Discussion Questions: Public Health Restructuring*
May 2005

(* developed by the Council of Ontario Medical Officers of Health, a section of alPHa)

DRAFT

Instructions/Notes:

- This questionnaire is for your organization's information. Your organization may choose to answer all or some of the questions (i.e. those that are relevant to your discipline) on the following pages. These questions are being provided to the seven Affiliate organizations of alPHa to help us determine areas of consensus and non-consensus among the various constituent societies of the broader alPHa membership.

- If answering some/all questions, please:
  (a) reply by **June 8, 2005** via e-mail to **linda@alphaweb.org** (response may be draft or final)
  (b) type in your organization’s responses in the spaces provided on the following pages
  (c) provide the following information in the spaces below:

  **NAME OF ORGANIZATION COMPLETING THIS QUESTIONNAIRE:**

  **DATE SUBMITTED TO ALPHA:**

- If there are questions that have not been included in the following pages and that your organization believes are relevant to the discussion, please add them and their respective answers.

- If your organization is unable to respond by June 8, we will accept submissions after this date until June 30. Our goal is to collect as many Affiliate responses by June 8 (so that the alPHa board can receive responses for review at least one week prior to its June 17 meeting) and to have all final responses from each Affiliate, COMOH and the Board of Health Section submitted to alPHa by June 30.

- The process alPHa would like to take with the responses:
  - **June 10:** alPHa to forward Affiliate responses received to date to alPHa Board for review
  - **June 17:** alPHa Board of Directors to review Affiliate responses received to date as well as COMOH and Board of Health Section responses
  - **June 30:** Final responses from each Affiliate organization's submitted to alPHa
  - **end of July:** alPHa Board of Directors to perform final review of constituent society responses (BOH Section, COMOH, Affiliates) -- meeting date TBD at June 17 Board Meeting
Public Health System Accountabilities

QUESTIONS

1. Are the existing outcome measurement strategies and tools sufficient to track and report against the established accountabilities (e.g. MPIQ, Program Based Budgeting, Accreditation)?

   No, current measurement strategies are insufficient because of their design. For example, the MPIQ is too subjective and detailed in some areas and vague in others. To accurately capture the quality of programming being implemented, an onsite audit by program experts along with the existing tools is needed. The multiple interventions and steps in public health programming mean that it does not lend itself easily to measurement. Some clinical programs are the exception. For example, teeth screened and immunizations given can be counted. Work to develop programming in schools that engages students or to develop a nutrition policy in a day care, are very difficult processes to quantify until they are completed.

2. If there are gaps, what mechanisms could be established to improve accountability?

   1. Scorecards?
   2. Audits?
   3. Questionnaires?
   4. Accreditation?
   5. Other? Health Units providing proof of funding and staffing expertise allocations to specific programs.

Optional Question

3. (What are the top 5 Mandatory Programs and Services Guidelines in need of revision?)

Chronic Disease, Injury Prevention, Cancer Prevention, Child Health, Infection Control
BACKGROUND

There is no formal accountability process in place for Ontario public health units. The current method for evaluating compliance with the Mandatory Health Programs and Services Guidelines is completion of the Mandatory Health Programs and Services Guidelines Indicator Questionnaire (MPIQ). It is recognized by both the Ministry of Health and Long-Term Care and the field that this evaluation tool is not an effective means of determining compliance. Apparently, a process is underway by the Public Health Division to revise the questionnaire.

The need for a formal public health accountability process is clearly a priority as evidenced by the following:

(a) Walker Report

The Walker Report (Expert Panel on SARS and Infectious Disease Control – April 2004) makes the following recommendation regarding Public Health Accountability:

23. The Ministry should immediately examine approaches to strengthen compliance with the Health Protection and Promotion Act and associated Mandatory Health Programs and Services Guidelines, in particular with regard to the resourcing and provision of mandatory health programs and services.

24. As part of the review of the Mandatory Health Programs and Services Guidelines for public health, it is recommended that consideration be given to the inclusion of public health risk communications as one of the program standards.

26. Ontario should establish an annual performance report for public health in Ontario to be tabled to the legislature and disseminated to the public. This report should be prepared by an appropriate third party research organization body and should indicate the status of the following areas:

(a) Human Resources
(b) Information Technology
(c) Facility Acquired Infections
(d) Mandatory Program and Service Compliance
(e) Health of the Population
(f) Central Epidemiological Capacity.

The Walker Report goes on further to specify the need for standards, accreditation and monitoring for infectious disease practices including audits by public health of hospital infection control policies, programs and resources.

(b) Campbell Commission 2nd Interim Report

One of the five immediate measures required to strengthen public health governance and ensure a uniformly high standard of protection across the province is:

2. Require by law the regular monitoring and auditing of local health units.
In 2003, the Office of the Provincial Auditor of Ontario reviewed public health. One recommendation of the resulting report is as follows:

To help ensure compliance with legislation and the Mandatory Health Programs and Services Guidelines, the Ministry should:

- Establish more valid measures for assessing the performance and overall effectiveness of public health programs and services delivered by local health units;
- Periodically verify the reliability of the compliance information reported by local health units; and
- Ensure that every local health unit has a full-time medical officer of health as required by legislation.

Where local Health Units are using other measurement tools, such as accreditation, the Ministry should:

- Obtain any resulting reports and analysis; and
- Assess whether any of these tools should be used by all local Health Units.

The Ontario Council on Community Health Accreditation (OCCHA) is the accrediting body for Public Health Units. It was formed in 1981. Currently, only Health Units with Public Health Research, Education, Evaluation and Development (PHRED) Programs must be accredited. Of the current 36 health units, 12 have been accredited by OCCHA. The OCCHA Standards were recently revised to place greater emphasis on the implementation of Mandatory Health Programs and Services Guidelines.

Recently, the Institute for Clinical Evaluative Sciences (ICES) published a report on and recommended the adoption of the Balanced Scorecard for public health units.

The following Terms of Reference apply to Public Health Accountabilities:

- Mechanisms to improve systems and programmatic and financial accountability.
- Strengthening compliance with the Health Protection and Promotion Act, associated regulations and the Mandatory Health Programs and Services Guidelines.

This subcommittee has been charged with the following responsibility:

- Mechanisms to approve accountability and compliance for public health programming and services
Governance and Structure

QUESTIONS

1. Should the autonomous Board of Health model be adopted province wide?

If the goal is good quality public health, then autonomy could be helpful, but not alone. Key to quality public health is autonomy along with Board composition, expertise authority and accountability. Currently these key factors are shared between the province and municipality in a way that creates inconsistent program delivery across the province.

2. If yes, what is the appropriate representation and membership of the Board?

An autonomous Board with elected municipal councilors, community representatives and strong provincial representation still need to have public health expertise, authority and accountability to produce programming that is both scientifically sound and locally appropriate.

3. Who should provide public health funding, and in what percentage?

The direction from “Operation Health Protection” to achieve a funding of 75%/25% by 2007/08 is appropriate.

4. Should the LHIN boundaries be used to determine the number and location of Public Health units?

   i. If so, how many Public Health Units should there be?

   ii. If not, how should the number and geographic location of public health units be determined?

Once the composition of expertise per health unit is determined, it can guide any realignment of boundaries. Given the disruption created by realignments, on site expertise versus access to expertise as needed should be considered.

Optional Question

4. (What factors should be considered in determining appropriate distribution of health units? (e.g. population size, critical mass of staff complement, geographic boundaries) Do we have recommendations on any of these factors?)
The factors mentioned are all relevant; however, population need weighted by public health risk is also worth consideration. It is challenging to come to agreement on what constitutes public health risk or cost to the health system in the short or long term but some parts of the province have specific needs that if not addressed would weaken the province’s health as a whole.
BACKGROUND

Ontario is the only Province not to have a regional model of health care delivery. In all other Provinces, public health is incorporated into regional health authorities and in many situations, the Medical Officer of Health does not report directly to the regional authority Chief Executive Officer. There are no Boards of Health. In some instances, public health programs and services are organizationally intact. In other regional health authorities, they are separated with no defined “health department” or “public health division”.

The Local Health Integrated Network (LHIN) System is viewed by many as the initiation of a regional health care system. Presently, all organizations to be incorporated into one (or more) of the 14 LHINs will retain their own boards. Public health units have been advised that in the short-term they will not be part of the LHIN Structure. It is important to note however, the Capacity Review Committee Terms of Reference (see below) address public health restructuring and LHIN geographic boundaries.

In Ontario, there is a “mixed bag” approach to governance and structure. Public health services within regional municipalities are closest in operation to provinces with Regional Health Authorities. In the regional municipality structure, Medical Officers of Health may or may not report directly to the Regional Chief Administrative Officer (CAO) and in some instances public health services have been combined with other services, e.g. Community and Social Services Department; People’s Services. In other instances public health programs (e.g. Healthy Babies Healthy Children) have been organizationally placed with other departments. Also in the regional model, regional council has the mandate and authority of a Board of Health and the Health Department may report either to a separate standing committee of regional council or to a combined (e.g. Health and Social Services) Standing Committee.

The same situation applies in single tier municipalities as in regional municipalities, e.g. City of Hamilton and Chatham-Kent.

A second variation exists where Health Unit staff have been integrated into the municipal administrative structure but a separate Board of Health has been retained. In these arrangements, the Medical Officer of Health may or may not report directly to the Municipal Chief Administrative Officer, but the MOH and the staff of the health department are part of the municipal administration and subject to its policies and procedures. However, the Board of Health in this model is autonomous and whatever the administrative structure, the Medical Officer of Health reports directly to the Board.

The third arrangement in Ontario is that of autonomous Boards of Health with staff who operate separately from the administrative structure of the municipality(ies) in which the health unit in question has jurisdiction. Unlike the regional/single tier municipality and municipal staff integration models above, an autonomous health unit operates single tier municipality according to its own policies and procedures. The Medical Officer of Health is the Chief Executive Officer of the health unit and reports directly to the Board of Health. Links with municipal structures primarily occur around budget matters.

(a) Walker Report

The Walker Report (Expert Panel on SARS and Infectious Disease Control p April 2004) includes the following recommendations which address governance and structure:

21. The Ministry should review, in conjunction, with the Medical Officers of Health, the Association of Local Public Health Units and the Association of Municipalities of Ontario, the existing number of public health agencies in the province. Within two years, the Ministry should act on the results of the review to consolidate the number of Public Health Units to between 20 and 25 units, retaining local presence through satellite offices.
22. The Ministry should commission a review of existing local Public Health units. The review should incorporate expert unit, and comparisons to appropriate jurisdictions to:

- Determine the required core capacities to be available at the health unit level, based upon core geographic, health status, health need, cultural mix, and core health determinants
- Identify key operational, systemic and governance barriers that contribute to or may impede the successful functioning of local health units; and,
- Recommend appropriate models of health unit consolidation where such consolidation is rational based upon the evidence generated above and would contribute to strengthening local public health resources.

25. The Ministry should immediately undertake a comprehensive external review of existing provincial Public Health Division capacity. The Ministry should act on recommendations arising from this review to revitalize provincial public health capacity within the context of public health renewal.

(b) Campbell Commission 1st Interim Report

The Campbell (Commission on SARS and Public Health in Ontario) 1st Interim Report made the following recommendations:

7. Reviews are necessary to determine if municipalities should have a significant role in public health protection, or whether accountability, authority, and funding should be fully uploaded to the province.

8. If local Boards of Health are retained, the province should streamline the processes of provincial leadership and direction to ensure that local boards comply with the full programme requirements established by the province for infectious disease protection.

(c) Campbell Commission 2nd Interim Report

The Campbell Commission 2nd Interim Report concentrates on governance and legislative changes needed “to fix the broken public health system revealed by SARS in 2003”.

On governance, Campbell notes the current split among the public health community as to whether the existing governance and funding arrangements should continue, i.e. joint local municipal and provincial governance and funding versus 100% provincial governance and funding. He does not make a definitive recommendation. Campbell does state that the governance issue must be resolved no later than the end of 2007 thereby allowing time for the Capacity Review process to be completed.

In the meantime, the Campbell Commission recommends five immediate measures required to strengthen public health governance and ensure a uniformly high standard of protection across the province:

1. Protect the local medical officer of health from bureaucratic encroachment;
2. Require by law the regular monitoring and auditing of local health units;
3. Change the public health programme guidelines to legally enforceable standards;
4. Increase provincial representation on local boards of health unit and set qualifications for board membership; and
5. Introduce a package of governance standards for local boards of health.
QUESTIONS

1. What are the key variables or factors which should be included in any approach used to determine Health Unit funding? (irrespective of weighting)

Key factors to determine Health Unit funding include:

1. current per capita funding
2. relative health of population
3. specific local needs relative to health risk and cost to health care system

A basic set of core public health services should be delivered across the province.

2. What other funding issues or challenges (outside of the allocation methodology or formula) exist? (i.e. funding or disbursement timing, synchronizing fiscal years, etc)

Health Promotion Ontario agrees with alPHA’s recommendations for:

1. multi year funding using a 3-year needs based funding framework; and

2. 100% programs to include administrative funding.

Funding needs to accommodate higher than average salary ranges that exist in some Health Unit areas because of market demand or recruitment challenges.
BACKGROUND

Ontario is the only province in Canada which does not provide 100% funding for public health. The current system in Ontario represents a heterogeneous funding approach. Provincially, there are cost-shared programs and 100% funded programs. Priority programs for the Ministry of Health and Long-Term Care have historically been funded 100% by the Province. Examples in this regard (past and present) include: Home Care, Family Planning, Sexually Transmitted Infection Clinics, the Healthy Babies/Healthy Children Program (recently transferred to the Ministry of Children and Youth Services) and Infectious Disease Control positions.

In a number of instances 100% funded programs are 100% funded in name only, as the province does not allow allocation of dollars for major expenses such as rent.

The process to determine cost-shared budgets is a bottom up approach with local Boards of Health determining the budget which in turn is reviewed and approved by the Ministry of Health and Long-Term Care as the last step in the process.

This contrasts with 100% funded programs where Health Units are advised of the grant to be received by the Ministry in question with no local Board of Health input and no apparent opportunity for same. It is a take it or leave it arrangement.

Regardless of the method of payment, it is the Province (with rare exception) which determines the programs and services to be delivered including program goals and objectives.

Section 72 of the Health Protection and Promotion Act addresses funding for public health:

72 (1) The obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act; and

(b) The expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act.

Autonomous Boards of Health therefore have the authority to establish annual operating budgets which by statute, obligated municipalities must provide. The independence of these Boards, in theory, ensures budgeting for public health services is not given short shift.

The situation is not as clear cut in regional municipalities and single tier municipalities. As the municipal council in these settings has the legislated duties and responsibilities of a board of health, budgeting for public health services is undertaken within the competitive process involving all other services provided by the council in question. Unfortunately, this often results in public health services receiving less financial resources than what is required.

(a) Walker Report

The Walker Report recommendations which speak to provincial/municipal funding are as follows:

19. Ontario should immediately dedicate 100% provincial funding beyond March 31, 2004 for the 180 positions committed to Public Health Units as part of the Ontario SARS Short-Term Action Plan.

Ontario should further develop an independent process and establish timelines for the establishment of 100% funding of all communicable disease programs in public health. This should be completed by December 31, 2004.
All such funding should be conditional on the Public Health Units supporting re-deployment of these communicable disease resources in the event of a public health emergency, as part of constructing province-wide public health surge capacity.

20. Ontario should immediately re-structure the existing cost-sharing agreement for public health with the municipalities to move to between 75% and 100% provincial funding of public health. Programs, including communicable disease programs funded at 100% by the province should be protected at 100%.

Implementation of the new cost-sharing agreement should be phased in within two to five years.

(b) Campbell Commission 1st Interim Report

The Campbell Commission 1st Interim Report endorses the Walker Recommendations and in addition states:

10. Public health funding against infectious disease should be uploaded so that the province pays at least 75% and local municipalities pay 25% or less.

I Campbell Commission 2nd Interim Report

The Campbell Commission 2nd Interim Report concentrates on governance and legislative changes needed “to fix the broken public health system revealed by SARS in 2003”.

Campbell includes the funding of public health in his discussion on governance. He notes the current split among the public health community as to whether the existing governance and funding arrangements should continue, i.e. joint local municipal and provincial governance and funding versus 100% provincial governance and funding. He does not make a definitive recommendation. Campbell does state that the governance and funding issue must be resolved no later than the end of 2007 thereby allowing time for the Capacity Review process to be completed.

Campbell goes on to say “more, public health resources are required in many areas”, including:

- Laboratory capacity, expertise and personnel;
- Scientific advisory capacity and capabilities;
- Epidemiological expertise;
- Surge capacity;
- Infectious disease expertise and personnel;
- Public health human resources excellence and capacity; and
- Infectious disease information systems.

(d) Capacity Review Committee – Terms Of Reference

The following Terms of Reference apply to this area as they do Governance and Structure:

- Identifying operational, governance and systematic issues that may impede the delivery of public health programs and services.
- Mechanisms to improve systems and programmatic and financial accountability
- Organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, Primary Care Reform and Municipal Funding partners.
- Staffing requirements and potential operating and transitional costs.
(e) Capacity Review Committee: Public Health Funding Committee

This subcommittee has been charged with the following responsibility:

- Development and implementation of a modernized and need based allocation methodology for public health funding.
**Public Health Human Resources**

**QUESTIONS**

1. What are the challenges and issues in recruiting and retaining medical officers of health?

The challenges in recruiting Medical Officers of Health include: inappropriate remuneration compared to other specialties; lack of autonomy; lack of understanding among medical students of the benefits of the career.

2. What are the challenges and issues in recruiting and retaining public health staff in general?

A recent report on Recruitment and Retention by the Peel Health Department (see attached) contains recommendations that are applicable to other health units and provincially. As marketing experts, Health Promotion Ontario recommends that rather than promoting public health as a career choice, market research needs to be done to determine what potential candidates/students want in a career. Careers in public health should then be marketed using that knowledge. For example, there is research showing that the current generation of students wants a career that allows them “work/life” balance but which also benefits society as a whole and allows career development. Public health practice with its inclusive preventive, community-based approach among other elements could satisfy these career aspirations if marketed well.

Besides this psychographic research, marketing of public health careers must be done in a manner that is current for the target audience. Dynamic electronic communication (computer discs) is preferable to print, and personal testimonies that convey how public health can satisfy career aspirations have been proven to be effective.

3. What strategies should be used to promote and retain public health staff?

Please see attached report mentioned in answer to Question #2.

Some Health Units have had good success in retaining staff by creating non-supervisory positions that front line staff can progress into. For example, in health promotion, staff have moved from Health Promotion Officer positions to Master’s level Health Planner or Project Manager positions where they provide expert analysis of current literature; field best practice; local issues and players in the form of a program plan for supervisor. They also work on large scale projects where their practical field experience is useful and they can allow supervisors to focus on direct supervision issues.
Optional Question

4. *(What are the key functions/capacities that should be present as a minimum in every Health Unit?)*

5. Additional question: How should these functions be implemented?

The key functions of public health in general can be described as:

- Population health assessment
- Health surveillance
- Disease and injury prevention
- Health protection
- Health promotion

However, these functions are not necessary to the same degree at a Health Unit level nor are they all the same type of function. Health Promotion, for example, is both a comprehensive set of interventions as well as a mode of operation. The interventions in health promotion are: health education; skill development or training; health communication through psychographic use and social marketing and environmental support through policy development.

To further explain what functions need to occur at a Health Unit level, it can be said that Health Units need expertise within these five areas to achieve the specific mandatory programs.

Ontario Health Units are not homogeneous in the type of staff they assign to programs. The trend in the last ten years has been to diversify the composition of staff to increase the pool of expertise available in a Health Unit.

Recognizing the range and complexity of public health programming and the need to ensure effective programming, Health Promotion Ontario recommends that each Health Unit have a multidisciplinary management team and staff that includes expertise on program development (Epidemiologist, Health Planner, Health Promotion Specialist) and program delivery (Public Health Nurse, Health Promotion Officer, Public Health Inspector).

Currently, there is more emphasis on the delivery of a program than effective program development through needs assessments, literature reviews, best practice program strategy reviews, local environmental scan of issues and partners and intervention analysis. This information should form a comprehensive plan that includes an evaluation.
Comprehensive planning does occur to some degree in Ontario Health Units; however, it is not consistently applied due to a lack of staff, expertise and a devaluing of program planning.

Finally, if specialized staff are not assigned to program development but it is the role of the Supervisor or Manager, program development is compromised because of the operational demands of supervision.

Dedicated staff are needed for effective program development either through specialized staff such as a Project Manager or a Health Planner; alternatively Supervisors need relatively small teams to allow time for this function.

Recognizing the need to strengthen program development in order to strengthen public health programming and accountability, Health Promotion Ontario recommends,

1. more multidisciplinary staff and management in public health, and

2. a staffing model which recognizes the need for program development expertise balanced with program delivery skills.

While front line staff have a role to play in informing program development with practical experience, Health Promotion Ontario recommended the strengthening of program delivery by ensuring there are staff at each Health Unit with program planning and analytical skills as well as support staff in finance and with human resource functions.

Specific personnel to develop and support program needed in each Health Unit include:

1. Public Health Epidemiology
2. Public Health Nutritionists
3. Health Promotion Specialists
4. Health Planners
5. Public Health Dentists
6. Human Resource Specialists

Some Health units also employ specialists in curriculum development, toxicology or infection control.

Specific staff needed to deliver programs in each Health Unit include:
1. Public Health Nurses

2. Public Health Inspectors

3. Health Promotion Officers

4. Community Development Workers

5. Public Health Dentists

6. Public Health Hygienists/Assistants.

Since Health Units are not homogeneous in the type of staff used to deliver programs, a decision needs to be made concerning whether this issue should be resolved to create more consistency of staff deployment to programs. The aim in assigning staff to programs delivered should be to match the most effective and efficient skill set to the program being delivered.

The Human Resources Capacity Review is a good opportunity to review this issue. If not fully resolved, a phased-in approach is recommended.
BACKGROUND

Staff complement and composition vary from health unit to health unit. There is no existing inventory of staff resources by discipline or specialty. Compensation for similar positions likewise varies from health unit to health unit. This is especially true for the positions of Medical Officers of Health and Associate Medical Officers of Health.

An important aspect of determining what Public Health Human Resources are required and by extension how to recruit and retain practitioners in the designated fields, is to define the mandate for Public Health. The following references assist in that regard.

(a) Walker Report

The Walker Report (Expert Panel on SARS and Infectious Disease Control – April 2004) calls for a review to "determine the required core capacities to be available at the Health Unit level, based upon core geographic, health status, health need, cultural mix, and core health determinants;" The Walker Report is much more specific on what it sees as the key areas to be addressed by the proposed Ontario Health Protection and Promotion Agency. These are:

(a) Human Resources
(b) Information Technology
(c) Facility Acquired Infections
(d) Mandatory Program and Service Compliance
(e) Health of the Population
(f) Central Epidemiological Capacity.

The Walker Report recommendation that speaks to public health human resource revitalization strategy is as follows:

18. It is recommended that Ontario immediately initiate discussions with the Association of Local Public Health (alPHA), Association of Municipalities of Ontario (AMO), and existing federal/provincial/territorial (F/P/T) processes, to design a Public Health human resource revitalization strategy. The strategy should contain the following components:

(a) The development, through the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities, of an increased capacity for the education and training of public health professionals. This could include increasing enrollment numbers at educational institutions as well as increasing post-graduate training positions or residencies.

(b) The development and support of a provincially funded training and education program for existing public health staff, with a focus on infection control. This should build upon the existing Public Health Research, Education and Development (PHRED) Program. Special emphasis should be placed on promoting cross-training opportunities between public health, acute care, long-term care, and other sectors.

(c) The development, in partnership with HRDC and educational institution, of a comprehensive campaign to promote public health careers in Ontario.

(d) The development of re-entry training positions in community medicine such that practitioners practicing in other specialties can become qualified to work in public health.
(e) The development of bridge training programs intended to update the skills and qualifications of skilled individuals with previous public health experience. This should be offered together with incentives to recruit back such individuals currently practicing in other fields.

(f) A review of recruitment and retention strategies for Medical Officers and Associate Medical Officers of Health, including remuneration.

(b) Campbell Commission 1st Interim Report

Justice Campbell in the 1st Interim Report of the Commission on SARS and Public Health in Ontario states as Principle 4 of 21 Principles:

“Safe Water, Safe Food and Protection Against Infectious Disease should be the first priorities of Ontario’s Public Health System”. The same report goes on to speak to the importance of emergency planning and preparedness as important roles for Public Health.

(c) Campbell Commission 2nd Interim Report

The Campbell Commission 2nd Interim Report states “more, public health resources are required in many areas”, including:

- Laboratory capacity, expertise and personnel;
- Scientific advisory capacity and capabilities;
- Epidemiological expertise;
- Surge capacity;
- Infectious disease expertise and personnel;
- Public health human resources excellence and capacity; and
- Infectious disease information systems.

(d) Canadian Public Health Association Issue Paper

The Canadian Public Health Association in their Board of Directors Issue Paper entitled: Focus on Health: Public Health and Health Services Restructuring (February 1996) emphasizes the following eight contributions of Public Health:

1. Focus on individuals and communities in a societal and global context.
2. Bales capacity in individuals and communities to improve health.
3. Facilitates community immobilization through community participation.
4. Embraces promotion, prevention, and protection.
5. Influences the orientation of the health system toward health outcomes.
6. Provides disease surveillance and control.
7. Builds partnerships among sectors at the local level.
8. Advocates for the health of the public.

(e) Centre for Public Health Practice – Rollins School of Public Health

The publication, the Public Health Competency Handbook: Optimizing Individual and Organizational Performance for the Public’s Health, published by the Centre for Public Health Practice of the Rollins School of Public Health, Emory University, Georgia defines the following as the central public health services:
1. Monitor health status to identify community health problems.
2. Diagnosis and investigate health problems and hazards in the community.
3. Inform, educate and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public health and personal health care work force.
9. Evaluate effectiveness, accessibility, and quality of personal and population based health services.
10. Research for new insights for innovative solutions to health problems.

(f) National Think Tank on the Future of Public Health in Canada

The proceedings of the “Think Tank on the Future of Public Health in Canada” held in Calgary, May 10, 2003 identified the following five essential functions of the Canadian Public Health System at all levels of the system including municipal/regional:

1. Population Health Assessment.
2. Health Surveillance.
3. Health Promotion.
4. Disease and Injury Prevention.
5. Health Protection.

(g) OPHA – Core Competencies

The Ontario Public Health Association literature review on core competencies in Public Health (March 4th, 2004), reinforces the work of the National Think Tank (see “e” above). It cites the following examples of disciplines in public health (not intended to be all inclusive):

- Public Health Nurses
- Public Health Inspectors
- Environmental Health Specialists
- Nutritionists
- Community Medicine Specialists
- Health Promotion Specialist
- Health Educators
- Program Managers
- Epidemiologists
- Health Information/Communication Specialists

There are many other disciplines not included in the OPHA list including Mental Health Providers, Dentists, Dental Hygienists, Policy Analysts, Toxicologists, Accountants, Human Resources Specialists, Researchers, Program Evaluators, Data Analysts, Graphic Design Specialists etc.
(h) Capacity Review Committee – Terms Of Reference

Concerning Public Health Human Resources, the following Terms of Reference apply:

- Core Capacities Required (such as Infrastructure, staff, and etc.) at the local level to meet communities’ specific needs (based on geography, health status, health needs, cultural mix, health determinants, and etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer)
- Issues related to recruitment, retention, education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, and etc.)

(i) Capacity Review Committee: Public Health Human Resources Subcommittee

This subcommittee has been charged with the following responsibility:

- The Creation of a comprehensive, made-for-Ontario public health human resources plan that identifies human resource requirements for public health services and supports the rebuilding of public health capacity in Ontario.

The Public Health Human Resources Sub-Committee will support the CRC by sharing their expertise and providing recommendations to produce the following deliverables:

- A map of the public human resource landscape including systemic gaps and future forecasting regarding core public health human resource needs.
- Sustainable recruitment, retention, and skills enhancement strategies that provide for an increased and sustainable supply of skilled public health professionals.
- Strategies to promote public health careers in Ontario and prioritized assessment of professions requiring increased enrollment in public health programs.
- A set of leadership skills for public health professionals.

The Sub-Committee will also liaise with the Ministry and OPHA on public health core competencies endeavours.
Research and Knowledge Transfer

QUESTIONS

1. What are the appropriate processes, mechanisms, structures that will lead to effective research and knowledge transfer?

To support knowledge transfer, the following is needed:

1. At a Health Unit level, on line access to academic journals and applied literature for literature reviews.

2. At the Health Unit level, phone access to centralized consulting service or research including: biostatistics (local and provincial); research design and evaluation.

3. At least one or access to a shared Epidemiologist per Health Unit.

i. Is the PHRED Program sufficient to meet this purpose?

The PHRED program meets part of this purpose now but its service varies from one PHRED to another. For example, the telephone consulting service is not understood to be available at all PHREDs.

(a) If so, should every health unit have a PHRED Program?

No. As outlined in answer to Question #1, Health Units need a combination of local and provincial services.

ii. Should this function be centralized in the Ministry of Health/Ontario Health Protection & Promotion Agency?

iii. Other mechanism(s)?

Optional Question

2. (What are the strategies to get the right mechanisms in place?)

Recommended mechanisms for research and knowledge transfer include:

1. Review what services provided by PHREDs are used now, by whom, in which Health Units.
2. Survey Health Units who are not using PHRED to see what the barriers are, i.e. awareness, access, timeliness.
BACKGROUND

Currently, the mandate for research and knowledge transfer has been formally delegated to those health units which house Public Health Research, Education, Evaluation and Development (PHRED) Programs. The PHRED Programs are:

1. City of Hamilton Public Health and Community Services;
2. Kingston, Frontenac and Lennox & Addington Health Unit;
3. Middlesex-London Health Unit;
4. City of Ottawa People Services; and
5. Sudbury and District Health Unit.

Established in 1984 (Hamilton and Ottawa), this Program was initially known as the Teaching Health Unit Program. At its peak there were 8 programs. A significant setback was incurred when the newly amalgamated City of Toronto cancelled its PHRED Program for cost reduction purposes. This, in effect, ended three former PHRED Programs (East York, North York and the “old” City of Toronto).

The Report of the Provincial Teaching Health Units Steering Committee (January 1997) entitled Public Health Research, Education and Development Partnership: Reinventing the Teaching Health Unit Program, defines the mandate and scope of responsibilities for the current PHRED Program (see References).

Originally funded 100% provincially, PHRED Programs are now cost-shared on a 50-50 basis. Budgets for PHREDS have not been increased for years even for non-discretionary increases.

(a) Walker Report

The Walker Report (Expert Panel on SARS and Infectious Disease Control - April 2004) defines research/knowledge transfer as a core function for the Ontario Health Protection and Promotion Agency. The Walker Report further recommends:

- The Ministry should conduct a review of the Public Health Research, Education and Development Program (PHRED) with the potential to expand both the research and training components. The Campbell (Commission on SARS and Public Health in Ontario) 1st Interim Report does not speak specifically to research and knowledge transfer but does support the principles recommended in the Walker Report.

(b) The Think Tank on the Future of Public Health in Canada

The Think Tank on the Future of Public Health in Canada held in Calgary, May 10, 2003 calls for strengthened linkages between the Public Health System and academic institutions. This includes core funding and structural mechanisms which would include:

(a) Teaching Health Unit Model of partnerships linking Public Health Departments with Academic Health Sciences Centres. These Centres could be linked using the National Centres of Excellence Models;

(b) Enhanced budget for CIHR in public health relevant research across the 4 pillars (basic science, clinical science, health services, population health);

(c) Base funding for capacity building in public health academic disciplines.
(c) Capacity Review Committee – Terms Of Reference

The following Term of Reference relates to Research and Knowledge Transfer:

- Core Capacities required (such as infrastructure, staff, and etc.) at the local level to meet communities’ specific needs (based on geography, health status, health needs, cultural mix, health determinants, and etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer)

(d) Capacity Review Committee: Research And Knowledge Transfer Subcommittee

This subcommittee has been charged with the following responsibilities:

- Review of Lessons Learned from the experience of the PHRED Program
- Appropriate Mandate and Structure for a Research and Knowledge Transfer System that supports Public Health and is anchored in Public Health Needs.