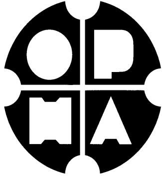

ONTARIO PUBLIC HEALTH ASSOCIATION
L'ASSOCIATION POUR LA SANTÉ PUBLIQUE DE L'ONTARIO

"CELEBRATING THE PAST"

Speech given by Dr. John E.F. Hastings

To the Annual Meeting of the Ontario Public Health Association

On the Occasion of its 50th Anniversary

November 15, 1999

Introductory Remarks

I feel honoured to have been invited to speak at this 50th Anniversary Conference of the Ontario Public Health Association on Celebrating the Past". As you will have noted, my own career in public health, primarily as an academic, almost coincides chronologically with the life span to-date of OPHA, of which I have been a career-long member and, in more recent years, an honorary life member. I am also delighted, as current past president of the Canadian Public Health Association, to bring its warm congratulations and best wishes on this occasion.

But, I must also admit to some trepidation over the task of presenting an overview of public health and its achievements over the last 50 years, with emphasis on Ontario. Inevitably, this will be a selective account, reflecting my personal perspective and experience. I ask your tolerance over the omission of events and achievements, which a definitive and comprehensive account would undoubtedly include and celebrate.

Finally, I wish to acknowledge the provision of valuable reference material and articles by Norma Freeman of the CPHA office, Fred Ruf and Brian Hyndman and the logistic support from Joanne Lacey of the Centre for Health Promotion at the University of Toronto, and my wife, Ulrike.

Introduction

The completion of the first 50 years in the life of the Ontario Public Health Association, as in the life of a person, is an occasion for celebration. It is a time to remember beginnings, to look back over the record of achievement in the intervening years, to take stock and to consider the relevance of this experience for the future. Knowledge and understanding of history provide identity and purpose. History roots us and helps to give stability and direction as we seek to meet the challenges of today and tomorrow.

The record of accomplishment by public health is one of the great human success stories of the 20th century in Canada and Ontario. While the focus for my presentation is on the 50 years since the founding of OPHA in 1949, this period cannot be put in context without some reference to the earlier years in the century. After all, the story is a continuous, indeed, a continuing one.

The Early Years, 1900 - 1945

In the early decades of the century, our country and province were predominantly rural and small town based societies. With growing industrialization, a high birth rate and extensive immigration before and after World War 1, the population grew rapidly. There was the beginning of a shift to the growing cities. Communities large and small were faced with socio-economic and health problems of staggering proportions. This was especially evident in the cities. Most had unsafe water supplies and sewage and waste disposal. Overcrowding and slum housing, poverty, poor diet, and unsafe food and milk supplies were major problems. Outbreaks of typhoid fever and, still, on occasion, smallpox and other omnipresent communicable diseases, such as diphtheria, German measles and whooping cough were rampant killers, and the cause of much long-term ill health. Children were especially vulnerable. Maternal and infant mortality were at levels, which today we would associate with the most destitute of Third World countries. Tuberculosis was a major and growing scourge. There were few families that were untouched by the sorrow of a mother's death in childbirth, the death of one or more infants and children, and of adults prematurely cut off in their prime.

Although the Ontario Public Health Act of 1884 had mandated the establishment of local boards of health with the appointment of medical health officers, public health services remained minimal, except in larger urban centres, until almost World War II. Almost all of these MHOs were for many years without formal training and part-time. Thus, for example, in 1924, in Toronto and the communities around, there were 30 part-time MHOs and only one full-time MHO in the city of Toronto itself. The Act also provided for the employment of sanitary inspectors but these also were few in number and trained on the job until the early 1930s. In the first years a few tuberculosis nurses, trained on the job, were appointed in Toronto and a few other large centres. But there were no formally trained public health nurses until the 1920s and virtually none of the other range of professionals, whom we associate with modern public health.

In the first years of the century, the new science of bacteriology was in its infancy, with antitoxins just discovered and the first toxoids still some 20 years or so in the future. Only smallpox vaccination was available voluntarily, except when outbreaks made it mandatory temporarily. As with other public health measures, vaccination was for years strongly resisted by much of the population, the media, many politicians and even some of the medical profession. Diagnostic public health laboratories were non-existent. Food production and distribution were essentially unregulated from a health point of view. There was no protection from industrial pollutants. Although the importance of proper sanitation had been demonstrated, few communities had installed even reasonably safe water, sewage and waste disposal systems.

Health care services were equally rudimentary in range and sophistication. Most doctors were general practitioners with a still limited range of diagnostic and effective therapeutic tools. Specialists were few in number, often trained in Europe or the United States, and only available in large centres. Well into the century, hospitals were still regarded as places of last resort and primarily for the poor. Anaesthesia and surgery were hazardous. Childbirth was dangerous and chiefly at home. There was no blood transfusion. Hospital acquired infections were common. More often than not, death was the result from hospitalization. It was only during and after World War II that the hospital came into its own as the hub of health care. Visiting nursing was available in the early years through voluntary groups, such as The Victorian Order of Nurses, but only limited to a few large centres. Families were dependent on their own resources or that of practical nurses. The care of mental illness was still essentially custodial, much as it had been for generations.

More generally, practical illiteracy remained high; only a minority had more than some primary school education. There were no school health or special counseling services. Public social support systems were minimal or non-existent. Those in need were dependent on families or on forms of personal or voluntary charity. For the growing middle class and even the wealthier members of society, life was still uncertain in times of childbirth and sickness. For the poor, life was much harsher.

It was in this context that the national progenitor of OPHA, the Canadian Public Health Association, came into being. A small group of prominent medical and other persons concerned about the state of the public health met in Ottawa on October 12, 1910 under the auspices of just-received Ontario Letters Patent for the establishment of a voluntary public health association.

A personal note: One of the five applicants for the Letters Patent was my great-uncle, Dr. Charles J.O. Hastings, who had just become Medical Officer of Health for the City of Toronto. Trained as an obstetrician, he turned, in his early 50s, to public health, largely because of the death of an infant daughter from milk-spread typhoid fever. During his tenure from 1910 - 1929, the Toronto Public Health Department became recognized internationally as a leading innovative and model department. He was president of CPHA in 1914 and 1916 and of the American Public Health Association in 1918.

To return to my story, it was decided to seek Dominion Government incorporation, which was granted by a special act on April 1, 1912. The first Annual Conference of CPHA took place at McGill University in December 1911. Indicative of the political significance of the event, among those addressing the conference were the Governor General, the Prime Minister of Canada and the Premier of Quebec. A major agenda item was a report, which included recommendations for a comprehensive plan for the prevention, control and ultimate eradication of tuberculosis. Resolutions concern the enactment and enforcement of legislation for compulsory vaccination against smallpox, enactment of provincial legislation to enable municipal regulation of house planning and

land development, development of courses in public health and hygiene, sanitary chemistry and bacteriology in all medical and engineering faculties, the establishment of medical inspection of schools and the establishment of municipal parks and recreation planning as part of overall city planning. They did not use the terms of health promotion, healthy public policy and determinants of health but they understood their spirit and meaning in the context of the day. Their commitment to advocacy and action was determined. Change had to occur, "come hell or high water".

And, change did occur! The first half of the century was a time of tremendous achievement for public health. Chlorinating of municipal water supplies and the development of sewage treatment facilities, together with the compulsory pasteurization of milk (in Toronto from 1914; in other cities soon after; in all of Ontario from 1938), saved the lives of thousands, especially the young, from typhoid fever, diarrhoeal diseases and bovine tuberculosis. Compulsory smallpox vaccination eliminated smallpox entirely in Ontario by the mid-1930s. What could be more dramatic than the virtual elimination of diphtheria, the second killer of children between two and fourteen years of age, within a few years after the first major immunization campaign outside France was undertaken in 1925, first in Toronto and then Ontario, using diphtheria toxoid prepared by the Connaught Laboratories at the University of Toronto. Programs against human spread tuberculosis and venereal diseases led to earlier diagnosis and to treatment and contact follow-up; sanatoria were built for tuberculosis cases.

Staffed primarily by public health nurses (in the early years trained on the job and only later in University programs), clinics for mothers and babies, home visits to newborns and school health services were instituted. Maternal and infant mortality declined so that by 1945, Ontario had one of the best records in the world. Inspection of the preparation and distribution of food was initially provided by inspectors trained on the job (only after 1934 in a formal program under the aegis of CPHA). Public health and industrial hygiene laboratory services were developed. The Connaught Laboratory, founded in 1923 as successor to an earlier antitoxin laboratory, provided a reliable supply of human and animal biologicals and was a major source of basic and applied research. The closely linked School of Hygiene at the University of Toronto, founded with Rockefeller Foundation support in 1927, provided post-graduate training for a range of public health professionals. For a time this included public healthy nurses until separate nursing faculty programs developed. Public health was also a pioneer in the development of medical social work, initially provided by public health nurses. There was a steadily increasing emphasis by public health on the importance of literacy and public education. The life of the public had dramatically improved and longevity was steadily increasing.

By World War II public health had successfully demonstrated the potential impact on the health of the population of bringing to bear a combined knowledge and techniques of sanitation, bacteriology, through the close collaboration between research and practice, public education, and the enhanced professional training of public health personnel, and an astute and unrelenting commitment to public health reform.

But this record of remarkable achievement in the space of half a century was not arrived at easily and without strong opposition, based on ignorance, indifference, and vested interests, still powerful forces in today's world. It all has a very modern ring!

Our predecessors knew what it was to be advocates and activists. They lobbied for legislation and by-laws and their enforcement. They fought for the resources to implement public health programs. They knew how to involve the public, the media and politicians. They were well aware of the vital importance of partnerships with an informed and engaged public. They found themselves accused of being murderers for having children immunized against smallpox, diphtheria and tetanus, of harming the dairy industry by pushing for milk pasteurization laws, of being supporters of immorality for instituting venereal diseases programs, of hurting landlords by speaking out on the evils of slum housing on the health of mothers and children and the poor in general, of hurting the economy by demanding safer working conditions, occupational health services, a safer environment, safe water and sewage systems and food control programs, and of poisoning people by chlorinating water supplies. They worked and struggled for whatever policies, legislation and programs they believed to be in the public interest. They knew the meaning of commitment, advocacy and activism and the importance of the involvement of an aroused and informed public.

Wartime to Peacetime: Years of Transition, 1944-1950

During World War II, the war effort took precedence over everything else. Public health was no exception, with personnel, financial resources and supplies, such as biologicals, being turned to the needs of the armed forces. With the end of the war, a fundamental change, which would affect the future health and well-being of Canadians, was to take place.

Social thinking in Europe and North America had been evolving about the potential role of the state, acting for the collective public interest, to provide some agreed level of protection and support for people and families faced with events of potential threat to their heath and well-being. These included childbirth and the period of rearing children, premature death of the breadwinner, sickness, disability, unemployment, inadequate housing, illiteracy, poverty, old age and death. The traditional support systems of a relatively stable rural society were clearly inadequate in an increasingly more mobile, industrializing, wage dependent, urban and nuclear family environment. Thus, for example, as early as 1917 and again in 1930, the Canadian Public Health Association had sponsored symposia on national health insurance. Advocacy by public health leaders over the years reflected this broader socio-economic concern about the threats to health and well-being.

For instance, Dr. Charles Hastings, in his presidential address in 1918 to the American Public Health Association stated: "Every nation that permits people to remain under the fetters of preventable disease and permits social conditions to exist that make it impossible for them to be properly fed, clothed and housed so as to maintain a high degree of resistance and physical fitness; and, who endorses a wage that does not afford sufficient revenue for the home, a revenue that will make possible the development of a sound mind and body, is trampling on a primary principle of democracy."

The experience of the Great Depression in the 1930s, compounded on the Prairies by years of severe agricultural drought, made the inadequacies of existing support systems patently clear. The experience of the war, when the country had come together to fight a major war, gave further impetus to the belief, by now a conviction, that if nationhood in a post-war era were to have real meaning, it had to include the realistic possibility of a fairer, more secure and healthier life for all Canadians, not only the more privileged members of society. It was with such ideals and political will that the first steps were taken between 1942 and 1944 by the Select Committee on Social Security of the House of Commons. They commissioned the preparation of reports on social security (Marsh Report) and health insurance (Heagerty Report), including a draft bill for comprehensive national health insurance. At the Dominion-Provincial Conference on Post-War Reconstruction in the fall of 1945, the federal government made specific proposals for a broad network of social security benefits and programs including health insurance on a cost-shared basis with the provinces. The proposal was rejected because the provinces and the federal government could not agree on a restructuring of tax powers and other fiscal arrangements for the post-war period.

However, one early step of direct relevance to public health development in Ontario and the other provinces was taken. In 1948, the federal government established the National Health Grants Program which, over the nearly three decades of its existence, provided a major stimulus for the development of basic public health infrastructure and programs in the provinces. The Program consisted of grants-in-aid, mainly on a shared-cost basis, for general public health (including formulation of provincial health plans), tuberculosis control, mental health, medical rehabilitation and crippled children, professional training (of public health physicians and later public health nurses), cancer control, public health research and child and maternal health. There was also a major grant for hospital construction. Later, support for other public health services, such as laboratory services, was added. The Program's inaugural statement noted that the grants were intended to enable the provinces to develop "fundamental prerequisites for a nation-wide system of health insurance", which was intended to follow over the next years.

In Ontario, a major transformation of the economy, stimulated by high natural increase in the population and by massive immigration, was getting under way. Ontario was to become the economic heartland of the country in the next few years. It was recognized that part-time public

health services provided by a myriad of mainly small municipalities through individual boards of health could not support the requirements for future services. An amendment to the Public Health Act, in 1945, provided for grants to local municipalities for the establishment on a county-wide basis of health units with full-time staff and services, comparable to the pattern of public health departments in large urban centres and a pioneer health unit established in the Timmins area in 1944. The intent was to replace over time the almost 900 local boards of health then in existence with fewer, larger, and economically stronger county ones. By 1950, there were 25 county health units and 12 urban public health departments providing full-time services to two thirds of the Ontario population. Further consolidation was to take place over the next years.

The Founding of OPHA, April 13, 1949

It was in this context that the Ontario Public Health Association was formed through Letters Patent under the Ontario Companies Act, with the purpose to "develop and diffuse in Ontario the knowledge, practice, and technique of preventive medicine and public health in all their branches". Encouraged by CPHA, planning for the new association was undertaken by a committee of the Ontario Health Officers' Association, probably the earliest public health association in Canada. Originally formed in 1886, in response to the naming of municipal medical health officers as required under the Ontario Public Health Act of 1884, the association lapsed after a few years but was re-established in 1912. It was recognized that an association with broader membership was now required, along the lines of the Canadian Public Health Association. CPHA also recognized the necessity for establishing provincial public health associations to provide a regional focus and continuity for public health workers in a country as geographically widespread and diverse in problems as Canada. An editorial in the May 1950 *Canadian Journal of Public Health* notes "The formation of the Ontario Public Health Association, bringing together medical officers of health, public health engineers, laboratory personnel, veterinarians, nurses and sanitary inspectors, constitutes an important milestone in the development of the Canadian Public Health Association's national work". Membership was also open to members of boards of health.

The first meeting of OPHA took place in conjunction with the 38th Annual Meeting of CPHA from June 12-14, 1950, in Toronto. Reflecting the broadened membership there were section meetings for public health administrators, public health nursing, sanitation, venereal disease control, vital statistics, epidemiology and public health education. An amazingly wide range of topics was discussed:

- The census and public health
- Problems in education of public health personnel
- Health of the mouth and food consistency
- Government pre-paid medical care in Saskatchewan
- (Non-government) pre-paid medical care in Ontario
- the layman in public health administration
- development of a cardiac register
- a film on the production and use of BCG
- organization of public health laboratories
- (Royal College) certification for physicians in the specialty of public health
- Report of CPHA Committee on Public Health Practice
- Health aspects of housing regulations
- Problems in environmental sanitation
- Industrial health problems from radio-active substances and from newer insecticides
- Special fluid changes in neurosyphilis
- Venereal disease diagnosis and control
- Cancer mortality index
- Mortality and lost years of life
- Traffic accidents
- The personal factor in accidents
- Veterinary aspects of communicable disease control
- The improvement of nursing
- Nutrition education
- Premature births
- Maternal and infant diphtheria antitoxin levels
- Infectious hepatitis in the army
- The national health grants program
- Provincial and local administrative policies
- Health education in the local health department
- New Ontario Plumbing Code

- Installation of septic tanks and wells
- Sanitation in flooded areas
- The East York – Leaside Sickness Survey
- Sampling techniques
- Morbidity data collection in industry
- Cortisone and ACTH
- Cocksakie virus and poliomyelitis

Years of Growth, Consolidation and Conceptual Development in Public Health, 1950 - 1980

The years from 1950 - 1980 in Ontario were years of major population growth from both natural increase and immigration. Rapid economic development and urbanization took place. Employment was high. There was increasing prosperity for all but a relatively small proportion of the population. Acting through federal and provincial governments, society by the mid-1970s, had put into place a support network of publicly funded and administered socio-economic benefits and programs, which affected all Canadians and brought a significant measure of security to their lives. In addition to the National Health Grants Program, these included family allowances, universal hospital insurance (in Ontario from 1959) and universal medical care insurance (in Ontario from 1969), additional programs for categories of public assistance recipients, old age assistance, old age security pensions, unemployment insurance and assistance, a program of support for public and subsidized housing, support for a major expansion of post-secondary education and support for hospital and laboratory facilities and facilities for the education of health personnel. Science and technology were undergoing explosive development. The prospect was for continuing economic growth and increasing prosperity.

The atmosphere of optimism and altruism was captured by the words of the Royal Commission on Health Services in 1964 in its recommendation, "That as a nation, we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind - there can be no greater challenge to a free society of free men".

For public health in Ontario it was a time of growth and consolidation across the province of programs, such as communicable diseases prevention and control, sanitation, maternal, child and school health, dental health, and public health education. Involvement took place in newer areas, such as non-communicable diseases, mental health, aging, environmental health, addictive substances (tobacco, alcohol), and health planning. The formerly widespread communicable diseases had ceased to be the chief cause of mortality, as a result of mass immunization, especially of children, the widespread development of water and sewage systems, compulsory pasteurization of milk and the regulation of food distribution and handling. Tuberculosis was in steady decline, as affected by the improved socio-economic conditions for families (income, social benefits, housing, and diet etc) and the impact of new anti-tuberculosis drugs. Sanatoria beds could be closed or turned to other purposes. However, poliomyelitis remained as a serious and increasing problem into the 1950s, with serious annual outbreaks (1-3000 cases, many paralytic, and several hundred deaths). The mass Salk vaccine campaign, beginning in 1955 with schoolchildren, rapidly changed the situation. In 1958, there were only 20 cases, of which 15 were unvaccinated, and no deaths. The Connaught Laboratory played a key role in development of the vaccine, again proof of the value of effective links between research and application. Of course, some communicable diseases remained as problems, for example, syphilis, infectious hepatitis and meningitis. But, the overall picture had been altered fundamentally. There were even a few who, for a brief time, proclaimed the impending demise of all infectious diseases. Events only a few years later with AIDS, hepatitis B, the blood-born disease crisis, threats of imported diseases and the omnipresent threat of an influenza pandemic, as well as increasing drug resistance, were to demonstrate the naivete of such assumptions. Surveillance and research continued to be vital components of public health. With the decline in communicable diseases and the aging of the population, public health attention turned to the diseases of middle and older life, such as heart disease, strokes, cancer and the threat at all ages of accidents, as the major causes of mortality and morbidity. Disease registers were set up. Increasingly sophisticated epidemiological studies and analyses led to enhanced emphasis on health

risks and to education about preventive lifestyle practices (e.g. diet, exercise), the preventive use of drugs to reduce risks, such as hypertension, and the control of environmental hazards. As early as 1964, a provincial anti-smoking campaign, in co-operation with non-government organizations, took place. These developments were stimulated by the U.S. Surgeon General's Reports in 1979 and subsequently and were dubbed the "Second Epidemiologic Revolution" by Milton Terris. These programs were the forerunners of the heart health, anti-tobacco, and accident prevention programs, for example, using the newer conceptualization and approaches which began to develop from the 1974 Lalonde Report (A New Perspective on the Health of Canadians), which gave new emphasis to lifestyle and environmental factors in the health of people as well as genetic factors and the impact of the health system.

Another major accomplishment for public health was the introduction of fluoridation of water supplies in most urban municipalities in the 1970s, but only after several years of intensive lobbying against strong opposition. The result was a dramatic drop in dental caries in children and young adults.

In the same years, public health nursing was able to broaden its program of preventive education and health promoting activities from traditional concerns with maternal and infant health and school health to include increased attention to the elderly, which with increasing longevity, were becoming a greater proportion of the population, and in turn, to other population groups identified as having special needs and risks.

The mental health movement had been pressing for significant change for some years in the handling of mental illness. Beginning in the 1950s and into the 1960s provincial public health policy led to the development of psychiatric units in general hospitals, with a concomitant reduction in the number of beds in large mental hospitals. Some hospitals were closed. With the introduction of psychotropic drugs an increasing number of people could be cared for in the community, provided appropriate supervision and support were available. Mental health clinics, group homes and other community-based services were developed. Unfortunately these were not sufficient in number and type to meet the need. Local health units, chiefly the public health nurses, all too often found themselves having to fill the gap of insufficient community mental health services and services for the retarded. The situation remains problematic to the present day.

The range of professionals and expertise in the public health team were broadened in the decades after World War II, to include, for example, public health nutritionists, health educators, family planners, sex educators, health administrators and health promoters, among others. There was also the beginning of greater applied research by health units and in some cases informal links with health science centres, which in the 1980s developed into the Teaching Health Units Program. This proved important in re-emphasizing links between research, teaching and practice. This now has been modified into the PHRED program. Overall the result was to make local public health more comprehensive in its perspective and scope. Research and teaching institutions were brought more in touch with practice needs and realities.

Two steps marked the end of an important era of success by local public health in the field of sanitation. Direct responsibility for the oversight of municipal water, sewage and waste disposal systems shifted in 1957 to the Ontario Water Resources Commission and later to the Ministry of the Environment. However, local public health unit sanitarians continued to be responsible for private systems. Pasteurization oversight shifted in 1962 to the Ministry of Agriculture. On the other hand, there has been an increasing involvement in programs related to hazards in the environment from industrial and other pollution sources, and in strengthening public health aspects of food handling and distribution.

Further changes in local public health organization occurred in 1967 when full-time public health services were mandated in all organized municipalities and multi-county district health units serving a larger population replaced the county units. The province increased its support to 75% of approved programs in these units.

Health system planning was also given emphasis through the Ontario Council of Health as the senior advisory body to the Minister, and its successors, the Premier's Council on Health Strategy and the Premier's Council on Health, Well-being and Social Justice, from the 1970s to the mid 1990s. Their planning studies were the basis for a number of subsequent changes, including the introduction from 1973 of District Health Councils which served as local advisory planning and priority setting bodies. Although most of the attention was

focussed on the health care system because of its size, complexity and increasing cost, there were nonetheless useful impacts on aspects of public health.

Thus, by the end of the 1970s, public health had developed into a mature and modern component of the wider health system. The next phase was to lead to a major re-conceptualization of public health, as it moved into the last two decades of the century.

Years of Challenge, 1980 - 1999

Since the 1980s, the socio-economic and political environment has been undergoing a period of major change, under the impact of Free Trade and the general globalization of trade and of serious recessions in the 1980s and early 1990s. There has been high unemployment, only now in 1999 starting to come down, with a shift away from heavy industry and traditional manufacturing to a more high technology and service economy. There has been widespread concern about the size of government debt and a political climate much less supportive of public social spending. The federal government, over a number of years, has been reducing transfer payment to the provinces for health, social services and post-secondary education and its own direct expenditure in health and social benefits. The provinces in turn have cut back on expenditure and have engaged in the 1980s in steps to hold down heath care expenditures in the hospital sector in particular. Since the 1990s in all provinces major restructuring has been underway in social, health and education sectors in an attempt to reduce cost. In the case of Ontario, and some other provinces, a more libertarian political philosophy, which believes in smaller government and greater privatization, has also been an important influence.

The big cities have continued to grow, as have the surrounding suburbs. The recently amalgamated municipalities of the former Metropolitan Toronto have become a megacity. Amalgamations of other cities with their surrounding communities are being planned. As well, most of the still high immigration has settled in the large urban centres or their suburbs. Toronto, in particular, has become one of the most culturally dynamic but also most multi-ethnic communities in the world. To an increasing extent, Ontario is becoming a province of regional diversity with problems of differing priority and magnitude – the megacity of Toronto and its immediate suburbs, the rest of the "Golden Horseshoe" area, the large urban centres elsewhere in the province, more populous and wealthy rural and small town areas, more geographically and isolated rural areas, of which the North is a special case. Politically, socially and economically the situation of the native peoples is a further distinct situation.

Of necessity, the provision of services, including public health services, while still at one level sharing common dimensions and conditions, at another, is becoming increasingly more complex and diverse. Designed originally to provide broad common services to all communities in the province and to make these available to all people in any given community, a combination of budgetary cutbacks and the now dominant conceptual perspective of population health, which target subsets of the population (based on factors, such as age, ethnicity, gender or other special need) with appropriate strategies to meet the particular circumstances, the provision of public health services has become much more specialized and complex. Accurate and up-to-date health status and community and environment data, together with sophisticated analysis and a range of service delivery options, are now the norm. Thus, even the basic mandatory services required by the Health Protection and Promotion Act of 1983 and the Mandatory Health Programs and Services Guidelines of 1989 and subsequent modifications now have to be implemented with the more complex reality of Ontario's diverse geographic, socio-economic and population health needs in mind.

The now well developed and accepted concept of health promotion, which since the Ottawa Charter of 1986, has become integral to public health thinking, strategies and programming, places special emphasis on determinants of health, health enhancing factors and modifiable risk factors. The result is that increasingly resources and interventions are aimed at positively affecting and

supporting healthy lifestyle choices, healthy living and working environments, healthy social support mechanisms and the reduction of modifiable risk factors. Thus, major re-thinking of public health priorities and programs is underway.

Fortunately, the Ontario model of local boards of health can build important links between communities and public health professionals and between local public health provision and the public. Public health is in a unique position to provide a flexible balance between leadership and partnership with the community and other groups and organizations within the community in fulfilling its mandate.

The situation was further significantly affected by a radical restructuring of provincial and municipal responsibilities by the Ontario government since 1997. This essentially moved local public health responsibility, including funding, entirely to the local municipalities. Recently the funding has been amended to a 50:50 shared-cost basis between the province and the municipalities. As well, some special targeted funds have been provided for special public health programs.

It is little wonder that public health has been experiencing a period of considerable challenges and stress, faced with the changing conceptual, socio-economic, demographic, political, funding and other environmental dynamics, as it seeks to ensure the health and well-being of the public and to fulfill its unique role and responsibility for health promotion, health protection and maintenance and disease prevention.

Concluding Comment

We do indeed live in challenging and changing times for public health. History reminds us that public health has always lived in challenging and changing times. The context differs and the body of knowledge and skills broadens and deepens over time. But, the fundamental mission of public health to promote and protect health and well being, to prevent disease, to ensure a safe and healthy environment, and to advocate for healthy public policies remains as valid today and for the future, as it has been in the past. Also, remaining constant are the requisites of insight, expertise, innovation, leadership, activism, partnership and political courage, as we advocate and work for the health and well-being of the public, our communities, our province.

I am profoundly confident that public health in Ontario will meet the challenge, as it has throughout its history. I also have no doubt that the Ontario Public Health Association, on its 100th birthday will be able to look back on the record of the intervening years since this, its 50th birthday, with pride at the victories for the health of the public and its part in their attainment.

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