

Naylor and others have clearly articulated the need for multi-jurisdictional collaboration in public health. It has become evident that, particularly during an emergency, multilateral approaches are often the most efficient mechanism to addressing gaps in public health capacity. To this end, the agreement on Mutual Aid During an Emergency is intended to outline common principles to enable any jurisdiction to request assistance and expertise from other jurisdictions in a timely and efficient manner.

Principles

The Agreement will be based upon the following principles:

- recognition that F/P/T governments have varying degrees of public health capacity and that collaboration could be beneficial when a jurisdiction is unable to manage by itself during an emergency or public health crisis;
- that sharing existing capacity and resources is a more efficient and effective way to provide surge capacity that results in little to no duplication in resources nor activities;
- that F/P/T governments can support one another, facilitated through the Public Health Network, to assist any jurisdiction(s) dealing with a public health event/crisis that is beyond its capacity;
• that each jurisdiction can establish the procedures necessary to provide assistance to others during public health emergencies, and enable emergency responders from a responding jurisdiction to be treated the same way for legal licensing purposes as emergency responders in the jurisdiction that made the request; and,
• that the provision of assistance will not endanger or severely limit public health capacity in any jurisdiction providing assistance.
Appendix B
Terms of Reference of the Council of the Pan-Canadian Public Health Network – Proposed

The Pan-Canadian Public Health Network (the Network) will provide policy advice to the Conference of F/P/T Deputy Ministers of Health on public health matters. The Network will receive its mandate and role from F/P/T Deputy Ministers of Health. It is the Conference of F/P/T Deputy Ministers of Health who will identify the scope and mandate of the Network and will hold the members on the Council accountable for the deliverables and performance of the Network.

1.0 Mandate

The mandate of the Council is to serve as the senior and central governance body of the Pan-Canadian Public Health Network (the Network). The Council is responsible for taking a strategic, coordinated view of the ongoing conduct and operation of the Network by:

- providing cohesion and coordination between ongoing public health groups, ensuring that activities are not duplicated;
- serving as the governance forum for developing and monitoring the key instruments of the Network;
- guiding the development of collaborative public health strategies;
- preparing, negotiating, implementing and adapting public health agreements as required, e.g., mutual aid during emergency; and,
- providing advice to the Conference of F/P/T Deputy Ministers of Health on public health matters.
2.0 Goals and Strategic Priorities

For the first year following its creation, the Network and Council priorities are to:

1. establish the Network and supporting structure;
2. create a framework for the initial six Expert Groups and immediately populate the following expert groups: Communicable Disease Control; Emergency Preparedness and Response; Canadian Public Health Laboratories; and Surveillance and Information;
3. establish a task group to oversee the implementation of the principles for the Agreement on Mutual Aid During an Emergency;
4. create a Task Group to develop an inter-jurisdictional agreement on Public Health Information Sharing; and
5. implement the re-alignment of the existing F/P/T and Health Canada groups currently dealing with public health issues within the Network.

Improving the health status of Aboriginal peoples will also be a priority for the Network. Other longer term priorities will be developed over the first year of implementation of the Network.

2.1 Instruments

The instruments the Council will use to achieve its short/medium term goals and priorities include:

- collaborative public health strategies;
- inter-jurisdictional agreements in five areas:
  - mutual aid during an emergency;
  - public health information;
  - public health laboratories;
  - international cooperation and coordination; and
  - interchange of public health researchers and providers;
- a framework for a common approach to public health legislation and regulation;
- mechanisms for sharing advice, information and expertise;
- a mechanism for sharing best practices in public health;
- facilitating the holding of collaborative workshops, conferences, etc.; and,
- the development of a secure, collaborative web site for information sharing.

3.0 Governance

3.1 Accountability

The Network, through its Council, is accountable to the Conference of F/P/T Deputy Ministers of Health (CDMH). The Council is accountable for:

- providing deliverables on priority issues as directed by the CDMH;
- identifying and developing strategies for public health priorities;
- providing advice to the CDMH on public health matters;
- implementing decisions of the CDMH; and
- monitoring and assessing the Network’s activities.

The Council ensures that the Network communicates with the F/P/T Deputy Ministers of Health on its public health responsibilities and activities and other partners, as appropriate. The Network’s linkage to government decision makers and others helps to ensure a broad synthesis of public health policy issues, horizontally linking public health policy issues in an integrated and robust fashion.

Reporting requirements – The Council is required to report to the CDMH twice per year: a mid-year update at the June CDMH and an annual report and work plan at the December CDMH. The latter report is communicated to FPT Ministers of Health. More frequent reporting is required when requested by the CDMH and/or during an emergency.

Authority of the Council – The Council has the authority to make decisions related to technical and operational issues in public health. Any policy decisions or other decisions (technical and operational) with related policy implications are required to go to the CDMH for consideration.
The Council has the authority to create, change or sunset Expert Groups as required addressing important public health issues. It is required to inform the CDMH to make these changes. The Council will oversee the work of the six initial Expert Groups:

- Communicable Disease Control;
- Emergency Preparedness and Response;
- Canadian Public Health Laboratories;
- Surveillance and Information;
- Non-Communicable Disease and Injury Prevention and Control; and
- Health Promotion.

The Council has the authority to create, modify or sunset:

- Issue Groups reporting to an Expert Group(s); and
- Task Groups to accomplish a time-limited ad-hoc assignment and reporting to the Council or an Expert Group.

The Council has the authority to provide strategic guidance and direction to the Network on the development of annual Network work plans which go to the CDMH for approval. The Council is authorized to leverage the instruments assigned to it by the CDMH, e.g., collaborative public health strategies, inter-jurisdictional agreements and framework for public health legislation. The relationships between the CDMH, the Network Council and other components of the network model are illustrated in section 4 of the February 2005 report “Partners in Public Health”.

3.2 Membership and Participation

The Council members will consist of one (1) senior representative from each participating (FPT) jurisdiction. In addition, those jurisdictions serving as co-chair are also entitled to have a separate member participate on the Council. Jurisdictional representatives are senior officials with public health expertise, decision making authority, corresponding responsibilities and thereby exercise leadership in public health within government. The federal co-chair is the Chief Public Health Officer of Canada. The selection of Council members is at the discretion of each jurisdiction. If the Council member is unavailable to participate in a Council meeting, a delegate can be formally appointed by the jurisdiction.

To facilitate vertical and horizontal linkages with the six Expert Groups and Task Groups, one Council member will be selected to serve in a liaison, champion and integration role for each of the Expert and Task Groups.

The Council will develop a set of roles and responsibilities for its members, to be attached to these Terms of Reference as an Appendix.

The Council invites non-governmental organizations (NGOs) to participate in Council discussions on issues that are directly relevant to their mandate or expertise. Representatives from non-governmental organizations will be invited, as appropriate, to participate and help inform Council discussion on issues that are directly relevant to their mandate and expertise. Aboriginal engagement in the Network Council deliberations will be an important feature of its operations.

3.3 Leadership

The Council will be co-chaired by a P/T member and the federal member, the Chief Public Health Officer of Canada. The term of the rotating P/T co-chair is 2 years. The Council will develop a set of roles and responsibilities for the co-chairs, to be attached to these Terms of Reference as an Appendix.

3.4 Meetings, Quorum and Decisions

Council meetings will be held a minimum of four (4) times per year. Additional meetings will be held as required. Minutes will be recorded by the Secretariat and distributed to members. Both Co-chairs or their designate(s) are required to be in attendance at the meeting.

Quorum for Council meetings shall be attendance by a simple majority of members. Decisions shall be made by consensus where consensus is defined as general agreement, either verbal or by poll.
3.5 Changes to the Terms of Reference

Changes to the Network Council Terms of Reference require approval by the F/P/T Conference of Deputy Ministers of Health. The Terms of Reference of the Council will be reviewed at least every three (3) years.

4.0 Support

4.1 Secretariat

The Public Health Agency of Canada provides the Secretariat for the Network's Council. The Secretariat's responsibilities include facilitating information sharing between the Council and other Network components. It is also responsible for other duties assigned by the Council. These may include the maintenance and sharing of information related to public health resources available to participating members of the Network, such as resources available during a public health emergency. The Secretariat may be comprised of F/P/T officials through secondment opportunities.

The Council will develop a set of roles and responsibilities for the Secretariat, to be attached to these Terms of Reference as an Appendix.

4.2 Resourcing

Resourcing for Secretariat support for the Network Council will be provided by the Public Health Agency of Canada. Additional resources for Council priorities will be drawn initially from existing resources.

Revised: February 2005
Appendix C
Organization of Existing Public Health Groups / Networks

Based on its review of the 84 existing public health groups / networks (as outlined in Section 7 of the main report), the Task Force's recommends the following as an initial series of 34 Issue Groups, aligned across the six initial Expert Groups. The full evaluation report is available as a separate document.
<table>
<thead>
<tr>
<th>Initial Expert Groups</th>
<th>Proposed Issue Groups</th>
</tr>
</thead>
</table>
| **Communicable Disease Control**      | Canadian Immunization Committee  
Canadian Immunization Registry Network (CIRN)  
Canadian Rabies Working Group – Raccoon Variant  
Canadian Tuberculosis Committee (CTC)  
F/P/T Advisory Committee on HIV/ AIDS  
Pandemic Influenza Committee (PIC)  
Steering Committee on Infection Control Guidelines  
Swine Avian influenza Steering Committee  
West Nile Virus Steering Committee  
National Working Group, Transfusion Transmitted Injuries Surveillance System (TTISS)  
Enteric Disease Surveillance Steering Committee (ENDS)  
Ad hoc Committee on Syphilis Surveillance  
Ad hoc FPT Sexually Transmitted Infections Directors Committee |
| **Emergency Preparedness and Response** | Council of Emergency Social Services Directors (CESSD)  
Council of Health Emergency Management Directors (CHEMD)  
National Emergency Stockpile System (NESS) Working Group |
| **Public Health Laboratories**         | Canadian Association of HIV Clinical Laboratory Specialists  
Laboratory Standardization Subcommittee  
Water and Food Safety Subcommittee  
Bioterrorism Response Subcommittee  
Reference Centre Advisory Subcommittee  
Infection Control and Surveillance Working Group  
Pandemic Influenza Laboratory Working Group |
| **Surveillance and Information**       | Canadian Integrated Public Health Surveillance (CIPHS) Collaborative  
Communicable Disease Surveillance Standards Working Group |
| **Non-Communicable Disease & Injury Prevention and Control** | Canadian Strategy for Cancer Control (CSCC) – Council  
Coordinating Committee for the National Diabetes Strategy (CCNDS)  
Steering Committee to the Second Cycle of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS2)  
Conference of Principal Investigators of Heart Health  
Canadian Task Force on Preventive Health Care |
| **Health Promotion**                  | F/P/T Advisory Network on Mental Health (ANMH)  
F/P/T Group on Nutrition  
Family Violence Initiative (FVI) – Provincial/Territorial Working Group  
F/P/T Advisory Committee on Recreation and Fitness (ACRF) Now Called F/P/T Physical Activity and Recreation Committee (PARC) |
Appendix D
Preliminary Terms of Reference for the Six Expert Groups

Introduction

This document provides preliminary terms of reference for the initial six Expert Groups:

• the three existing F/P/T groups which will function as Expert Groups of the Public Health Network are:
  • Communicable Disease Control;
  • Canadian Public Health Laboratories; and,
  • Emergency Preparedness and Response.

The draft terms of reference included in this appendix have been adapted from the current terms of reference for these existing groups to reflect linkages to the larger Pan-Canadian Public Health Network. These three groups involve a range of public actors and have been functioning from one to four years. Further consultation is required on these preliminary versions of terms of reference to validate or modify the text with current and potential future actors in these areas.

• Three new groups which will be established as expert groups of the Network are:
  • Surveillance and Information;
  • Non-Communicable Disease and Injury Prevention and Control; and
  • Health Promotion.

The draft terms of reference for these new groups represent initial thinking to guide functioning of expert groups in each area. Given that these groups do not yet exist, these terms of reference are at a very early stage of development. Extensive consultation and further development is required for these terms of reference to be at the stage of readiness for approval by the Council of the Public Health Network.

Each set of terms of reference has been organized and formatted in five sections within common parameters to complement the approach taken with the Council’s terms of reference. Section 1 provides background information to position the expert
group’s links to the Network and, where appropriate, to existing F/P/T committees. Section 2 proposes a mandate for the expert group and section 3 outlines the goals and strategic priorities of the expert group. Section 4 focuses on governance: accountability; membership and participation; leadership; meetings, quorum and decisions; and, changes to the terms of reference. Section 5 outlines support to the expert group in terms of secretariat and resourcing.

Each of the six initial expert groups has common wording related to accountability and changes to the terms of reference. The remainder of the contents varies across expert groups, reflecting different origins, needs and approaches. While membership and participation is expected to vary from one expert group to another, the following draft principles have been developed to guide proposed consultations related to membership and participation from non-governmental experts in public health. These include:

- where a sectoral network, alliance or coalition exists, Network consultations will target the alliance as a whole, as opposed to individual member organizations;
- a diversity of expertise and perspectives will be sought. Non-government actors may be drawn from academic, professional, voluntary sector and organizations representing Aboriginal and other potential partners; and
- a host of participation mechanisms may be considered, including:
  - membership in the expert group;
  - associated or affiliate membership/participation in the expert group;
  - corresponding membership/participation related to initiatives of expert groups;
  - planned and regular participation in key policy and planning for an expert group;
  - reference group advising/reporting to an expert group; and
  - ad hoc engagement on matters deemed appropriate by expert group.

A notation is included in each draft terms of reference to flag the need for consultation related to Network involvement by non-government actors.

In future drafts of each terms of reference, it is expected that at least three Appendices will be developed. Appendix A will outline roles and responsibilities for expert group members, co-chairs and secretariat. Appendix B will outline expert group relations to other components of the Network. Appendix C will include other related information.

**Communicable Disease and Control Expert Group Preliminary Terms of Reference**

**1.0 Background**

The Communicable Disease Control Network (CDCN) is a Canadian F/P/T initiative intended to strengthen public health in Canada. Using its advisory and decision-making capabilities, the aim of the CDCN is to develop a more integrated national approach to communicable disease prevention and control through effective F/P/T coordination of national strategies and recommendations.

The CDCN will improve the efficiency and consistency of public health initiatives through:

- creation of a coordinated, national network providing an effective forum to raise and resolve issues without being restricted to single issues or diseases;
- broad-based information and data sharing amongst F/P/T jurisdictions;
- enhanced national capability for the detection of emerging and re-emerging communicable diseases;
- improved responsiveness to emerging health threats;
- reduction in gaps and overlaps in various simultaneously occurring initiatives (e.g., research initiatives); and
- efficiencies created by the development of standard process frameworks that can be customized and used by provinces/territories.
2.0 Mandate

As part of the proposed Canadian Public Health Network, the purpose of the CDCN is to provide strong leadership in communicable disease prevention and control through the development, recommendation, and approval of national policies, practices, guidelines and standards.

Through collaboration among F/P/T public health officials, the mission of the CDCN is to create a cohesive, national framework for communicable disease prevention and control activities and an integrated, action-oriented approach to related public health surveillance and response. Specifically, the CDCN will develop strategies to:

- improve the public health system's capability to anticipate, prevent, identify, respond to and monitor communicable diseases;
- link the separate public health activities related to communicable disease across F/P/T jurisdictions;
- improve the timeliness, accuracy and completeness of communicable disease information;
- bridge activities to other public health groups (such as the Canadian Public Health Laboratory Network) and health care groups; and
- identify and address public health priorities related to infectious disease.

3.0 Goals and Strategic Priorities

Strategic priorities and goals of the CDCN include:

- definition of core functions of public health and the various roles and responsibilities of F/P/T and local jurisdictions with reference to communicable disease prevention and control;
- creation of an operational framework for standardized public health practices, measures, and guidelines for communicable disease prevention and control;
- provision of direction and counsel to various CDCN national committees, which function as issue groups linking to the CDCN in its role as a PHN expert group;
- development of data sharing agreements and common standards for data amongst all levels of government;
- recommendations and development of public health information infrastructure;
- input into human resource planning and development with particular focus on education and training; and
- development of effective and integrated plans to respond to communicable disease threats (including bio-terrorism response) and guidelines for communicable disease control.

4.0 Governance

4.1 Accountability

The CDCN functions as one of six expert groups of the Pan Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on communicable disease prevention and control and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its issue groups, subsequently referred to as national committees. CDCN is also accountable to the other five expert groups and task groups (exact number is variable) of the PHN through regular communications (i.e. sharing of Records of Decisions and forward agendas), identification of cross-cutting issues and opportunities for cooperation, collaboration and integration. The CDCN will develop a set of roles and responsibilities for its members to be attached to these Terms of Reference as an Appendix.

The CDCN shall work within the context of a CDCN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The CDCN strategic plan shall be updated by the CDCN at least every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

4.2 Reporting Requirements

The CDCN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent
reporting is required when requested by the PHN Council and/or during a public health emergency.

4.3 Authority

The CDCN has the authority to make decisions related to technical and operational issues in communicable disease prevention and control. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the appropriate PHN expert and task groups for approval by the Council for recommendation to the Conference of Deputy Ministers of Health.

The CDCN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related CDCN recommendations require PHN Council approval prior to their implementation.

4.4 Membership and Participation

The CDCN shall be composed of no less than 16 and no more than 20 members including the Co-chairs. CDCN voting membership shall include senior-level, decision-making representatives from the following jurisdictions and organizations:

a) the Chief Public Health Officer, or designate, from each of the provinces and territories; and
b) one representative from each of:
   i. Public Health Agency of Canada (PHAC); and
   ii. Health Canada’s First Nations Inuit Health Branch.

CDCN non-voting membership shall include one representative from each of:

a) two expert groups of the Pan Canadian Public Health Network:
   i. Canadian Public Health Laboratory Network (CPHLN); and
   ii. Network for Emergency Preparedness and Response (EPRN);

b) Department of National Defence (DND);
c) Correctional Service Canada (CSC); and
d) Citizen & Immigration Canada (CIC).

In order to draw upon their expertise, CDCN may call upon representatives from other government and non-government health related organizations as non-voting participants in CDCN committees and/or as otherwise required.

Members other than Chief Medical Officers of Health shall be appointed by their respective organizations for a term of three years (renewable). Where a member resigns during that term, a replacement member for the balance of the term shall be appointed by the organization being represented.

CDCN members shall make a commitment to be actively involved in the work of the Network and to make attendance at meetings and fulfillment of network activities a priority. CDCN members may name a designate to attend meetings in the event of the member’s unavailability for a meeting.

4.5 Leadership

The CDCN shall be co-chaired by the PHAC CDCN member and one provincial CDCN member for a term of three years (renewable). CDCN Co-chairs shall preside over Committee meetings.

4.6 Meetings, Quorum and Decisions

The CDCN shall hold regular meetings and teleconferences to discuss and address business related to strategic priorities; goals; objectives; initiatives; current issues; communications; member relations; and funding and resource requirements (including strategic and operating plans and operating budgets). Emergency meetings shall be called by the co-chairs as required.

Quorum for meetings shall be attendance by a simple majority of voting members. Matters requiring decisions may be raised at CDCN meetings by any CDCN member or representatives of national committees (issue groups). Substantive matters requiring a decision by the CDCN shall be raised by means of a written briefing note. Briefing notes shall describe the issue, the decision required and recommendations. Briefing notes and supporting documents shall be forwarded to CDCN members one week in advance of the meeting date.
Each voting member, including the co-chairs, receives one vote. One authorized delegate may represent an absent voting member. Such delegate shall receive one vote. Decisions shall be made by consensus of voting members where consensus is defined as general agreement, either verbal or by poll. When consensus cannot be reached, decisions shall be made by a two-thirds majority of voting members present.

4.7 Changes to Terms of Reference

Minor amendments to the CDCN Terms of Reference may be made by the Co-chairs subject to ratification by the Network members at the next meeting of the CDCN. The Terms of Reference may be amended at any meeting of the CDCN by consensus or by vote and require approval by the Council of the Pan Canadian Public Health Network.

5.0 Support

5.1 Secretariat

A dedicated Secretariat shall be established at the Public Health Agency of Canada to administer and facilitate the work of the CDCN. The Secretariat shall report to the CDCN Co-chairs and be administered on a day-to-day basis by the PHAC CDCN Co-chair or his/her designate. The Secretariat shall provide scientific, technical, policy and secretariat capacity and support for the CDCN.

The Secretariat shall provide support to and participate in CDCN meetings as required but will not function as a voting member of the CDCN. CDCN meeting agendas shall be prepared by the Secretariat, in consultation with the Co-chairs, and issued one week prior to meetings.

The Secretariat shall record in the records of decisions of meetings all resolutions and voting results. Decisions resulting in action items shall be recorded as such for follow-up. Action items shall include designated accountabilities. Records of decisions of CDCN meetings shall be prepared by the Secretariat and distributed to CDCN members, other PHN secretariats, and other clients and partners as appropriate, within two weeks of the meeting date.

5.2 Resourcing

The Secretariat shall be funded by PHAC until such time as permanent operational funds are established for the CDCN. CDCN expenses shall be borne by the Public Health Agency of Canada (PHAC) and paid in accordance with Treasury Board policies. Additional person(s) approved to attend meetings shall be responsible for their own travel and accommodation expenses.

Date prepared: November 2004

Emergency Preparedness and Response Network (EPRN) Expert Group Preliminary Terms of Reference

1.0 Background

The Emergency Preparedness and Response Network is tied to the second element of the mandate of the Pan-Canadian Public Health Network – to support provincial and territorial government efforts in managing public health emergencies or emergencies with public health implications.

The EPRN is one of the six expert groups and its generic role is to develop and maintain a strong, coordinated and seamless emergency response capacity in support of provincial and territorial government efforts to manage public health emergencies or emergencies with health implications. It takes over the mandated responsibilities of the FPT EPRN on Emergency Preparedness and Response in operation since June 2001. In October 2001, F/P/T Ministers of Health established the Special Task Force on Emergency Preparedness and Response. In its final report to Ministers, the Task Force recommended that:

- the F/P/T Network continue to oversee the implementation of the recommendations of the Report and follow-up actions;
• an annual report be prepared and presented at the Conference of Deputy Ministers and Ministers of Health at their annual meeting; and
• review the effectiveness of this structure after three years.

The broader F/P/T emergency preparedness sector has the overarching lead in intergovernmental coordination during emergency situations. To facilitate this role, governments are in the process of developing a National Emergency Management System, through provincial and territorial government emergency management senior officials and the Department of Public Safety and Emergency Preparedness Canada (PSEPC). As such, not only is there a recognition of the need to work closely together within the health sector but also to collaborate more broadly with other F/P/T governmental departments on emergency preparedness and response.

2.0 Mandate

The mandate of the EPRN is to develop a strong, coordinated and seamless emergency response capacity (pan-Canadian emergencies management approach) in the health sector and provide advice on related issues, as appropriate.

The Expert Group’s objective is to develop a National Health Emergencies Management System by formulating an emergency preparedness and response framework that will encompass the full spectrum of emergencies management including: prevention preparedness response, and recovery.

The EPRN, led by the Public Health Agency of Canada’s Centre for Emergency Preparedness and Response (CEPR), is responsible for the implementation of the 31 recommendations of the Special Task Force on Emergency Preparedness and Response Final Report. The Expert Group is accountable to the CPHN and ultimately to the Conferences of Deputy Ministers and Ministers of Health in carrying out this task.

The Expert Group, through the coordinating and overseeing of provincial and territorial government efforts in managing health and public health emergencies, ensures a common approach to carry out the recommendations included in the final report of the Special Task Force on Emergency Preparedness and Response and the implementation plan. The EPRN provides oversight on the preparation of the annual report to Ministers of Health through the PCPHN Council and the Conference of Deputy Ministers of Health.

The Expert Group ensures that the Health Emergency Management system is supportive of and consistent the guiding principles and provisions of the National Framework for Health Emergency Management and with the operating principles of the National Emergency Response System.

The EPRN may also address related or emerging emergency preparedness and response (EP&R) issues of common concern, as appropriate.

3.0 Goals and Strategic Priorities

The Expert Group in building and sustaining the National Health Emergency Management system is chiefly concerned with:

• Leadership and Coordination;
• Surge Capacity;
• Training and Education;
• Surveillance and Detection Infrastructure;
• Supplies; and
• Communications.

4.0 Governance

4.1 Accountability

The EPRN functions as one of six expert groups of the Pan Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on emergency management and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its issue groups. EPRN is also accountable to the other five expert groups and task groups (exact number is variable) of the PHN through regular communications (i.e. sharing of records of decision and forward agendas), identification of cross-cutting issues and opportunities for cooperation, collaboration and
integration. Appendix A outlines the roles and responsibilities of the Co-chairs, members and secretariat in fulfilling these accountability requirements.

The EPRN shall work within the context of an EPRN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The EPRN strategic plan shall be updated by the EPRN every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

The EPRN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent reporting is required when requested by the PHN Council and/or during a public health emergency.

4.2 Authority

The EPRN has the authority to make decisions related to technical and operational issues in emergency management. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the appropriate PHN expert and task groups for approval by the Council for recommendation to the Conference of Deputy Ministers of Health.

The EPRN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related EPRN recommendations require PHN Council approval prior to their implementation.

4.3 Membership and Participation

Provincial/territorial jurisdictions designate the current members of the Special Task Force on Emergency Preparedness and Response as the lead officials. Health Canada’s (Public Health Agency of Canada’s) CEPR Executive Director is the designated federal government member. Membership also includes selected representatives from Emergency Social Services, Emergency Health Services and a medical officer of Health designated by the CPHN. The expert group will welcome as non-voting members representatives from the Communicable Disease Control Network, the Canadian Public Health Laboratory Network and the Public Health Surveillance and Information Network.

4.4 Leadership

The EPRN is co-chaired by one federal and one PT official. The federal Co-chair is the Public Health Agency of Canada’s Director General of CEPR. The P/T Co-chair is selected from one of the PT members.

The term of the P/T co-chair is for one year. The P/T co-chair is chosen from the P/T representatives and elected by consensus. The mandate of the P/T co-chair can be extended for one year upon agreement from the P/T membership.

4.5 Meetings, Quorum and Decisions

The Expert Group on Emergency Preparedness and Response will meet twice a year. The Expert Group will hold as many teleconferences as deemed necessary to deliver on its mandate and responsibilities. The Expert Group is deemed to be meeting in sufficient numbers to carry decisions when eleven jurisdictions are represented.

The National Forum on Emergency Preparedness and Response will take place once a year and will rotate its venue from one jurisdiction to another.

4.6 Changes to Terms of Reference

Changes to the Terms of Reference of the EPRN require approval by the PCPHN Council. The Terms of Reference will be reviewed at a minimum every 3 years.
5.0 Support

5.1 Secretariat

The Government of Canada, through the Public Health Agency of Canada's Centre for Emergency Preparedness and Response, provides the Secretariat for the EPRN.

The Secretariat is responsible for facilitating information sharing between the EPRN and other PHN components. It is also responsible for other duties assigned by the EPRN co-chairs. These may include the maintenance and sharing of information related public health resources available to participating members of the Network, such as resources available during a public health emergency. The Secretariat manager is a member of the Expert Group.

Records of Decisions of the meetings and teleconferences will be prepared by the Secretariat and circulated to the Expert Group members in a two week time frame.

5.2 Resourcing

The Secretariat shall be funded by PHAC until such time as permanent operational funds are established for the EPRN.

Date prepared: November 2004

Canadian Public Health Laboratories (CPHLN) Expert Group Preliminary Terms of Reference

1.0 Background

The Canadian Public Health Laboratory Network (CPHLN) was established in 2001 by provincial public health laboratory directors who recognized a void in inter-provincial communication and in communication with the National Microbiology Laboratory following the demise of the Technical Advisory Committee (TAC) in 1994. The establishment of the CPHLN was coincidental to the terrorism of September 11, 2001 and to the subsequent anthrax bioterrorism. In addition to addressing concerns regarding increased bioterrorism threats and potential lethality of bioterrorism agents, the scope of the Network was expanded to include other aspects of public health such as food and water safety in response to water quality problems in Walkerton, Ontario and North Battleford, Saskatchewan.

At present, the CPHLN is in the initial stages of its development and is currently determining how best to provide leadership in the development of a proactive network of public health laboratories that will serve to protect the health of Canadians. It is also considering how to positively influence and support the broader Canadian public health and health care renewal initiative. The Network's current mandate is to develop and implement strategies to:

- coordinate pathogen detection, infectious disease prevention and control;
- conduct laboratory-based surveillance including the development of early warning systems to monitor and detect emerging pathogens, antibiotic resistant organisms and outbreaks; and
- counter bioterrorist threats.

The benefits envisioned by the CPHLN include:

- a coordinated national laboratory response network;
- national standardization of laboratory procedures and quality assurance methods leading to greater consistency of results;
- expanded training available to Network participants regarding protocols, best practices and emerging technologies;
- enhanced national capability regarding the detection of emerging pathogens, antibiotic resistant organisms and outbreaks, and the prevention and control of infectious diseases;
- reduced duplication of effort; and
- enhanced support for laboratories through increased collaboration.
2.0 Mandate

As part of the proposed Pan Canadian Public Health Network, the purpose of the CPHLN is to provide strong leadership in communicable disease prevention and control through the development, recommendation, and approval of national policies, practices, guidelines and standards.

The mission of the CPHLN is to provide leadership in public health laboratory functions through the development of a proactive network of public health laboratories to protect the health of Canadians.

The vision of the CPHLN is to become an action-oriented national microbiology network providing value-added advice and services in direct support of the broader Public Health System.

The CPHLN’s guiding principles are:

- leadership;
- stewardship;
- partnership;
- integrated management;
- value of public health surveillance and early detection; and
- best practice.

3.0 Goals and Strategic Priorities

The following provides a graphical overview of the CPHLN strategic orientation. For more details concerning strategic priorities and strategic goals, refer to the CPHLN Strategic Plan:
4.0 Governance

4.1 Accountability

The CPHLN functions as one of six expert groups of the Pan Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on public health laboratory functions and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its issue groups, subsequently referred to as national committees. CPHLN is also accountable to the other five expert groups and task groups (exact number is variable) of the PHN through regular communications, identification of cross-cutting issues and opportunities for cooperation, collaboration and integration. The CPHLN will develop a set of roles and responsibilities for its members to be attached to these Terms of Reference as an Appendix.

The CPHLN shall work within the context of the CPHLN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The CPHLN strategic plan shall be updated by the CPHLN at least every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

The CPHLN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent reporting is required when requested by the PHN Council and/or during a public health emergency.

The CPHLN has the authority to make decisions related to technical and operational issues related to public health laboratory functions. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the appropriate PHN expert and task groups and the PHN Council.

The CPHLN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related CPHLN recommendations require PHN Council approval prior to their implementation.

4.2 Membership and Participation

The CPHLN shall be composed of no less than 13 and no more than 26 core members, including the chairs.

The Core Membership shall include the following:

- the Laboratory Director or designate of each Province or Territory that has a Public Health Laboratory, and where the province or territory has no provincial public health laboratory, the province or territory shall be represented by a member-at-large;
- the Scientific Director General or Designate of The National Microbiology Laboratory (NML) and three designates from the NML reference centres (Maximum four representatives);
- one representative from the Department of Defence Research and Development Canada;
- one representative from the Centre for Emergency Preparedness and Response, Ottawa;
- one representative from the Laboratory for Foodborne Zoonoses, Guelph;
- one representative from the Centre for Infectious Disease Prevention and Control, Ottawa; and
- one representative from the Council of Chief Medical Officers of Health.

Core members shall be appointed by their respective organization. In the event that a core member resigns during his or her term, a replacement for the balance of the term shall be appointed by the representative organization. Core members shall make a commitment to be actively involved in the work of the CPHLN, to make attendance at meetings a priority, and commit to furthering the objectives of the CPHLN as defined by the strategic plan. Core members shall arrange to have a designate to attend meetings in the event that they are unavailable to attend.

Due to the responsibilities of the CPHLN to contribute to the minimization of bioterrorism threats and to the health and safety of Canadians, all core members taking part in discussions...
pertaining to national security will be required to have Level II Secret Clearance. Where national security is not a topic of discussion, the participation in CPHLN discussions is open to members or their designates, who do not have Level II Secret Clearance.

Any designate who attends a CPHLN meeting in the place of a core member must have Level II Secret Clearance when discussions involve matters of national security. Non-CPHLN members are not permitted to attend CPHLN meetings except at the invitation of the Chair/Vice Chair and with appropriate consideration for security clearance requirements.

Loss of membership can occur by a vote by the CPHLN core membership where the consensus of the voting members results in a vote to revoke a particular membership. Reinstatement may occur following a formal written request and a subsequent consensus vote by the CPHLN membership.

Addition of new members can occur by a vote by the CPHLN core membership where the consensus of the voting members results in a vote to accept a new member that shall represent an additional organization. Only core membership shall have full voting status in all CPHLN voting processes.

Additional Members to the CPHLN are regarded as Associate CPHLN Members and they shall have no voting status in CPHLN voting processes. Associate Members shall be assigned to specific subcommittees or working groups of the CPHLN, and shall have voting status as is pertinent to the discussions and decisions of the given subcommittee or working group.

4.3 CPHLN Committees, Subcommittees, and Working Groups

The CPHLN shall create committees, subcommittees and working groups as required and subsequent to ratification by PHN Council, to address important public health laboratory issues.

Members to the above shall be nominated and approved by the CPHLN for a term of three years (renewable). Members to the above may also include representatives from associate membership.

Where a subcommittee member resigns during that term, a replacement for the balance of the term shall be appointed by the Subcommittee and approved by the CPHLN. All members of the above shall have voting status as is pertinent to the discussions and decisions of the given committee, subcommittee, or working group.

Committee, subcommittee, or working group members shall have laboratory expertise in the particular area of focus and shall represent federal, provincial, territorial or regional laboratories. All attempts shall be made to attain representation from each jurisdiction and geographic region.

4.4 Leadership

The CPHLN shall be chaired by one provincial/territorial CPHLN member in good standing. The term of the chair is two years. The vice-chair will automatically succeed the chair at the end of the two year term of the current chair.

The CPHLN shall have a vice-chair held by one P/T CPHLN member in good standing. CPHLN members shall appoint the new vice-chair for a term deemed necessary to succeed the position of chair. In the event that a chair should resign the vice-chair will assume the position of chair and the CPHLN will appoint a new vice-chair. In the event that a vice-chair should decline or resign the chair position, the CPHLN will appoint a new chair/vice-chair.

The chair or, in his/her absence, the vice-chair shall preside over CPHLN meetings. The chair and vice-chair shall participate as appropriate in conjunction with the Scientific Director General of the NML or his designate in the delivery of CPHLN submissions to the Council of Deputy Ministers of Health and/or other jurisdictional bodies with a bioterrorism response or public health mandate. The Chair, Vice Chair, Scientific Director General of the NML (or his designate), and the CPHLN Network Manager shall constitute the CPHLN Executive. The chair and vice-chair shall work closely with the Network Manager and, through the Secretariat staff to further the goals and objectives of the CPHLN according to the strategic plan.

The CPHLN Executive will be responsible for development of a budgeting process for the CPHLN
for approval and accountability by the core membership.

4.5 Meetings, Quorum and Decisions

The CPHLN shall hold semi-annual meetings to discuss and address business related to strategic priorities, goals, objectives and initiatives; current issues; communication flow; member relations; and funding and resource requirements, including annual budget and operating plans.

Quorum for meetings shall be attendance by a simple majority of members. Decisions shall be made by consensus where consensus is defined as general agreement, either verbal or by poll. When consensus cannot be reached, decisions shall be made by a simple majority of the members present. Each core member shall have one vote.

No decision by the CPHLN is legally binding in anyway as the CPHLN is not established as a legal entity. Records of Decisions will be recorded by the Secretariat and distributed to members. Agenda items should be forwarded to the Secretariat no later than two weeks prior to the meeting. The agenda and required material will be circulated in advance of the meeting.

4.6 Changes to CPHLN Terms of Reference

Minor amendments to the Terms of Reference may be made by the CPHLN Executive and is subject to ratification by the core membership at the next meeting of the CPHLN. The Terms of Reference may be amended at any meeting of the CPHLN by consensus or by vote.

5.0 Support

5.1 Secretariat

A dedicated Secretariat shall be established at the NML in Winnipeg, to administer and facilitate the work of the CPHLN. The Secretariat will consist of a Network Manager and key personnel which shall include a Scientific Information Officer, a Standards Development Officer and a Biosafety and BioSecurity Development Officer, and these positions shall report to the Network Manager.

Other staff may be hired as required to the Secretariat based on the advice of the Network Manager, endorsement by the CPHLN membership and availability of the required funds.

The Secretariat shall report to the CPHLN chair and be administered on a day-to-day basis by the Scientific Director General of the NML or his/her designate. The Secretariat will provide support to and participate in CPHLN meetings as required but will not function as a voting member of the CPHLN.

CPHLN meeting agendas shall be prepared by the Secretariat, in consultation with the chair, and issued at least one week prior to meetings. Records of Decisions of CPHLN meetings shall be prepared by the Secretariat and distributed to Network members, and other clients and partners as appropriate, within two weeks of the meeting date.

5.2 Resourcing

Funding for the CPHLN Secretariat shall be provided and administered by the NML until such time as permanent operational funds are established for the CPHLN.

Date prepared: November 2004
further collaborate public health responses that monitor health trends, identify emerging threats, support program planning, implementation and evaluation and identify research opportunities. The PHSIN will direct activities towards both generic and identified gaps in public health surveillance and information and coordinate implementation of recommendations approved by the PHN Council or Conference of Deputy Ministers of Health regarding:

- common principles and a pan-Canadian strategic framework to enable health surveillance activities to occur within secure networks;
- protocols for the ownership, analysis, integration and dissemination of information, including the protection of privacy;
- strengthening inter-sectoral and inter-jurisdictional collaboration by developing formal agreements that allow data and information sharing;
- developing and implementing national consensus standards for public health surveillance including case definitions, classification systems and data elements;
- development of human resource capacity for health surveillance;
- national capability and capacity regarding surveillance of current and emerging disease and pathogens; and
- establishment of public health research priorities.

3.0 Goals and Strategic Priorities

The goals and strategic priorities of the PHSIN include:

- establishment of the PHSIN and its supporting structure;
- review the terms of reference and mandates of the related Issue Groups;
- establish linkages with other Expert and Issue Groups related to Public Health Surveillance and Information Network that are not directly associated with the PHSIN;
- develop and implement, through the PHNC, an interjurisdictional agreement on Public Health information/data sharing; and
- establish its priorities and workplan for the coming 2 years.

4.0 Governance

4.1 Accountability

The PHSIN functions as one of six expert groups of the Pan Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on public health surveillance and information and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its two issue groups. PHSIN is also accountable to the other five expert groups and task groups (exact number is variable) of the PHN through regular communications (i.e. sharing of records of decisions and forward agendas), identification of cross-cutting issues and opportunities for cooperation, collaboration and integration. The PHSIN will develop a set of roles and responsibilities for its members to be attached to these Terms of Reference as an Appendix.

The PHSIN shall work within the context of a PHSIN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The PHSIN strategic plan shall be updated by the PHSIN at least every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

The PHSIN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent reporting is required when requested by the PHN Council and/or during a public health emergency.

4.2 Authority

The PHSIN has the authority to make decisions related to technical and operational issues in public health surveillance and information. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the
appropriate PHN expert and task groups for approval by the Council for recommendation to the Conference of Deputy Ministers of Health.

The PHSIN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related PHSIN recommendations require PHN Council approval prior to their implementation.

4.3 Membership and Participation

The PHSIN shall be composed of no less than 15 and no more than 26 core members, including the Chairs. The Core Memberships shall include the following:

• one representative from each Province and Territory;
• the Director General of the Center for Surveillance Coordination of the Public Health Agency of Canada;
• one representative from Health Canada;
• one representative from each of Health Canada Infoway, Statistics Canada, Canadian Institute for Health Information and the Canadian Institute for Health Research; and
• one Aboriginal representative.

Appointed members will serve for a term of two years. Nominating parties wishing to change their appointed representatives will do so by informing the Chairs of the Committee of their intention.

4.4 Leadership

The PHSIN will be co-chaired by the Public Health Agency of Canada representative and one provincial/territorial PHSIN member. The term of the chair is 2 years.

4.5 Meetings, Quorum and Decisions

Meetings will be held a minimum of 4 times per year. Additional meetings will be held as required. Records of Decisions will be recorded by the Secretariat and distributed to members. Quorum for Expert Group meetings shall be attendance by a simple majority of members.

Decisions shall be made by consensus where consensus is defined as general agreement, either verbal or by poll. In exceptional circumstances, when consensus cannot be reached, decisions shall be made by a 2/3 majority of the members present. Each member shall have one vote.

4.6 Changes to Terms of Reference

Amendments to the Terms of Reference may be made by the PHSIN and are subject to ratification by the Public Health Network Council.

5.0 Support

5.1 Secretariat

A Secretariat will be established by the Center of Surveillance Coordination of the Public Health Agency of Canada to initially support the work of the PHSIN, its Issue Groups and, where appropriate, task groups related to its mandate.

5.2 Resourcing

The Secretariat shall be funded by the Public Health Agency of Canada until such time as permanent operational funds are established for the PHSIN.

Date prepared: November 2004

Non-Communicable Disease and Injury Prevention and Control Network (NCDIPCN) Expert Group Preliminary Terms of Reference

1.0 Background

The Non-Communicable Disease and Injury Prevention and Control Network is a proposed new expert group of the Pan-Canadian Public Health Network.
2.0 Mandate

As part of the proposed Pan-Canadian Public Health Network, the purpose of the NCDIPCN is to provide strong leadership in non-communicable disease and injury prevention and control through the development, recommendation, and approval of national policies, practices, guidelines and standards.

Non-communicable disease and injury prevention and control activities in Canada focus on comprehensive population approaches involving policy/environmental changes in multiple settings. In many cases, prevention and control activities involve the primary health care system and the development of supportive government policies. The focus is on the primary, secondary and tertiary prevention of non-communicable diseases in populations at an increased risk of non-communicable diseases and injury, rather than on social determinants of health at a general population level. Successful non-communicable disease and injury prevention and control is achieved by:

- building the knowledge base;
- focusing prevention efforts on common risk factors;
- strengthening capacity;
- surveillance, monitoring and evaluation; and
- building and expanding partnerships.

The mandate of the NCDIPCN is to:

- ensure coherent, comprehensive and integrated approaches to the prevention and control of non-communicable diseases and injuries;
- advise the Council on strategic directions and priorities for non-communicable disease and injury prevention and control in Canada;
- improve the public health capacity to anticipate future non-communicable disease public health challenges;
- encourage process for developing, implementing, maintaining and updating standards, guidelines, and best practices in non-communicable disease and injury prevention and control and control;
- facilitate processes whereby applied research can best be translated into policies, programs and practice;
- work with existing issue groups, and when necessary, establish new issue groups and develop and formalize linkages across the Network to advance priorities and monitor progress, and
- implement decisions of the Council related to non-communicable disease and injury prevention and control.

3.0 Goals and Strategic Priorities

Strategic priorities and goals of the NCDIPCN include:

- creation of an operational framework for standardized public health practices, measures, and guidelines for non-communicable disease and injury prevention and control;
- providing direction and counsel to various NCDIPCN issue groups;
- input into human resource development related training in non-communicable disease and injury prevention and control;
- development of data sharing agreements and common standards for data related to non-communicable diseases and injuries amongst all levels of government;
- improve the timeliness, accuracy, completeness and facilitate the knowledge translation and dissemination of information on non-communicable diseases and injuries; and
- development of effective integration plans to address non-communicable disease and injury prevention and control.

4.0 Governance

4.1 Accountability

The NCDIPCN functions as one of six expert groups of the Pan Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on non-communicable disease prevention and control and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its initial groups. NCDIPCN is also accountable to the other five expert groups and task groups of the PHN through regular communications (i.e. sharing of records of decisions and forward agendas), identification of cross-cutting issues and opportunities for cooperation,
collaboration and integration. The NCDIPCN will develop a set of roles and responsibilities for its members to be attached to these Terms of Reference as an Appendix.

The NCDIPCN shall work within the context of a NCDIPCN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The NCDIPCN strategic plan shall be updated by the NCDIPCN at least every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

The NCDIPCN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent reporting is required when requested by the PHN Council and/or during a public health emergency.

The NCDIPCN has the authority to make decisions related to technical and operational issues in non-communicable disease and injury prevention and control. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the appropriate PHN expert and task groups for approval by the Council for recommendation to the Conference of Deputy Ministers of Health.

The NCDIPCN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related NCDIPCN recommendations require PHN Council approval prior to their implementation.

4.2 Membership and Participation

The Non-communicable Disease and Injury Prevention and Control Expert Group will be composed of no less than 14 and no more than 22 members, including the chairs:

- one representative from each participating P/T jurisdiction;
- one representative from the Centre for Non-communicable Disease Prevention and Control, Ottawa, (Public Health Agency of Canada);
- one representative from the Health Promotion Network;
- one representative from the Public Health Surveillance and Information Network;
- one representative from the Public Health Network Council;
- one representative from the Canadian Collaborating Centres on Injury Prevention and Control; and
- one representative from the Aboriginal community.

Appointed members will serve for a term of three years. Nominating parties wishing to change their appointed representatives will do so by informing the NCDIPCN Co-Chairs of their intention.

4.3 Leadership

The Expert Group will be co-chaired by one P/T member and the Public Health Agency of Canada's Director– General of the Centre for Chronic Disease Prevention and Control (CCDPC). The selection process for the P/T co-chair will be determined in the first year of the operation of the Network. The term of the rotating P/T co-chair is 2 years. With the consensus of the Council members, this term can be renewed.

4.4 Meetings, Quorum and Decisions

Meetings of the NCDIPCN will be held a minimum of four times per year. Additional meetings will be held as required.

Quorum for NCDIPCN meetings shall be attendance by a simple majority of members.

Decisions shall be made by consensus where consensus is defined as general agreement, either verbal or by poll. When consensus cannot be reached, decisions shall be made by a 2/3 majority of the members (present). Each member shall have one vote.

Non-NCDIPCN members are not permitted to attend NCDIPCN meetings except at the invitation of one of the co-Chairs. Matters requiring decisions may be raised at NCDIPCN meetings by any NCDIPCN member or representative.
Substantive matters requiring a decision by the NCDIPCN shall be raised by means of a written briefing note. Briefing notes shall describe the issue, the decision required and recommendations. Briefing notes and supporting documents shall be forwarded to NCDIPCN members one week in advance of the meeting date.

Each member, including the co-chairs, receives one vote. One authorized delegate may represent an absent voting member. Such delegates shall receive one vote.

Decisions shall be made by consensus of voting members where consensus is defined as general agreement, either verbal or by poll. When consensus cannot be reached, decisions shall be made by a two-thirds majority of voting members present.

4.5 Changes to Terms of Reference

Changes to the NCDIPCN Terms of Reference require approval by the Network Council. The Terms of Reference of the Council will be reviewed at a minimum every 2 years.

5.0 Support

5.1 Secretariat

A dedicated Secretariat shall be established at the PHAC’s Centre for Chronic Disease Prevention and Control (CCDPC) in Ottawa, to administer and facilitate the work of the NCDIPCN.

The Secretariat shall report to the NCDIPCN chairs and be administered on a day-to-day basis by the Director General of the CCDPC or his/her designate.

The Secretariat will provide support to and participate in NCDIPCN meetings as required but will not function as a voting member of the NCDIPCN.

NCDIPCN meeting agendas shall be prepared by the Secretariat, in consultation with the chair, and issued at least one week prior to meetings. Records of Decisions of NCDIPCN meetings shall be prepared by the Secretariat and distributed to Network members, and other clients and partners as appropriate, within two weeks of the meeting date.

5.2 Resourcing

The Secretariat shall be funded by PHAC and administered by CCDPC until such time as permanent operational funds are established for the NCDIPCN.

NCDIPCN expenses shall be borne by the Public Health Agency of Canada and paid in accordance with Treasury Board policies. Additional person(s) approved to attend meetings shall be responsible for their own travel and accommodation expenses.

Date prepared: November 2004
strategic directions and priorities for health promotion and population health; and
• develop linkages across the Network to advance priorities and monitor progress.

3.0 Goals and Strategic Priorities

Expected Scope (for consideration by Expert Group):

• although expected to focus more on upstream interventions, the scope represents a continuum of health issues, ranging from intersectoral collaboration to address the determinants of health to improving health promotion in health care settings;
• this will involve close collaboration with other Expert Groups, in particular: non-communicable disease and injury prevention and control, and communicable disease control;
• examples of breadth of issues of concern include:
  - developing skills, knowledge and capacity in health promotion and population health;
  - sharing best practices;
  - influencing health behaviours;
  - maintaining optimal health with illness;
  - improving access to services, e.g. community and health promotion programming and services; and
  - building community capacity to influence social and environmental conditions for health (urban planning, recreation, availability/access to healthy food, child development, social support networks etc.)

4.0 Governance

4.1 Accountability

The HPN functions as one of six expert groups of the Pan-Canadian Public Health Network. In this role, it is accountable to the PHN Council for fulfilling its mandate, including advice to PHN Council on communicable disease prevention and control and for acting on PHN Council decisions related to its mandate.

It is accountable for overseeing, linking and directing the work of its issue groups, subsequently referred to as national committees. HPN is also accountable to the other five expert groups and task groups (exact number is variable) of the PHN through regular communications (i.e. sharing of records of decisions and advance agenda), identification of cross-cutting issues and opportunities for cooperation, collaboration and integration. The HPN will develop a set of roles and responsibilities for its members to be attached to these Terms of Reference as an Appendix.

The HPN shall work within the context of a HPN strategic plan, which will contribute to the PHN strategic plan/Pan Canadian Public Health Strategy. The HPN strategic plan shall be updated by the HPN at least every two years and submitted to the Council of the Pan Canadian Public Health Network (PHN) for approval.

The HPN is required to report to the PHN Council at least twice per year to shape the regular PHN reports to the Conference of Deputy Ministers of Health: the mid-year report; and the annual PHN report and workplan, which is communicated to the FPT Ministers of Health. More frequent reporting is required when requested by the PHN Council and/or during a public health emergency.

• The HPN is accountable to the Public Health Network Council.
• The HPN will have authority to take decisions that promote convergence and collaboration on public health issues of mutual interest where participating members voluntarily agree to joint actions.

The HPN has the authority to make decisions related to technical and operational issues in health promotion. Any policy decisions – or other decisions (technical and operational) with related policy or resourcing implications – require consideration by the appropriate PHN expert and task groups for approval by the Council for recommendation to the Conference of Deputy Ministers of Health.

The HPN has the authority to advise and recommend to PHN Council on creating issue or task groups, defining and adjusting their mandates, and sunsetting them. Related HPN recommendations require PHN Council approval prior to their implementation. Appendix B provides a visual depiction of HPN, its issue groups and
relation to other PHN components. It also includes parameters related to HPN issue groups.

### 4.2 Membership and Participation

The Health Promotion Network will be composed of no less than 15 and no more than 26 core members, including the Chairs. The core members will include:

- one representative from each participating FPT jurisdiction;
- one Pan Canadian Public Health Network Council member;
- one representative from each of the following PCPH Network Expert Groups: non-communicable disease and injury; communicable disease control;
- representatives from appropriate non-government organizations, e.g. academic, voluntary sector, professional organizations, population groups; and
- representatives from other government organizations as appropriate.

Appointed members will serve for a term of 2 years. Nominating parties wishing to change their appointed representatives will do so by informing the Chairs of the Committee of their intention.

### 4.3 Leadership

The Expert Group will be co-chaired by one P/T member and the federal member. The selection process for the P/T co-chair will be determined in the first year of the operation of the Network. The term of the rotating P/T co-chair is 2 years. With the consensus of the Council members, this term can be renewed.

### 4.4 Meetings, Quorum and Decisions

Health Promotion Expert Group meetings will be held a minimum of 4 times per year. Additional meetings will be held as required. Minutes will be recorded by the Secretariat and distributed to members.

Quorum for Health Promotion Expert Group meetings shall be attendance by a simple majority of members.

Decisions shall be made by consensus where consensus is defined as general agreement, either verbal or by poll. When consensus cannot be reached, decisions shall be made by a 2/3 majority of the members (present). Each member shall have one vote.

### 4.5 Changes to Terms of Reference

Changes to the Health Promotion Expert Group Terms of Reference require approval by the Network Council. The Terms of Reference of the Council will be reviewed at a minimum every 2 years.

### 5.0 Support

#### 5.1 Secretariat

A dedicated Secretariat shall be established at the Public Health Agency of Canada to administer and facilitate the work of the HPN.

The Secretariat shall report to the HPN Co-chairs and be administered on a day-to-day basis by the PHAC HPN Co-chair or his /her designate. The Secretariat shall provide scientific, technical, policy and secretariat capacity and support for the HPN.

The Secretariat shall provide support to and participate in HPN meetings as required but will not function as a voting member of the HPN.

HPN meeting agendas shall be prepared by the Secretariat, in consultation with the Co-chairs, and issued one week prior to meetings.

The Secretariat shall record in the Records of Decisions of meetings all resolutions and voting results. Decisions resulting in action items shall be recorded as such for follow-up. Action items shall include designated accountabilities.

Records of Decisions of HPN meetings shall be prepared by the Secretariat and distributed to HPN members, other PHN secretariats, and other clients and partners as appropriate, within two weeks of the meeting date.
5.2 Resourcing

The Secretariat shall be funded by PHAC until such time as permanent operational funds are established for the HPN.

*Date prepared: November 2004*
Appendix E  
Strengthening Public Health Infrastructure Task Group – Highlights

The Special Task Force on Public Health was instructed to work with existing F/P/T bodies to complete its assignment. To that end, the Strengthening Public Health Infrastructure Task Group\(^1\) (Task Group) is playing an important role through its work on issues related to public health infrastructure.

Public health infrastructure is the “foundation” to the business of public health. Having adequate numbers and distribution of qualified public health personnel, sufficient laboratory, surveillance and emergency response capacities are necessary for the timely identification, detection and control of emerging and re-emerging infectious diseases.

As of February 2005, the Task Group has made progress towards an action plan to address the full range of public health system infrastructure issues. A strong and robust infrastructure is essential and necessary to support the operation and performance of the public health system’s functions.

Working closely with the F/P/T Special Task Force on Public Health, and with the Joint Committee on Health Human Resources and following extensive consultations with members of existing networks (i.e., Emergency Preparedness and Response Network, Communicable Disease Control Network, Canadian Public Health Laboratories Network, the Canadian Public Health Association) the Task Group also commissioned studies of public health workforce capacities and benchmarks in the UK, USA and Australia. From this work, the Task Group

---

\(^1\) The Task Group on Strengthening Public Health Infrastructure Task Group (Task Group) is a working group of the Advisory Committee on Population Health and Health Security (ACPHHS). Created in the fall of 2003, its mandate is to build on recommendations from the report of the National Advisory Committee on SARS and Public Health (Naylor Report), as well as other pertinent reports, to address infrastructure gaps where F/P/T collaboration would be of benefit.
has assessed and developed recommendations for the following four priority areas for system infrastructure development:

- **Sufficient and Competent Workforce**;
- **Organizational Capacity**:
  - Public Health Network and Expert groups;
  - Public Health Strategies and Goals;
  - Agreements and Protocols;
  - Public Health Legislation;
  - Emergency Response and Surge Capacity; and
  - Public Communication and Citizen Engagement;
- **Information and Knowledge Systems**:
  - Information, Surveillance, and Infostructure; and
  - Knowledge Development and Translation;
- **Cross-cutting issues**:
  - Public Health Laboratories;
  - Aboriginal Health;
  - Collaborating Centres for Public Health; and
  - System Resources.

The Task Group’s progress report provides a high level summary of the phasing-in of system development, recommends further study where needed, and scopes out the size of the investment that is required over the next 10 years.

To succeed, the Task Group has noted that its advice will need to make their way into the work plans of public health system leaders and have their implementation tracked in a systematic and transparent fashion. To that end, building and maintaining system infrastructure should be an ongoing responsibility and supported by a number of key players and structures (e.g., P/T public health organizations/the Public Health Agency of Canada, provincial/territorial Chief Public Health Officers/ the CPHO of the federal Agency, and by the Pan-Canadian Public Health Network). Improved system governance and transparency of decision-making, in addition to actual measurement of system performance should make the fulfillment of this responsibility a reality.
Appendix F
F/P/T Ministers of Health
Communiqué – September 2003

Annual Conference of Federal-Provincial-Territorial Ministers of Health

Public Health Elements

The federal, provincial and territorial Ministers of Health agreed today to continue to make public health a top priority by improving public health infrastructure and increasing institutional, provincial, territorial and federal capacity that builds on current strengths and successes across the country.

The Ministers agreed to collaborate on the development of an enhanced public health system and have asked officials to return later this fall with an update that would include progress on:

- clarification of roles and responsibilities for preventing and responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions;
- creation of a national network of centres of public health science;
- strengthened public health human resources, including the need for more robust regional and national public health emergency response capacity, and
- enhanced national surveillance and information infrastructure.
Appendix G
First Ministers’ Communiqués – The Public Health Network

Council of the Federation
Niagara-on-the-Lake, Ontario – July 30, 2004 (excerpt)

Protecting Canadians and Their Communities

Confirming the need for a strong and coordinated national system for emergency management and public safety, Premiers agreed to a framework for interprovincial/territorial emergency management mutual aid. The framework is based on a well established agreement between Quebec and the Atlantic provinces and six New England states. In recent years, teams from neighbouring jurisdictions have responded to emergencies including floods, forest fires, hurricanes and ice storms.

Building on this type of cooperation, the Premiers’ framework establishes procedures for governments to call upon each other for assistance during public emergencies, and ensures that emergency responders from a neighbouring province or territory are treated the same way for legal and licensing purposes as emergency responders in the province or territory which made the request. Premiers directed their Ministers responsible for Emergency Measures to take the next steps in implementing the framework.

To ensure that cooperation on emergency management and public safety takes place among all governments, Premiers also directed their Ministers to work with the federal government to:

- develop a coordinated strategy for emergency response and readiness for Canada, respecting provincial and territorial laws and plans already in place, and initiate a joint strategic review of emergency management to identify gaps and priorities;
- strengthen the Disaster Financial Assistance Arrangements to prevent downloading by the federal government of costs related to disaster recovery and establish a new program to provide
substantial financial assistance for disasters such as the SARS outbreak and the BSE crisis;
• renew the federal commitment to emergency management training; and
• develop a Canada-wide system for emergency public alerting.

Premiers Hamm and Doer will provide a progress report on Ministers’ actions at the next meeting of the Council of the Federation.

First Ministers Meeting – “A 10-Year Plan to Strengthen Health Care”
Ottawa, Ontario – September 16, 2004 (excerpt)

Public Health Network Elements

First Ministers recognize the progress that has been made by all jurisdictions to strengthen Canada’s public health system, including the creation of the new Public Health Agency of Canada. All governments commit to further collaboration and cooperation in developing coordinated responses to infectious disease outbreaks and other public health emergencies through the new Public Health Network.
Appendix H
Terms of Reference – F/P/T Special Task Force on Public Health

Background

At their September 2003 meeting, F/P/T Ministers of Health:

- recognized the need to act, individually and together, to improve public health infrastructure and capacity at the local, provincial and territorial, and federal levels;
- agreed to collaborate on the development of an enhanced public health capacity and have asked officials to return later this Fall with an update, which includes:
  - clarified roles and responsibilities for preventing and responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions;
  - the creation of a national network of centres of public health science;
  - strategies and approaches to strengthen public health human resources including the need for more robust regional and national public health emergency response capacity; and,
  - enhancement of national surveillance and information infrastructure.

Purpose

To conduct the reviews mandated by F/P/T Ministers of Health to improve public health infrastructure and capacity at the local, provincial and territorial, and federal levels.

To task bodies with the appropriate expertise (e.g., ACPHHS) to undertake the work necessary to ensure that the F/P/T Ministers’ decision is carried out.
Role and Function of the Special Task Force

The Special Task Force will fast track the reviews, and develop recommendations for an action plan for Ministers’ consideration. A preliminary report containing early findings and recommendations should be available for presentation to F/P/T DMs in early January 2004. The activities and reporting from the Task Force will be conducted in a parallel fashion, so that recommendations can be approved and implemented while the review proceeds to completion.

The Special Task Force will provide overall oversight to ensure there is a coordinated and strategic approach to improving public health infrastructure and capacity. Various existing F/P/T mechanisms will assist the Special Task Force including ACPHHS (taking advantage of the expertise of its Strengthening Public Health System Infrastructure Task Group), the F/P/T Emergency Preparedness and Response (EPR) Network, the Council of Chief Medical Office of Health (CCMOH) and others as appropriate. The Special Task Force’s coordination role will encompass work already underway by these existing bodies.

The Special Task Force will strive to incorporate the recommendations of federal, provincial and territorial reports on public health as appropriate.

The Special Task Force will discuss the proposed work plan at their first meeting. It will work with ACPHHS co-chairs (or their representatives) to develop a work plan that avoids overlap with work currently underway and, at the same time, enables the Special Task Force to ensure that the overall objectives for public health infrastructure and capacity are being met.

Nominating Process

F/P/T DMs will nominate members of the Task Force by responding to a letter from the Conference of F/P/T DMs co-chairs that will be used to circulate these Terms of Reference to P/Ts. The responses will be circulated through the F/P/T Health Support Committee.

Task Force Structure

Reporting: To the Conference of F/P/T Deputy Ministers of Health.

Co-Chairs: Canada, British Columbia

Membership: F/P/T DMs will nominate members drawing on expertise in public health (such as infectious disease control, public health laboratories, chronic disease and disease outbreak surveillance and epidemiology) and emergency preparedness in their jurisdiction as appropriate.

Liaison will also be established with related P/T and federal authorities as appropriate to conduct the reviews and develop recommendations (including how the health sector relates to other sectors and F/P/T interfaces with other authorities).

The co-chairs of ACPHHS, of the Strengthening Public Health System Infrastructure Task Group and the chair of CCMOH will also be members. The co-chairs of the EPR Network may be invited to attend if appropriate.

While strongly encouraged, membership by all jurisdictions is not mandatory.
**Timelines/Critical Path**

Note: As recommendations are developed, there will be provisions for Deputies to approve and implement as necessary.

**November-December 2003**

Establish Task Force. Initial work to develop work plan, gather information, develop preliminary findings

**Early 2004**

Update on progress of the Special Task Force to the Conference of F/P/T Deputy Ministers of Health

- directions from DMs to implement recommendations, as applicable

**April 2004**

Interim report to the Conference of F/P/T Deputy Ministers of Health.

- directions from DMs to implement recommendations, as applicable

**June 2004**

Final report to the Conference of F/P/T Deputy Ministers of Health including: clarification of roles and responsibilities and action plan with timelines and recommendations of the Task Force.

**September 2004**

Final Report to be forwarded to the Conference of F/P/T Ministers of Health

Approved at the November 20, 2003 teleconference of F/P/T Deputy Ministers of Health.

F/P/T Deputy Ministers also agreed to a two-phase approach for the work of the Task Force:

**In Phase One**

That the Task Force would focus on developing principles / characteristics / attributes for:

- public health lab network;
- public health human resource capacity; and
- surveillance and infrastructure requirements;

and in doing so, clarify roles and responsibilities in public health, particularly across these three areas. The Task Force would also engage in an early dialogue on a definition of a Canadian Public Health Agency.

**In Phase Two**

That the Task Force build on phase one initiatives and develop a broader collaborative public health strategy to include infectious and non-infectious issues, and define a model for an agency.
Appendix I
Members – F/P/T Special Task Force on Public Health

Co-Chairs

Dr. Perry Kendall
Provincial Health Officer,
Ministry of Health Planning, British Columbia

Ian Shugart
Senior Assistant Deputy Minister,
Health Policy Branch,
Health Canada

Members

Dr. Nicholas Bayliss
Provincial Health Officer,
Alberta Health and Wellness

Dr. Ross Findlater
Chief Medical Health Officer,
Saskatchewan Health

Marcia Thomson
Assistant Deputy Minister, Health Programs,
Manitoba Health

Dr. Sheela Basrur
Chief Medical Officer of Health &
Assistant Deputy Minister,
Ministry of Health and Long-Term Care, Ontario

Mary Kardos-Burton
Co-Chair, Advisory Committee on
Population Health and Health Security,
Assistant Deputy Minister,
Community Health Division,
Ministry of Health and Long-Term Care, Ontario

Dr. Alain Poirier
Directeur national de santé publique et sous-ministre adjoint,
Direction générale de la santé publique,
Ministère de la Santé et des Services sociaux,
Québec
Dr. Wayne McDonald  
*Chief Medical Officer of Health,  
Department of Health & Wellness, New Brunswick*

Dr. Lamont Sweet  
*Chief Health Officer,  
Department of Health & Social Services, Prince Edward Island*

Dr. Jeff Scott  
*Provincial Medical Officer of Health,  
Department of Health, Nova Scotia*

Dr. Sam Ratnam  
*Director Public Health Laboratory, Newfoundland & Labrador*

Dr. André Corriveau  
*Chief Medical Officer of Health & Assistant Deputy Minister, Population Health & Clinical Services, Department of Health & Social Services, Northwest Territories*

Colleen Hemsley  
*A/Communicable Disease Officer,  
Health & Social Services, Yukon*

Wayne Govereau  
*Executive Director of Population Health,  
Health and Social Services, Nunavut*

Scott Broughton  
*Co-Chair, Advisory Committee on Population Health and Health Security, Special Advisory to the Deputy Minister, Health Canada*

Dr. David Mowat  
*Co-Chair, Strengthening Public Health Infrastructure Task Group, Director General, Public Health Agency of Canada*

**Alternate Members**

Dr. Joel Kettner  
*Chief Medical Officer of Health, Manitoba Health*

Dr. Karim Kurji  
*Associate Chief Medical Officer of Health, Ministry of Health and Long-Term Care, Ontario*

Marg Rappolt  
*Associate Deputy Minister, Ministry of Health and Long-Term Care, Ontario*

Dr. Horacio Arruda  
*Direction générale de la santé publique, Ministère de la Santé et des Services sociaux, Québec*