



March 29, 2004

The Honourable Carolyn Bennett, P.C., M.P.
Minister of State for Public Health
Brooke Claxton Building
Tunney's Pasture
Ottawa, Ontario
K1A 0K9

Dear Minister Bennett:

As President of the Canadian Chiropractic Association I am writing in response to your open letter to Canadians concerning a new approach to public health in Canada which has a posted deadline of 29 Mar 2004.¹ In the response I will also be covering the issues raised in your earlier letter *Strengthening the Pan-Canadian Public Health System*.²

When I first read the article *Public Health Agency to exist in a 'virtual' sense for now* in the Hill Times I was pleased to read your comment:

At the same time I'm interested in looking at public health much broader than infectious diseases. We have... a real opportunity to collaborate on those things but also to do some of the things that Health Canada's been doing around obesity, diabetes, smoking... we need to make serious inroads on those...³

When Drs. Keenan and Tucker reported back on their meeting of 10 Mar 2004 with your Senior Policy Advisor, Mr. Rob White, we read your above letters with new hope that we, as a profession, could become more present on the national stage. Before I answer your specific questions I would like to explain why I think our profession could and should be more active in assisting the

¹ <http://www.hc-sc.gc.ca/english/pha/index.html>.

² <http://www.hc-sc.gc.ca/english/pha/strengthening.html>.

³ Bennett, Carolyn, Public Health Minister. Health Section. *The Hills Times*, Monday, February 2 – February 8, 2004, Policy Briefing 29.

The CANADIAN CHIROPRACTIC ASSOCIATION
ASSOCIATION CHIOPRATIQUE CANADIENNE
1396 Eglinton Avenue W., Toronto, Ontario M6C 2E4
Tel: (416) 781-5656 • Fax: (416) 781-0923
E-mail: ccachiro@ccachiro.org • www.ccachiro.org

federal government and its agencies in protecting and improving the health of Canadians. I would also like to address broad introductory issues under the headings:

- **Our Role with Patients** wherein I outline our special skills and the significance of neuromusculoskeletal disorders on the health of Canadians,
- **Obesity, diabetes, smoking, inactive living** wherein I underline the importance of these issues, and the need for a change in the way that they are being met,
- **The Challenge to Canada's leadership** wherein I emphasize the need for a paradigm shift in health policy and suggest that we echo Senator Kirby⁴ in his recommendation that we employ our health providers more effectively.

Thereafter, I will respond directly to each of your questions.

Our Role with Patients

Doctors of chiropractic have a strong background in anatomy and in the neuromusculoskeletal systems, so much so that we have a very large and growing number of Canadians who depend on us to provide professional and effective advice on how to lead healthier lives, to get back to work earlier, to provide effective treatment for debilitating spinal joint dysfunction, and to help them return to full and pain free functioning after experiencing spinal injury or problems. There are 6,700 doctors of chiropractic in Canada. We treat 4.5 million patients⁵ each year but we know that this is a conservative estimate of the actual number we treat over a longer period because many of our patients come in response to a particular health episode but may not return for several years until there is another episode. We are the third most frequently consulted health care practitioners in Canada after physicians and dentists.⁶

While we do more than treat bad backs, we certainly are known as back pain specialists. And back pain is a significant problem in Canada. Statistics Canada reports that approximately 80% of Canadians will experience back pain at some point in their lives⁷ while Health Canada estimates musculoskeletal disorders, including back pain, cost society \$16.4 billion in combined direct and indirect

⁴ The Health of Canadians – The Federal Role: Interim Report Volume Four – Issues and Options , The Standing Senate Committee on Social Affairs, Science and Technology *Chair: The Honourable Michael J.L. Kirby Deputy Chair: The Honourable Marjory LeBreton*, September 2001.

⁵ Miller W. Use of Alternative Health Care Practitioners by Canadians. *Canadian Journal of Public Health* 1997; 88(3): 154-58.

⁶ Canadian Institutes for Health Information. (2001). Seeking Care. *Canada's Health Care Providers*, page 11. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_35_E

⁷ Statistics Canada. Statistical report on the health of Canadians, 1998. Statistics Canada. National population health survey, 1996-97.

costs.⁸ In a recent survey that The CCA commissioned we learned that $\frac{2}{3}$ of adults report experiencing back pain in the past year and that 88 % of Canadians rate back pain as a 'very' or somewhat important health issues.⁹

Obesity, diabetes, smoking, inactive living

The chiropractic profession is very concerned about these ubiquitous health problems. Indeed every health professional should be very concerned because they have such a terrible impact on so many Canadians. One cannot escape the daily reminders in the media about the effects of these lifestyle choices on Canadians' health but they are most clearly addressed in the CIHI report that was distributed 25 February 2004:

Among the major health problems facing Canadians over the next 10 to 20 years will continue to be heart disease, cancer, mental health problems, AIDS, asthma, obesity and diabetes. These problems are related to our diet, exercise, substance-use patterns and other health behaviours.¹⁰

Later, in that same report there is one particular arresting vision statement which is derived from a First Nation, Inuit and Métis health forum held in June 2002. This forum agreed that a health system be based on

a paradigm shift from an illness-based model to one that is population-based and stresses prevention and individual decision-making and responsibility for health.¹¹

We are in an important position and well trained to effectively counsel millions of Canadians about these ubiquitous health problems. We can see the obvious health effects and know the consequences of these poor life style decisions. Moreover we are in contact on a 'hands-on' basis with our patients, sometimes for brief intense periods when they are most susceptible to suggestions about changing life threatening habits and patterns. Of course we do this as a matter of course, but how much more effective would we be if all care providers and the government of Canada agreed to support one another in dealing with these challenges. There are a wonderful variety of ways we could implement this including:

- Producing joint statements and public service documents
- Developing joint research across disciplines
- Jointly engaging the public in resolving these issues

⁸ Policy Research Division, Strategic Policy Directorate, Population and Public Health Branch. Economic Burden of Illness in Canada 1998.

⁹ [http://www.ccachiro.org/client/cca/cca.nsf/object/Back+Pain/\\$file/5360+back+pain.pdf](http://www.ccachiro.org/client/cca/cca.nsf/object/Back+Pain/$file/5360+back+pain.pdf)

¹⁰ Canadian Institutes for Health Information. (2004). Not all Canadians enjoy good health. *Improving the Health of Canadians*, page 6.

¹¹ Canadian Institute for Health Information. (2004). Not all Canadians enjoy good health. *Improving the Health of Canadians*, page 96.

- Ensuring that messaging to the public is endorsed by all of us and appears in jointly produced documents (printed, website etc)
- adopting a posture of cooperation between us all with the intent of marginalizing the notion of competition between the health care professions and the levels of government

We agree with the concept of a paradigm shift; but we see it as a necessary shift for the entire system for all Canadians.

The Challenge to Canada's leadership

The federal government has shown an ever-expanding interest in revising its role in Canada's health care system while Canadians are increasingly concerned about the kinds of health care they have been getting and the efficiency of its delivery. Governments at every level sense that they must make an effort to expand services and use resources better than they have been doing. In the Kirby Report prevention of illness and promotion of healthy lifestyles in a co-operative approach is being recommended as the major solution to curing a health care system that cannot continue to be funded, structured or managed as it has been. Kirby also states "We need to move away from the current hierarchal approach to one that enables the full range of abilities of each type of professional to be used."¹² In our submission to the Kirby Senate Committee we stated that there was an urgent need

to provide flexibility of patient choice . . . realigning public resources to recognize and support existing but under funded health care interventions. . . ensuring that the most appropriate and cost-effective care is provided to patients based on quality outcome and patient satisfaction measures as supported by research.¹³

So the challenges are many and multitudinous. While your office has a mandate for prevention as opposed to the broader issue of healthcare, it is quite difficult to separate prevention from care.

Letter from the Minister - Question Sets

¹² The Health of Canadians – The Federal Role: Interim Report Volume Four – Issues and Options , The Standing Senate Committee on Social Affairs, Science and Technology *Chair: The Honourable Michael J.L. Kirby Deputy Chair: The Honourable Marjory LeBreton*, September 2001.

¹³

<http://www.ccachiro.org/client/cca/cca.nsf/web/Presentation+to+the+Standing+Senate+Committee+on+Social+Affairs!OpenDocument>

Below I will go directly to the text of your letter and embed my responses to your questions section by section. The questions are underlined and in italics.

Question Set 1 CO-OPERATION BETWEEN GOVERNMENTS ON PUBLIC HEALTH

What are the challenges in achieving greater collaboration in public health where responsibility for public health is shared by all governments?

I believe that the challenges mimic those that require federal/provincial/territorial co-operation in all spheres such as fisheries, natural resources, health and finance. All carry the requirement to strive for greater collaboration. Each governmental entity is responsible to its own constituency and so tailors its strategic thinking and its messaging to that audience. There are many differences, some based on differing demographics, some based on traditional competition, and some based on quite different regional histories and economic profiles. In jurisdictional squabbles the leadership needs to constantly remind itself that the individual Canadian is the customer or the patient. Unfortunately it is often the case that a regional government can exploit traditional enmities such as suspicion of the West of the Ontario power center or the generations-old tension between Upper and Lower Canada in order to gain credibility. Therefore this is not just a challenge for public health. It is also a challenge for Intergovernmental Affairs.

Somehow, in the debates surrounding our health system we fail to acknowledge the importance of the patient who really should be in the driver's seat. It is important to maintain and indeed improve access to services but it is also important to bring responsibility for making health decisions home to individual Canadians.

Thus the problem of co-operation is a problem that must be addressed by several ministries simultaneously. Of course, the public health agenda must compete with other agendas for attention. But health is widely important. I would like to point out that there is an intimate connection between our health and our economy. SARS for example had a dramatic negative effect on our economy while the costs are legion requiring billions to address. It is notable that Mad Cow Disease is actually a potential health threat to humans and has not directly caused any Canadians to be ill. At the same time more pedestrian threats to health have lead to diabetes, heart disease, cirrhosis, joint dysfunction and a host of environmentally related disorders which are just beginning to be explored.

The main challenge is to situate this problem in such a way that it does not inspire competition among regions but rather sets it in the context of a group problem, which we all share, which we will all work together to solve.

How should federal/provincial/territorial governments co-operate in this area?

Given that we argue for a paradigm shift in health policy, naturally we support the idea that we need to devise new strategies to forge agreement. These strategies have certain principles implicit in them if there is any hope for collaborative action.

There needs to be a mechanism to separate the activities of the Agency from the activities of the political leadership. Otherwise the Agency's activity will be subject to more forces than it can contend with. In the case of the recent SARS outbreak there was a degree of confusion about the lines of authority and communication.

If there is to be co-operation there must actually be collaborative development. In other words a well-designed, well-funded agency would be severely hampered unless the stakeholders sense that there was a process of development and implementation which valued and acknowledged their contribution from the early stages and continuously thereafter.

This is at odds with the role of a Chief Public Health Officer if that officer must be concerned about competing jurisdictions. The CPHO needs to be able to move quickly across jurisdictions in order to meet any threat to public health. How then can jurisdictions maintain their autonomy?

Clearly, there needs to be a buffering protocol such as a joint committee or cross jurisdictional, cross-disciplinary advisory/policy-making body which provides the broad framework within which the CPHO will act. Such a group would meet regularly, yearly or twice yearly such as most professional or business organizations do in order to formulate policy and review the events of the past period. Between those times the CPHO is free to execute the business of the office at arms length from the advisory/policy-making body and the legislatures of the federal/provincial/territorial governments. This group could be struck as the Board of Governors for the Health Agency but given that it ought to represent federal/provincial/territorial governments and all the regulated health professions¹⁴ it would need to be a substantial group.

¹⁴ Regulation varies from province to province in that a group may be regulated in one province and not in another. Chiropractic is regulated in every province but other groups are regulated only in some. In such cases we recommend that regulation in any province accords national recognition to such a profession so that it can be represented thoroughly to the Agency.

Are there "gaps" in Canada's existing public health system that could be addressed through the collaborative approach described above? If so, what are the priority areas where this approach should be contemplated?

There are two types of gaps in Canada's existing public health system that could be addressed through the collaborative approach described above: The first is the communications gap between jurisdictions. The policy-making, cross-jurisdictional Board would provide the communications links which are missing.

The second gap is a deplorable gap in communications between the regulated health professions. Because provinces regulate these, they are variously represented federally, if at all. In our own chiropractic profession we are determined to ensure that Canadians get the best care possible from the most appropriate provider. We are delighted that so many medical doctors refer to us and come to us as patients but there are still far too few connections between our professions. And patients suffer thereby. Clearly, having all regulated health professions involved would provide the necessary crucible to form a whole systems¹⁵ approach to health care.

We believe that priority areas begin with public health risk factors for the young. Obesity is an epidemic affecting millions of Canadians. "Obesity is a widespread problem in Canada with important public health implications. The World Health Organization (WHO) has recognized the rise in obesity rates as a worldwide epidemic requiring immediate action."¹⁶ Addressing it soon must be given a very high priority. Tobacco use is also a striking priority for young persons. If we could halt our youth from joining the ranks of smokers, in due course tobacco use would cease to be an issue. Thereafter we see increasing readiness to deal with health threats followed closely by the need to reduce public health risk factors for the whole population including those neuromusculoskeletal factors.

Is there merit in seeking to build a process of citizen/stakeholder engagement into future intergovernmental arrangements in area of public health? If so, how should it be structured?

Implicit in the structure above is the representative citizen/stakeholder engagement through various jurisdictions who each have their own means to engage the public. All ministries, departments and regulated health organizations already have their communications processes in place. Adding yet

¹⁵ Verhoff, MJ, Whole Systems Research: Towards an integrative approach. A seminar presented to the School of Pharmacy Studies, University of Toronto, 19 March 2004.

¹⁶ Canadian Institutes for Health Information. (2004). *Improving the Health of Canadians*, page 107.

another process at the federal level could actually tend to dilute the efforts of intergovernmental arrangements since direct citizen/stakeholder input would cut across this process. Below, in response to the final question, I will argue that citizen/stakeholder consultation should occur at the regional level with representatives of the Agencies Board of Governors and their support staff members.

Question Set 2 DEFINING A PRECISE MANDATE AND MISSION FOR THE CANADIAN PUBLIC HEALTH AGENCY

What should the new agency's priorities be in terms of issues, target populations, programs, health protection and promotion, improving public health capacity and reducing public health risk factors?

The new agency should first target those issues which affect our youth such as obesity, tobacco use, drug use and health threats. Then these same targets should be broadened out to the whole population.

Then there is need to address and ameliorate the effects of poverty on all who feel its affects. "This connection seems relatively simple: the more comfortable and better off you are, the healthier you are likely to be and the longer you are likely to live."¹⁷

In our view the best way to accomplish both these is to actually give Canadians more choice in health care. To give more choice we need to remove barriers to access, e.g. A person who requires a chiropractic adjustment may be too poor to pay for it, consequently that person would have to either suffer the disability or rely on a treatment which could be less appropriate, less effective, more intrusive and more costly. Moreover, and this is the unjust and inefficient part, they might be forced to have a treatment they do not want.

We believe that improving public health capacity and reducing public health risk factors would be dramatically impacted by the kind of co-operation we envisage between the political leadership and the professions.

At its most basic level this kind of co-operation leads to the development of wonderful and innovative multidisciplinary settings such as Anishnawbe, a clinic which is something of an urban sanctuary to the Aboriginal community in downtown Toronto. Anishnawbe is staffed by a manager, 14 'medicine people' (elders and traditional healers), a chiropodist, six chiropractors (the clinician in a charge along with five interns), two community outreach nurses, five medical

¹⁷ Canadian Institutes for Health Information. (2004). *Improving the Health of Canadians*, page 23.

doctors, five naturopaths, a nurse practitioner, elders and helpers, a senior nurse, a traditional assistant and three traditional counsellors.¹⁸

At its most sophisticated level interdisciplinary collaboration has led to a number of joint research initiatives between the profession and the Canadian Institutes for Health Research. Chief among these is the appointment of two chiropractic research chairs, Dr. Greg Kawchuk DC PhD at the University of Calgary and Dr. Mark Erwin DC PhD at the University of Toronto. Details of these appointments and other research activities are found in our most recent Research Bulletin.¹⁹

What criteria should be used to determine the mandate and functions of the new agency?

One criterion should be need, especially for those populations most dependent on an enlightened leadership such as the youth, the aged and the poor. The issues we have referred to above are the kinds which demand attention.

A second criterion is urgency. What are the health threats which will cause damage quickly? Urgency is not simple because it is tempered by the spread of the problem. How many are or how many could be affected by the threat or problem?

A third is cost-effectiveness. Can we forecast that an intervention can have a beneficial outcome and is therefore worthy of an investment? For this the agency should be prepared to have some very thorough research take place. In chiropractic, health care economist Dr. Pran Manga of the University of Ottawa has demonstrated that increased use of chiropractic care could save millions in Ontario alone.²⁰ In obesity for example there are no clear single solutions but rather a whole spate of them including issues around advertising to children, junk food in school cafeterias, labeling foods, time spent with TV and video games, exercise programs in schools, active living promotion activities and the like. These issues need a close evaluation in order to see which strategies could be effective and which ones are not. Many current strategies, food guides, promotions, health curricula in schools are obviously not working as well as they should.²¹

¹⁸ Canadian Memorial Chiropractic College. (Winter 2000). External Clinics Feature. A Haven for Healing. *Primary Contact*. pp. 8, 9 & 19.

¹⁹ [http://www.ccachiro.org/client/cca/cca.nsf/object/Committee+Update+B8/\\$file/Bull8.pdf](http://www.ccachiro.org/client/cca/cca.nsf/object/Committee+Update+B8/$file/Bull8.pdf)

²⁰ <http://www.chiropractic.on.ca/Main.html>

²¹ It is ironic and striking that health planners feel that by having health courses in schools school children will stop smoking, stop drinking Coke, eat more vegetables etc. Many children pay no attention whatsoever to health advice given in the curricula. Some teachers suggest that these approaches to behavioural change are naïve and ineffective.

A fourth criterion is value. For example enhancing the vaccination/immunization program for all children across Canada is a high priority, high value item. I must point out that while our profession does not have vaccination in its scope of practice, we recognize its value for our children and support public policy in this area as you can see from the link to our position statement found on the CCA website.²²

What contribution can/should the Chief Public Health Officer for Canada make in relation to advancing Canada's interests in international organizations like the World Health Organization or the Pan-American Health Organization?

Broadly speaking the Chief Public Health Officer is responsible for Canada's state of public health. Nonetheless the CPHO needs to co-ordinate activity and share information with International organizations especially in regards to public health threats.

In terms of employing health professionals throughout the world this might be best done in co-operation with other authorities and organizations in Canada through a secondment process where Canadian experts would receive temporary assignments for specific missions. Information sharing to determine 'best practices' is very important. This can be done, at least in part, through working with organizations and conferences that already exist. Part sponsorship of international conferences on public health or sponsoring and international stream to national conferences can quickly and efficiently generate a comprehensive store of data on public health issues.

Question set 3 ENSURING THAT THE FEDERAL PUBLIC HEALTH AGENCY REMAINS ACCOUNTABLE TO CITIZENS

What types of structures would best link the agency to these various kinds of groups, in the interest of transparency and accountability?

If the agency were to adopt the Board of Governors style structure suggested above, transparency would be assured in the same way that it is assured in parliament, by open proceedings which may be recorded and observed. All groups may link either through their provincial jurisdiction or for national groups through the agencies communications secretariat. Additionally, the agency may establish working committees made up of consumer groups, health experts and experts in communications.

In order to enhance co-operation, federal/provincial/ territorial ministries could jointly sponsor regional hearings and committees when such hearings are required to explore a specific issue.

²² <http://www.ccachiro.org/client/cca/cca.nsf/web/Vaccination+and+Immunization?OpenDocument>

**On what specific matters should the agency report regularly to Canadians?
How regularly? In what kind of report?**

There could be two kinds of reports, the annual report and the special report.

The Annual Report

The first annual report needs to establish the datum for reports to follow. In all those areas that concern public health such as obesity, tobacco use, response to threat and immunization. This datum can be ascertained, at least in part by the published work of the CIHI. Then targets or at least directions can be indicated and reported on in subsequent reports.

The annual report should also deal with progress in reducing inefficiencies in public health through collaborative efforts between the jurisdictions and the professions. There is much to be done with these as you have suggested in your text, *Kill or Cure*²³. Dr. Michael Rachlis echoes this claim in his recent book *Prescription for Excellence*:

... doctors are working in an increasingly inefficient structure. Even if the numbers of doctors doubled, unless we were to change the structure in which they work, Canadians would still have inadequate access.²⁴

Hence a major piece of this annual report could be the identification of inefficiencies and indications of the plan to deal with these. Subsequent reports would naturally update the Canadian progress on the reduction of inefficiencies.

At the same time, a portion of this section would highlight those projects, sites, Community Health Centres, clinics and hospitals which had excellent results in managing a public health problem. The kinds of problems would naturally include a range made up of dealing with health threats and dealing with specific prevention issues such as the success of an immunization program in a region or the overall reduction of obesity in a school district.

The Special Report

The special report would be made at any time in response to a health threat, to set the stage for a comprehensive plan to deal with West Nile Virus or Avian Flu⁷ for example. The special report on such issues would also be rendered when such a health threat had been contained. This report would be rendered at the discretion of the CHPO since the timing of such health threats cannot be precisely predicted.

²³ Bennett, Carolyn, Archbold Rick (2000). *Kill or Cure? How Canadians Can Remake Their Health Care System*. Toronto, Canada.

²⁴ Rachlis M. *Prescription for Excellence* Toronto: Harper Collins, 2004 p. 202.

The special report can also be rendered at any time on a case/issue specific basis. There is now sufficient data available to write an action-oriented report on childhood obesity. It is simply a question of compiling it, looking both in and outside North America for jurisdictions which have handled this issue better than we have, and then developing and disseminating a plan to the stakeholders and the public. In this case these could easily include all of us in the health professions who would willingly assist with any such plan. Such a plan would reasonably and necessarily require the support of the health ministries, health related organizations, municipalities, district school boards and ministries of education. Such a plan could also be rendered more effective if it engaged the media, business and industry (especially the food industry), consumer groups and organized labor and groups which promote healthy living.

What types of requirements or mechanisms would help ensure that the agency fulfils its mandate responsibly and in a fiscally prudent manner?

The Board of Governors mechanism where the board is answerable to the federal parliament and provincial legislatures while the Chief Public Health Officer is answerable to the board provides the means whereby parliament can exercise due diligence through the office of the Auditor General. Special or unique arrangements need not be made since quite clearly parliament has the means and the will to review spending as required.

What mechanisms should the agency establish so that Canadian citizens can directly help shape its direction and priorities from one year to the next?

The Agency should establish advisory committees which are regionally based and which comprise all the regulated health professions and representatives from of the region. These advisory committees would solicit input from the public which together with reports from other regions would assist the Board of Governors for the Agency in developing broad policy to guide the work of the Chief Public Health Officer. In those jurisdictions where there are regional health authorities, these authorities could provide a natural venue for collaboration with the Agency.

Thank you for considering our responses to your questions. We stand ready and most willing to serve the Agency and its work, recognizing in that work the potential for the reform necessary to protect the health of Canadians especially the underserved and vulnerable.

Yours truly,



Grayden Bridge, D.C.
President

Enclosures:

- 1) The Canadian Chiropractic Association Presentation to the Standing Senate Committee on Social Affairs, Science and Technology: Canada's Health Care System, May 2001 (aka the Kirby Report)
- 2) The Canadian Chiropractic Association *Survey of Canadian Adults: Back Pain*. Environics Research Group, May 2003
- 3) The CCA *Canadian Chiropractic Research Bulletin #8*
- 4) The Canadian Memorial Chiropractic College's article featuring the Anishnawbe Health Toronto: A haven for healing. Primary Contact, Winter 2000.
- 5) *Enhanced Chiropractic Coverage under OHIP as a Means of Reducing Health Care Costs, Attaining Better Health Outcomes and Achieving Equitable Access to Health Services*. Dr. Pran Manga for the Ontario Chiropractic Association, 1998.
- 6) The Canadian Chiropractic Association Position Statement on Vaccination and Immunization