

# **PUBLIC HEALTH RENEWAL IN ALBERTA**

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**A report of the October 1, 2008 Think Tank**

**October 14, 2008**



## **ACKNOWLEDGEMENTS**

The 2008 APHA Public Health Renewal in Alberta Think Tank would not have been possible without the support, vision, and dedication of many individuals. Of particular note:

The APHA Public Health Renewal in Alberta Think Tank Planning Committee (list alphabetical)

Chair, Dr. Louis Hugo Francescutti  
Ms. Janice Blair  
Ms. Maya Charlebois  
Ms. Cathy Gladwin  
Ms. Joy Jaipaul  
Mr. Ken Kyle  
Ms. Mary McIntyre  
Dr. Candace Nykiforuk  
Ms. Karoline Philipp  
Ms. Cynthia Smith  
Ms. Sharon Yanicki

The Public Health Renewal in Alberta Think Tank Speakers and Panelists

Mr. Les Hagen  
Dr. Paul Hasselback  
Dr. Trevor Hancock  
Dr. Malcolm King  
Dr. Brent Moloughney  
Ms. Alison Nelson  
Dr. Tom Noseworthy  
Dr. Gerry Predy  
Dr. Ardene Vollman

A special thank you to Rose Martial, a Chipewyan/Dëne Suliné from Cold Lake First Nation who honored us with an opening prayer and her participation.

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The Public Health Agency of Canada  
The Royal College of Physicians and Surgeons of Canada  
And our other supporters

## INTRODUCTION

On May 15, 2008, the Alberta Government announced the transition to having one provincial board responsible for health service delivery in the province of Alberta. With the ongoing re-organization of Alberta's health system, Alberta is presented with a window of opportunity to strengthen public health and by so doing once again demonstrate leadership in securing the future prosperity, health, and well-being of our people.

Public health, defined as the organized efforts of society to keep people healthy and prevent injury, illness and premature death, can be a great enabler, helping to secure the environments and circumstances wherein people have the freedom to lead lives they have reason to value.

We live in a society where for the first time, this generation of children and youth are projected to live shorter lives than their parents. The cost of treating illness and disease continues to increase (comprising roughly 1/3 of the 2008 provincial budget, more than double any other sector) while increasing staff shortages and an aging workforce and population stress our system's present and future. Additionally, research suggests that up to half of current deaths are preventable. Clearly things are not as they should be, nor as they could be. What is the answer?

On October 1<sup>st</sup>, 2008 over 140 persons from across the province gathered in Edmonton to participate in the Alberta Public Health Association's Public Health Renewal think tank. In attendance were:

- members of Alberta's Legislative Assembly
- faculty members from many of Alberta's colleges and universities
- representatives from federal and provincial government
- representatives from Alberta Health Services and the many health regions throughout the province, and
- representatives from Alberta's non-profit and business sectors

Attendees listened to and engaged in discussion with a number of speakers and panelists, and participated in a facilitated dialogue to gather and prioritize recommendations to guide and strengthen public health through this renewal process.

This report presents a summary of the suggested actions resulting from the day's deliberations and additional submissions received online, and will be presented to government October 14<sup>th</sup>, 2008.

Following the presentation of Public Health Renewal in Alberta to government, the Alberta Public Health Association will be monitoring progress on the suggested actions and issuing periodic updates on the status of public health renewal in Alberta.

APHA is proud to have led this process and we look forward to continued input into the public health renewal process.

## **RECOMMENDATIONS**

Input from attendees was distilled into a list of nineteen recommendations grouped into the following categories:

- 1) the organization and structure of public health
- 2) the role of the Chief Medical Officer of Health
- 3) defining the value of public health
- 4) increasing the profile and presentation of public health
- 5) human resource planning
- 6) education and research
- 7) sustainability
- 8) inter-sectoral action to address the determinants of health

### **1) THE ORGANIZATION AND STRUCTURE OF PUBLIC HEALTH**

Recommendation #1.1 – Alberta Health Services (AHS) create a separate division of public health within its structure, led by a Vice President of Public Health or equivalent to represent the interests of public health at the AHS Executive level.

Recommendation #1.2 – Alberta Health Services keep the six core functions of public health (health promotion, health protection, disease and injury prevention, health assessment, disease surveillance, and emergency preparedness) together within its organizational structure as the mandate of the division of public health (see Recommendation #1.1).

Recommendation #1.3 - Alberta Health Services, Alberta Health & Wellness (AHW), APHA, and other interested stakeholders create a provincial advisory committee external to government with representation from the cross-section of public health disciplines and sectors, the AHS Board, AHW (the public health ADM), and the Chief Medical Officer of Health.

Recommendation #1.4 – Alberta Health Services and Alberta Health & Wellness, in consultation and collaboration with a provincial advisory committee, develop a means to balance the provincial coordination and leadership of Alberta's system for public health with the need for local autonomy and representation in decision making regarding public health priorities, service delivery, and resource allocation.

## **2) THE ROLE OF THE CHIEF MEDICAL OFFICER OF HEALTH**

Recommendation #2.1 – Alberta Health & Wellness reinforce the independence and autonomy of the office of the Chief Medical Officer of Health (CMOH) by having the CMOH report directly to the legislative assembly.

Recommendation #2.2 – The Chief Medical Officer of Health be seen as the voice for public health and provide an annual report to Albertans including a focus on the social determinants of health, achievement of health goals for Alberta, Aboriginal health status, and the application of an inequities lens to improve population health in Alberta.

## **3) DEFINING THE VALUE OF PUBLIC HEALTH**

Recommendation #3.1 – Alberta Health Services, Alberta Health & Wellness, the Alberta Public Health Association, and other stakeholders develop the business case for increasing investment in public health in Alberta to at least the equivalent of funding the full ounce of prevention (one ounce of prevention = 6%, therefore funding the full ounce of prevention is equivalent to funding public health with 6% of the health care budget) utilizing a strategy focusing on consistent core funding as opposed to short-term project funding cycles.

Recommendation #3.2 – Alberta Health Services and Alberta Health & Wellness invest in infrastructure development for health assessment and disease surveillance, to enable the monitoring and reporting of health status and public health program and policy effectiveness.

## **4) INCREASING THE PROFILE AND PRESENTATION OF PUBLIC HEALTH**

Recommendation #4.1 – Alberta Health Services and Alberta Health & Wellness develop and implement a communications strategy to keep the public health workforce and general public informed regarding the public health renewal and health care reorganization process.

Recommendation #4.2 – The Alberta Public Health Association lead, with other stakeholders and in liaison with Alberta Health Services and Alberta Health & Wellness, the development of a strategy to increase the visibility and build public understanding and support of, and demand for, public health's services (linked with Recommendation 3.1).

## **5) HUMAN RESOURCE PLANNING**

Recommendation #5.1 – Alberta Health Services, Alberta Health & Wellness, and Alberta’s colleges and universities develop a training and recruitment strategy to ensure sufficient numbers of public health professionals are entering the workforce.

Recommendation #5.2 – Alberta Health Services, Alberta Health & Wellness, Alberta’s colleges and universities, and other stakeholders develop a continuing education strategy which funds and supports increased training in public health competencies and skills for the public health workforce.

## **6) EDUCATION AND RESEARCH**

Recommendation #6.1 – Alberta Health Services, Alberta Health & Wellness, and other stakeholders work to achieve sustainable funding required for a unified cross-Alberta approach to public health education and research in Alberta.

Recommendation #6.2 – Alberta Health Services, Alberta Health & Wellness, Alberta’s colleges and universities, and other stakeholders facilitate community based research partnerships for the application of research expertise to local and community priorities and situations.

## **7) SUSTAINABILITY**

Recommendation #7.1 - Alberta Health Services and Alberta Health & Wellness, in consultation and collaboration with a provincial advisory committee, develop a strategy for Alberta’s public health and health care systems which focuses on these system’s viability and sustainability in the face of increasing external challenges (i.e. food security, fuel security, economic security, etc).

## **8) INTER-SECTORAL ACTION TO ADDRESS THE DETERMINANTS OF HEALTH**

Recommendation #8.1 – Alberta Health & Wellness adopt a health impact assessment framework and process for reviewing existing and new public policy and legislation in Alberta.

Recommendation #8.2 – Alberta Health & Wellness support inter-ministerial and inter-sectoral action to address the determinants of health.

Recommendation #8.3 – Alberta Health & Wellness provide leadership within the provincial government and health system to apply an inequities lens to improve population health and to support and advise on action related to the social determinants of health.

Recommendation #8.4 - Alberta Health & Wellness, Aboriginal Relations, and other ministries work with Alberta's treaty organizations, Aboriginal nations, the federal government, and other interested organizations to (1) clarify jurisdictional and accountability issues related to health and wellness, (2) develop and fund a provincial healing and wellness strategy, (3) strengthen Aboriginal disease surveillance and reporting systems, and (4) develop an Aboriginal Human Resource Planning strategy to increase opportunities for Aboriginal workers within our health and wellness system.

## **APPENDIX A - SUGGESTED ACTIONS FROM THE FACILITATED DIALOGUE**

### GREEN CARD SUGGESTIONS (Top two from each table)

- We suggest a couple independent voices be established to raise the profile of public health
  - This includes a key lead for public health in AHS
  - CMOH has independence (not tied to ministerial policy) and is supported by sufficiently resourced secretariat
- The mandate and infrastructure of the CMOH support would include health assessment of policies of other ministries eg education, agriculture, environment, etc
- CMOH clear authority and resources to speak for health of Alberta
  - Do annual report to legislature
  - Public face of public health
- Address social determinants
  - Poverty, education
  - Youth is a resource
- Establish an interministerial commitment to public health by having public health component in each of their portfolios and every government policy decision
  - Must consider the impact on public health
- CMOH is independent and has a long term mandate irrespective of government. CMOH reports to legislature and communicates to public freely. CMOH maintains open communication with minister of health and the premier
- Articulating the value and benefits of public health from a variety of perspectives eg economic, environmental, social
- Public health awareness
  - Advocacy, public perception, recruitment, of full range of public health eg functions and practitioners, self-help and self-care, decrease barriers between programs
- Strategically framing and documenting and promoting public health to the public
- Data is like manure, it works best when it is spread around
- Marg/Aslam develop a process for wide stakeholder participation in recruitment of the CMOH to build a transparent and trustworthy culture
- Put a public face on public health
  - Communication regular, honest, simple, informative
- Establish a ph system has long term goals and strategies
  - Accountable to the public
- CMOH reports regularly
- How should public health be structured within AHS?
  - A separate public health division

- Keep all six core functions together
  - Keep some local autonomy
- The Plan – AHW, AHS
  - Within 3 months or less
  - Broad government of Alberta endorsement
  - Champion eg premier
- We suggest the immediate creation of a provincial advisory committee to exist outside of government consisting of about 15 representatives from front-line practitioners, members of marginalized populations, reps from various sectors to give advice and insight to AHS and AHW on public health issues
- Focus on broad determinants of health vs just personal health practices
- Environmental scan of current public health structures, programs, services throughout province to determine best/promising practices to inform the development of new ph structure and services
- Require the use of health impact assessments for all government policies and programs
- We suggest that AHW place a priority on revisiting previous reports and consultations in order to clearly articulate a vision and values for prevention and quality of life that will resonate and be embraced by every Albertan
- APHA initiate a mobilization campaign that reflects a number of key messages
  - Prevention is underresourced 3%
  - Sustainable, multi-year funding is essential for primary prevention
  - Take action on the social and environmental factors that affect our health
- Define a change management strategy, including roles and responsibilities and then communicate ASAP
- Motivating the public, health care workers and government re: the value of health in the broadest sense
- Integration of first nations and vulnerable populations into public renewal planning
- We suggest that the CMOH add an inequities lens to the regular report to the Minister on the health status of the population
- Reduce the poverty gap through social and income support programs and policies
- Strategically framing, documenting and promoting public health to the public – humanize public health
- Make healthy choice the easy choice
- Allow people to understand ph value through all perspectives
- We suggest that an intersectoral entity ie premier’s council be struck to focus on reviewing, articulating, and making recommendations related to the SDOH
- Review in government

- Cross ministry collaboration, public health act and regulations, look at legislation and regulation overlaps redundancy silos, set 10-20 priorities for 10-20 years, health impact assess for leg and gov policy/programs
- AHW (Marg/Raj) develop a cross ministry model built on the SDOH to promote health and achieve a coordinated response through program and policies that improve and maintain health of Albertans
- We suggest that AHW develop a business case to address funding and resources for public health – example: explore directing a % of funding from AHFMR to public health, institute of health economics to conduct consensus conference on public health
- We suggest that the Ab Gov fund an initiative that develops strategies for investing and developing the community leadership competencies that will ensure a holistic approach to strengthening communities
- Consistent core funding for public health functions minimum 6% of health budget
- Two billion dollar endowment for public health – additional to 6% operation
- Creating new roles within public health to work with communities and individuals (CHRs, health promoters, relationship-builders)
- The same core activities in the RHA Act be identified in the AHS Act to ensure the public health mandate continues
- The AHS structure should include a chief operating officer for public health
- AHSB forms a Board committee on public health chaired by a Board member – CMOH is a member of the committee
- AHS develop a multidisciplinary public health integration team as well as having a public health representative as part of the current integration teams ie IT, seniors, HR, etc
- Better marketing of public health – we need to do a better job of communicating and sharing our messages

TABLE A

- Government/public health needs to design framework for “health and wellness” not just acute – spiritual, emotional, mental, etc
- Framing public health in the media
- Document the value (in concrete ways) of public health in environmental, social, economic, medical/health
- Make public health tools/services readily available/accessible/understood by blatantly showing cause and effect of decisions/situations (i.e. healthy lifestyles)
- Prevention is 1<sup>st</sup> step in management
- Erase “them” and “us” as two entities – one us
- Public health needs to be more proactive

- Public health needs to not only have people (politicians, public, etc) come to them for information/discussion sessions, public health needs to go to THEM (these groups) to promote health as well
- Roles and responsibilities need to be clearly defined by government and public health

TABLE B

- CMOH report to legislature
- Tools around public advocacy
- Build on success
- Learn from tobacco control
- Common public health goals and then core functions
- Public reporting
- Annual reporting
- Consider the observatory model
- BC model looks promising (lenses)
- Define system-based priorities
- Need to continue with community input
- Centralized expertise required (AHW or AHS)?
- Separate public health practice from political ideology
  - Independence of CMOH office
  - Informed by evidence and experience of practitioners
- Legislation (public health) should set boundaries for public health practice
  - Accountability to legislature rather than CMOH
- Define what is in AHS vs AHW (i.e. medical, legal expertise)
- Health impact assessment – independent of government
- Health advocate similar to children’s advocate
  - Make recommendations to government
- Look at Ontario Public Health Agency as a model
- Develop a public health plan and resource appropriately
- Tools at local level (i.e. communication tools, budgeting across sectors, governance, IT)
- Annual report to legislature
- Training and education - front line
- One school of public health
- Change management plan required for entire systems change
- Public face of CMOH
- Help public make informed choices
- Speak to population health strategy rather than individual responsibility

TABLE C

- We suggest that a public health lead (AHW + AHS) work with CMOH and be responsible for moving the public health framework to action

- Need for more than one champion
- Hire secretariat support
- Concern about external consultant – creates report – report is cherry picked for information
- What's the pragmatic approach to ensure public health is a valued part of the health system
- Go to your champion with clarity of vision for the province – how do you get there
- Can't rely on politician (or 1 person) to be your champion
- Prov MOH must be champion
- Need someone internal to the system – that knows it well
- Many options – some within ministry, some provincial, some regional/local depending on what you want to achieve
- We suggest that the CMOH is the public face of public health
- We suggest that there is secretariat support/sufficient resources for the CMOH
- We suggest that the CMOH has an independent voice (not tied to ministry policy)
- We suggest that there is a VP of public health at the senior management table at AHS
- We suggest that AHW and AHS develop a communications strategy immediately to let Albertans know about the health reform process (which includes public health) and its potential impacts
- We suggest that AHW makes public the role and vision for public health in Alberta
- We suggest that AHW develop a business case to address funding and resources for public health
- We suggest exploring directing a percentage of the AHFMR to public health
- We suggest that AHW engage the Institute of Health Economics to conduct a consensus development conference on public health (funding to come from Ministry of Health)

TABLE D

- see demonstrated public acknowledgement (appt of CMOH)
- build an office; supports for CMOH role
- ½ ounce of prevention to 1 ounce of prevention
- Need for clarity around public health – roles and funding and staffing and strategies and evidence. It should be developed as a package. Can make these more explicit with the two distinct bodies.
- Structurally, cannot be too big, or too small. Consider critical mass related to the local delivery of services.
- Need complement of expertise at the local level

- Need local entities, autonomy, be able to interpret local needs, within a larger provincial structure
- Strong role (provincial) for surveillance, data, evidence
- Need centralized repository nationally for health information/research – evidence for public health programs
- Require that research is applied to local research needs. Local staff need to have the skills to do this with experts available to help
- Meeting needs of existing public health staff, mid career, and meeting up to expectations/competencies. Provide supports to develop needed skill sets in staff. School of public health as large role here. Make education/training accessible. New students and older staff.
- Put public policy through a health lens. Assess how these policies developed by other sectors impact health
- Conduct environmental scan of current public health structures and practices
- Need to keep distinct rural and urban needs and approaches in mind when planning
- Strengthen the voice of the APHA – increase membership
- Explicitly communicate the core functions of public health – what they mean, who is responsible
- Share public health documents so other ministries and businesses can use in their own planning
- Lofty provincial goals – inter-ministerial planning – address SDOH

TABLE E

- We need broader focus on SDOH – our focus must be moved away from total focus on health services especially for acute care/illness model and emergencies
- Outside walls of traditional health service public policy needs long term commitment to SDOH (i.e. equal access wait times were messages to public re rational for health system reorganization)
- We need to create business cases – put dollar value to – so politicians and government employees, public can understand why it is important to focus on SDOH. Social marketing plans need good planning to avoid pitfalls (legal concerns)
- U of A Student, giving courses on building business case
- Build in more transparency with AHW decisions
- Key need to give government planners some “wins”
- AH Board on is scripted not discussion even between board members
- Workers (healthcare) need core training a little more in depth (i.e. promote PHAC courses to allow similar baseline education)
- Revisit public health act to include SDOH (i.e. public health act in Quebec) - authority over health of population

- Our public health is very focused on regulatory issues so not broad enough
- Include population health goals in the gov (AHW) in report card
- Report publicly that we are or not meeting these goals
- Set population health goals/strategies and budget for work to achieve goals
- We are trying to focus on health promotion but all are tied of short term funding (e.g. now funding is only available for kids in the justice system instead of on preventing kids from getting into justice)
- We need more money to implement basic programs
- Can we better fund preschool development and support families so we don't end up with kids dropping out of school/crime
- We are not enforcing basic safety issues due to political climate
- The OH should no be responsible to Minister –report to Legislature
- Need mechanism to let public know issues
- CMOH need to report Legislature to health of population and be able to communicate freely with public on health issues. Alternatively, maybe more acceptable, CMOH report to minister through legislature and report to legislature
  - If CMOH is independent (with long term mandate not politically determined) but communicates clearly and early (before going public) to minister
- Establish Inter-ministry action plans to SDOH. Need overarching influential decision makers at table. Budget (business cases) brought forward including finance. Cross sectoral agenda for population health each ministry should have accountability for goals contributing to population health to the Premier eg health impact of their dept policies – how are each ministry contributing to improvements in health

#### TABLE F

- We suggest that AHW fund the 6 core functions of public health in an appropriate and sustainable manner (less project funding) to prevent a sporadic, reactive, band-aid approach that reduces knowledge transfer and impetus for change
- We suggest that AHW place a priority on revisiting previous reports and consultations to clearly articulate the vision and values for prevention and quality of life that will resonate and be embraced by every Albertan
- We suggest that an intersectoral entity i.e. Premiers council – be struck to focus on reviewing, articulating, and making recommendations related to the social determinants of health
- We suggest that APHA initiate a mobilization campaign that reflects a number of key messages
  - Prevention is under-resourced – currently 3%
  - Sustainable, multi-year funding is required for primary prevention

- Take action on the social and environmental factors that affect our health
- We suggest that the AB Gov fund an initiative that develops strategies for investing and developing community leadership competencies (ie planning using a community development approach, developing collaborations and partnerships, advocating quality of life, facilitating change, etc) that will ensure a holistic approach to strengthening communities

#### TABLE G

- Marg/Aslam develop a process for wide stakeholder participation in the recruitment of the CMOH to have a transparent process and build trust for the skills of incumbent in the position
- Aslam/Pam Whitnack should ensure that public health is a full partner in the overall health services review and design of future delivery system to address lack of current participation and decision regarding what constitutes public health in the new structure
- AHW (Marg/Raj) develop a cross ministry model built on the SDOH to promote health and achieve a coordinated response through program and policies that improve and maintain health of Albertans
- Aslam develop a systematic approach for the provision of public health services using aspects of other successful models to help clarify role of public health as part of the AHS structure with needed resourcing by November 1, 2008
- APHA be actively involved with and develop and publish an annual status report on the implementation and progress to members, AHW, AHS, and to the public.
- APHA become a vehicle for gathering ideas and perspectives and providing input to the restructuring to provide a conduit for individuals working within the system (advocating for membership) and the public
- APHA do quarterly surveys of their members regarding the implementation and public renewal and report back to AHW/AHS
- AHS (Pam W, Chris E, Paddy) ensure that public health representative be part of the current integration teams (IT, Seniors, HR, Lab)
- AHS develop a multidisciplinary public health integration team

#### TABLE H

- Transparency
- Provincial advisory committee (about 15 people)
- Need balance with local levels
- We suggest that AHW and AHS create a provincial advisory committee
  - To exist outside of government
  - Consisting of front line practitioners, members of marginalized populations

- Reps from various sectors
- To give advice and insight to AHS and AHW on public health issues
- We suggest that the AHS Board have representation and engagement of public health practitioners for community, practice issues, healthy environment for staff
- More open dialogue on health of public with more opportunity for input from practitioners
- Incentive for acute care to work with public health so that dollars would flow to public health as savings are realized in acute care, particularly at the rural level
- Funding model needs to have new money at least for the immediate future to decrease disease and injury
- Need a method of dividing the province or keeping the province divided into small enough areas so that segments are still able to be identified
- At the local level public health needs to be integrated within itself so it can be integrated within the larger health system
- Public health within AHS needs to be a separate division
- Keep core functions – all 6 – together
- Public health needs dedicated increased funding – ½ ounce versus full ounce
- Clear leadership now – with decision making occurring at the appropriate level

TABLE I

- Strong trained and educated workforce, developing core competencies for public health
- Training for employees, developing core competencies for public health and training in that more educational opportunities in various means (online, voice, etc) and mandatory and relevant public health opportunities for education
- Outlined education opportunities – more dialogue on content of preceptorships, faculty and practicum placement, funding/resources to permit efficient/effective
- Public accountability – speaking to legislature (MOH), public figure for public to relate to and recognize, report card (public), process and content component of reporting, ability to speak in advocacy, increased openness in front of public leading to increased ownership
- Communication – multiple message, plain language, info in various languages, meet expectations of public's expression of needs (vulnerable populations), look at adding other languages to health warnings and messages, time to listen to public's needs, consistent messaging, resource funding to meet time and resource needs of public
- Government/health sector communication – intersectoral forum, all ministries incorporated, educating all ministries on SDOH and how they fit

in that picture, Sweden model (incorporating all departments), get on agendas for other departments

- Good public ideas – government proactively seeking public consultation, community health committees, open forums, building community mobilization, regular basis for consultations, follow-up to consultation
- Integration of public health into all areas of SDOH, health impact assessment
- Measurement and reporting tools – look at quality and not only quantity, measuring behavior change, within program design incorporating measurement expectations, accountability all the way through a program not just at the end, tools meeting needs of reporting and reporting reflecting work being done, new tools and accurate tools, developing tools to measure SDOH at a population level
- Funding – sustainable funding, don't ask public health workers to do more without further and sustainable funding (ie HPV program roll-out), why fund quick fix funding
- Awareness of other aspects leading to increased health (ie sport, rec, environment), support and encouragement, collaboration provincially, connecting other elements and aspects of health (i.e. built environment concern, green space allocation, safety concerns)
- Require health impact assessment for every government policy and program (new and existing)
- Consistent core funding for public health functions to % of total health budget
- Reduce poverty gap through social and income support programs and policies

#### TABLE J

- we suggest that the CMOH add an inequities lens to the regular report to the Minister on the health status of the population
- we suggest that AHS dedicate staff resources to the public health renewal process for an integrated system
- we suggest that AHS and AHW, as well as local organizations and professionals, strive for transparency and strong communication regarding public health
- better marketing of public health – do a better job of communicating and sharing our messages and building demand for public health/prevention
- strong surveillance system to inform public health action

#### TABLE K

- a provincial group (BC Example) that plans and strategizes around issues that affect health and across public health functions

- an arms length health council (advisory group) that is non-political to maintain the priority public health functions over the longer term (multi-sectoral) consistency to complement the internal structure of public health
- evaluation to inform decision making around the core functions
- a CMOH model on an auditor general reporting to the legislature
- processes that allow for long term planning
- what are the consequences of future energy/resource constraints and what are the potential actions to deal with the impacts
- commit and carry through with public health reform informed by what has gone on in BC and NS and identify champions in AB to make this reform happen
- build on reforms from other jurisdictions and be informed by previous reports
- commitment from decision makers to undertake and follow through the reformation process following the consultation exercise
- urban design reform to support more active transportation incentives for public health
- putting more emphasis on early childhood education and development to improve results in the future
- a serious effort to reduce child poverty
- social marketing to promote healthy eating and active lifestyles to combat the marketing of goods and lifestyles that are unhealthy
- improve surveillance to understand what the issues are
- healthy public policy throughout government (healthy lens)
- sustainable core public health functions with long term goals and strategies

#### TABLE L

- central data repository, integrated info systems province wide
- common messages/resources across province
- central programming
- clearinghouse of information/knowledge/research findings so that knowledge exchange is improved
  - need good management of this information for use by practitioners, include a good process for sharing/retrieving/implementing knowledge
- joint appointments across ministries
- direct link between CMOH and CEO (AHS/AHW)
- facilitate a whole-of-government approach to new policy-making (eg including health impact assessment of all policy)
- policies and supportive environments to enable people to make the positive lifestyle choices
- ensure that an equity lens is applied to all policy decisions in addition to health impact assessment

- minister needs to indicate what health goals for Alberta are – provided an acceptable process for determining those goals is in place
- place a person on equal level with Aslam and Paddy for public health (a CEO for public health)
- immediately fund a pan-Alberta tripartite proposal for education and research
- plan for action on workforce retention
- structure needs to be communicated quickly, effectively – improve transparency in process for determining what public health organization will look like
- the same core activities in the RHA Act be identified in the AHS Act to ensure the public health mandate continues

TABLE M

- set direction in head office and set have it locally
- location of management matters – regional and local level
- could lose a lot of gains
- need to describe what we value and want to keep – get AHS preserving the gains made since 1995 regionalization
- have a government that engages in public debate and not facilitation – want leadership
- ensure local priorities are identified and acted on. Community health councils are “toothless wonders”
- need regional governance with a provincial responsibility as well
- visibility local, can still be provincial
- run the show with people with provincial responsibilities
  - macro level policy AHW
  - micro level policy community
- public health has to get traction that is exists with the AHSB
- data collection system needed o enhance surveillance
- issues in health – political culture confuses the executive wise in developing policy
- august meeting had a great process – a report needs to be released to generate public discussion and foster trust
- AHSB need to have a weekly communication – get out in front of the public even if it is to share what discussions are underway
- Bring knowledgeable people together to identify the problems and generate solutions and act on them
- We need an ear for the collective voice
- The AHSB must be a health board, not an illness board. The vision must reflect this – patient centered does not
- The AHSB could form a board committee public health chaired by a board member
  - Education, understanding, nucleus for thought

- The CMOH would sit at the right hand of the Chair
- The committee would be intrinsic to the Board itself
- Need to make a compelling case to increase the budget for public health – it will not be a transfer of existing budgets, but a portion of new dollars need to have a public health budget – enveloped funding from AHW, a public health information system
- Hold CMOH and CEO AHSB to account to achieve health status indicators eg decrease rate of low birth weight babies CEO will be responsible 2 years from now will have.....(hold the CEO accountable) eg what % of girls @ K would get which vaccinations
- Choose prominent indicators that are measurable and have a broad impact over a 3 year cycle eg high school dropouts, boil water advisory
- Tie people's jobs and their continuity to performance indicators

#### TABLE N

- Government of AB make public health a #1 priority now!
- Minister makes sure that a structure to make sure there's a public health plan (starting now)
- Governments need to put a public health lens on any government policy being developed (ie rules for new urban development)
- All agencies to more intersectoral communication among all agencies and departments
- Government policy to provide more health impact studies on any/all new programs
- Individuals need to take more personal responsibility for their own health
- To find evidence based success stories that increase personal individuals responsibilities actions on their own health
- All groups need to make more decision based on evidence
- All groups need to exploit the fact that municipal governments have the closest, fastest response to citizen needs
- Need to educate the public on the real meaning of primary care – that its not physician centered
- Need to make public health awareness and support for public health
- Public health needs to give away many things we do to other groups – spread the knowledge
- Governments need to ensure that all plans involve/take into account the highest level, middle management, front line workers, clients – and ensure that a systematic process is always used
- Re workforce – there is a need to retain the people we have and bring new trained people into the system
- Government needs to understand and show that it actually cares about social determinants of health and social justice

#### TABLE O

- Evidence informed decision making (Hamilton and Bhatti)
- Thinking outside the box
- Developing cultural competency
- Recognizing multi views of health and wellness
- Creating interdisciplinary pre professional (medicine, nursing), educational opportunities on common approaches and health issues (eg addictions, mental health, screening)
- Relationship and community building – social support – creating connections
- Best practice understanding (efficient outcomes vs what works in communities)
- Integration of seniors and children (intergenerational)
- Recognize process – valuing alternative health beliefs, previous experiences
- Clear jurisdictional issues (roles, responsibilities, functions)
- Increase community health centres and integration with primary care
- Create new positions within public health to work with individuals and communities (eg CHRs, health promoters, relationship-builders)
- Focusing on wellness and quality of life
- Developing motivational forces for the public, health care workers and government re the value of health in the broadest sense

TABLE P

- Use a health impact assessment for any legislation in Alberta
- Stronger public health advocacy from public, NGOs
- Increased education/teaching – wellness of whole person – nutrition, return to traditional foods
- Address social determinants, poverty, education – healthy meals for school kids
- More attention to mental health/addiction
- Look at circular structure instead of hierarchical structure – everyone is informed/involved
- Better communication overall
- Cross ministry collaboration – has trickle down effect at local level
- Celebrate – be proud of services – look at local level for guidance
- Make sure public health is in government's strategic plan (eg September 2007)
- CMOH – clear authority and resources to speak for health of Albertans
- Review public health act and regulations
  - Consider enforcement provisions (AB is less regulated)
- Equity – health for all
- Look at leg and reg overlap – eliminate redundancy and silos
- Set 10-20 core priorities to address over next decade/2 decades

- Need for selflessness
- Investment in research and communicate on research (not proprietary)
- Focus on/involve youth – ask them
- Public health workforce – policy for recruitment, education seats
- Build public awareness of full range of public health (eg not just public health nurse) – also to stakeholders
- Build reporting structure to make sure communication flows in all direction
- Raise taxes to look after the economic inequity eg Scandinavian countries
- Look at incentives for active transport (dept of transportation should consider this)
- Increased health promotion
- Kids can walk to school
- School disparity – funding for special programs
  - Balance choice and excellent programs