Public health physicians are caught in a losing battle

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Recent reports in the *Edmonton Journal* and *Calgary Herald* have drawn attention to the departure of four public health physicians from their positions in Alberta. This story, in part, reflects wider challenges that exist in practicing public health medicine throughout Canada, and how our country chooses to protect and promote the health of Canadians. Is it time for the Canadian medical community to raise its head and ask a few pointed questions about why? Why have many provincial medical associations across the country failed to advocate for these physicians until after the crisis has peaked and the damage has been done? Why, outside of Quebec, are public health physicians usually under the employ of public bodies with a consequent restraint in their ability to speak on healthier public policy, let alone an inability to speak on working conditions and compensation? Why does public health risk have to increase before this specialty is acknowledged for its input into health care?

Community medicine specialists and other public health physicians receive specialized training in population health risk assessment, disease surveillance, program planning and evaluation, health promotion, disease prevention, health protection, and health administration. They are expected to be health advocates, monitor the health of the population, apply public health legislation, and develop, implement and manage public health programs, in addition to being consultants to physicians, public health disciplines, political bodies, media, school boards and directly with the public. They have influence over local, regional and provincial health advances, along with health funding and standards. This is not a typical specialty, but rather a multifaceted position to care for a population.

In a specialty that is subjected to unprecedented political and public scrutiny, we should celebrate the incredible successes achieved by a limited group of professionals. Not only have we seen the disappearance of many communicable diseases which are often seen as the purview of public health, but the incidence rates of cardiovascular disease, injury, and childhood illnesses have all been reduced through the efforts of public health physicians and colleagues over the decades. Tobacco use reduction, safer motor vehicles, stronger supports for new families, and efforts to reach marginalized populations have their genesis or implementation substantively in public health practice.

The 2008 report of the Chief Public Health Officer was quietly released in mid-June[1]. It seems unacceptable in this political climate to draw attention to Canadian populations that remain at risk for serious health consequences for suffering from inequalities in education, socioeconomic status, race or gender. Two of the lead recommendations call for the need to foster collective will and leadership and a commitment to change, something that requires governments to step to the plate to tackle uncomfortable issues such as child poverty, addictions, housing, income distribution, education, food security, and employment.

[1] http://www.phac-aspc.gc.ca/publicat/2008/cphorsphc-respcacsp/index-eng.php

Almost forgotten is the Naylor report of 2003 [2] which flagged that many specialists are not currently practicing in community medicine and vacancies persisted in many health units. Naylor noted that one-third of specialists will retire within 10 years and that many residents were choosing fields other than the roles of Medical Health Officers. As Naylor reported:

> *Relatively poor remuneration is not the only drawback to working as a public health physician. Other potential disincentives are the challenges of working in a political and bureaucratic environment and bearing ultimate responsibility for the health of thousands of citizens in a particular region… The challenge now is to ensure not only that we are better prepared for the next epidemic, but that public health in Canada is broadly renewed so as to protect and promote the health of all our present and future citizens.*

Before and after Naylor there are a slew of reports on the need to strengthen the public health system, build public health infrastructure, address training and establish competencies. Despite growth in other public health professions in response to these calls, the cadre of public health physicians has continued to dwindle and expertise is being lost. In the wake of these reports the specialty has once again attempted to organize its voice.[3]

The contributions of public health have had major impacts in reducing the growth of health services. However, with the growing population, ageing and growing demand is measured in wait lists, emergency room overcrowding, and inability to find family physicians – not in the success of how much worse the system would be without preventative innovations.

Public health physicians have spent the decade bringing the issues of social determinants of health to the table. Now the battle is shifting to newer challenges such as obesity, high sugar diets, shifting addiction patterns, expectations of cleaner air and water, and climate change. Such battles are often fought within political arenas with opponents wielding substantive economic weapons that buy votes at the ballot boxes. The balance of supporting a vibrant economy while mitigating the damages inflicted by changing technologies and newer threats to health is a delicate tightrope to traverse. Public health specialists have honed a variety of tools in their training to ensure the public's health is not only protected, but enhanced. These specialized tools are not found in most physicians' bags.

A challenge of sustaining public health systems is that reductions tend to have longer as opposed to shorter term impacts, and do not generate the same degree of public outrage as reductions in direct health care provision, as no surgeries are cancelled and no prescriptions go unwritten. This makes it all the more important to ensure ongoing attention is paid so that a competent and effective public health system exists for all Canadians. So perhaps the time has come to collectively value these contributions and the constant scrutiny that these specialist practitioners endure. Quebec is one of the few provinces that has consistently acknowledged the unique role of the specialty in supporting the public's health.

The beginning step may be for the medical community to rally together to support a withering public health medical force. The specialty needs the respect of colleagues through understanding of the real tensions and constraints that the specialty carries. Realistic compensation is one step, acknowledgement of peers is another, and recognition by the community as an integral component in the network of health services is essential. To lose this branch of medical professionals will have long term repercussions that will only be realized after the deed is done, as Alberta is learning. Can you contact your provincial association and extend your voice? In addition, visit the specialty society website (www.nsscm.ca) and see what more you can do to support your Public Health colleagues.

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[2] http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/7-eng.php#s7b1

[3] National Specialty Society for Community Medicine www.nsscm.ca