

**Enhanced Local
Public Health Capacity
in Ontario**

**Position Paper of the
Council of
Ontario Medical Officers of Health**

**Presented to the
Capacity Review Committee
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Table of Contents

Introduction	Page 1
System Governance and Structure.....	Page 1
Recommendations	Page 6
Public Health System Accountabilities	Page 7
Recommendations	Page 9
System Funding.....	Page 9
Recommendations	Page 11
Public Health Human Resources	Page 12
Recommendations	Page 15
Applied Public Health Research and Knowledge	
Transfer/Translation.....	Page 16
Recommendations	Page 17
Conclusion.....	Page 18
References	Page 19

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Introduction

The Council of Ontario Medical Officers of Health (COMOH) welcomes the opportunity to provide input into the deliberations of the Capacity Review Committee (CRC). As a group of highly committed public health professionals, COMOH fully supports the Ministry of Health and Long-Term Care (MOHLTC) undertaking a capacity review of local Public Health Units to inform the development of long-term strategies to enhance capacity of this level of the public health system.

A series of reports released over the past few years has provided a consistent and detailed analysis for system renewal.¹⁻⁷ This paper will not re-iterate the many pertinent recommendations from these reports, but focus on critical factors that must be addressed to improve the ability of local public health units to effectively respond to the current and emerging needs of Ontarians. Recognizing the CRC's terms of reference, COMOH has given particular attention to the following inter-related issues:

- System governance and structure
- Public health system accountabilities
- System funding
- Public health human resources
- Research and knowledge transfer.

System Governance and Structure

Public health strives to improve the population's health "through the organized efforts of society."⁸ The National Advisory Committee on SARS and Public Health (Naylor report) identifies system governance as critically important to "ensure clear decision making authority and public accountability, that ensures a clarity of roles and responsibilities within a systems-wide perspective, and maximizes resources to achieve public health objectives."³ Among Canadian provinces and territories (P/T), the participation of local municipal elected representatives in the governance of public health units is unique, as is the role that municipalities play in their funding and administration. The reports of the Expert Panel on SARS and Infectious Diseases⁵ (Walker report) and the SARS Commission⁶ (Campbell report) indicate a need to address these municipal roles. The second interim Campbell report in particular, provides substantial discussion of this issue.⁷

Briefly, there are three main types of governance and administrative models that are seen for local public health in Ontario:

- Public health in regional municipalities:
 - Regional Council has the mandate and authority of a Board of Health
 - Public health department reports to a separate or combined standing committee
 - Medical Officer of Health (MOH) may or may not report directly to the region's Chief Administrative Officer (CAO)
 - Public health services may be combined with other services or organizationally placed in other departments
- Public health integrated into the municipal administrative structure, but with a separate Board of Health:
 - Board of Health is autonomous
 - MOH reports to Board of Health
 - MOH may or may not report directly to the CAO
- Autonomous Board of Health:
 - Operates separately from the administrative structure of the municipality(ies)
 - Board of Health has its own policies and procedures
 - MOH is the Chief Executive Officer (CEO) of the health unit and reports to the Board of Health.

The Walker and Campbell reports describe the current mix of opinion within the public health community regarding the current roles of municipalities in the local public health system. Part of the complexity is the entanglement of the three roles of funding, governance and administration. There is little doubt that from a determinants of health perspective, that municipal governments are a key system stakeholder that public health needs to partner with and strategically influence. The importance of these public health-municipal linkages are illustrated in England's public health renewal documents that speak of "joined-up working" between local health authorities and municipalities.⁹ Among other Canadian P/Ts, there is the sense that in the inclusion of public health within regional health authorities over the past decade, that these linkages with municipalities have become weakened to the disadvantage of public health strategies and programs.¹⁰

Consistent with these observations, COMOHE views that it is important to maintain municipal engagement in public health. *Operation Health Protection* announced that the provincial share of funding for local public health units will be increased to 75%.¹¹ COMOHE favours a provincial funding component of at least 75%, since without municipal funding, it is perceived that municipal engagement on the Board of Health and in public health issues would be significantly reduced. There does not appear to be a clear rationale for selecting 75/25, 80/20 or some other specific funding ratio. However, at the

upper end of ratios (e.g. 90/10), public health effort to secure funds versus a return on municipal engagement is likely to be inefficient.

Municipal elected officials currently comprise the majority of members of Boards of Health. While elected officials are an important local stakeholder, there are many other local perspectives that should ideally comprise a local Board of Health. The primary reason for membership on a Board of Health should be to act in the interests of the health of the community. As described in Justice Campbell's second interim report, municipal officials who are members of Boards of Health can have a conflict of interest in being also responsible for municipal budgets that fund public health programs.⁷ At its most extreme, municipal officials in some Boards of Health have acted with the sole interest of controlling public health expenditures.⁷ A majority position on Boards of Health is also not consistent with the decrease in funding share by municipalities for local public health units. Consequently, more than half of the Board of Health members should be recruited from the community.

The expected competencies for Board members should be made explicit and used in their recruitment and selection. The existing Board and public health unit are in the best position to identify suitable candidates. An external audit process is required to ensure that the desired process and competency expectations are fulfilled. An alternative approach, which is used in British Columbia to select regional health authority board members, is to have an independent provincial body do the screening of candidates based on the desired set of competencies.¹² Regardless of the approach that is specifically used, the objective is to achieve competent and appropriately motivated community Board members by a process that is free of manipulation from local or provincial levels.

While the selection of competent Board members is an important determinant, it does not ensure the effective functioning of Boards. The expected roles of Boards need to be made explicit and a process of assessing Board performance instituted. For example, the U.S. Centers of Disease Control and Prevention (CDC) and their partners have developed a local public health governance instrument to assess the extent that Boards fulfill core public health functions.¹³ Processes also need to be in place to support Board development, as well as the capacity to take action to address significant gaps in performance.

Consistent with the majority of the Board being comprised of interested community members, Boards of Health need to be the independent, sole purpose governance body for local public health units. This recommendation for autonomous Boards of Health would not change if, as is recommended in Justice Campbell's second interim report, local public health becomes 100% provincial funded should suitable stability not be created by the increase in provincial funding now taking place.⁷ The maintenance of local boards is an essential component of ensuring local public health programs are tailored and informed by local needs and that the MOH remains independent of the province as an advocate for the health of the local community served by the Board of Health.

While shifts in funding and governance need to support engagement of municipalities, enmeshment of public health within the bureaucratic environment of municipalities is undesirable. While not universal, the vast majority of COMOH members feel that the inclusion of public health within municipal administrative structures has not optimized the potential impact of the public health system and in some instances has had deleterious effects. There is therefore a need for public health to be administratively independent of municipalities, which is consistent with the creation of sole purpose Boards. This however, does not preclude Boards from making arrangements with municipalities or other organizations for the provision of particular administrative services such as human resources, legal, and other services.

A critical component in the governance of local public health units is the executive function. The *Health Protection and Promotion Act (HPPA)* stipulates that:

- The MOH is to report directly to the board of health on issues relating to public health concerns and to public health programs and services
- The MOH is responsible to the board for the management of the public health programs and services
- Employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the MOH of the board.

As previously described, it is COMOH's belief that some existing administrative and governance relationships between the Board of Health, health unit staff and municipalities do not fulfill the language and intent of the *HPPA* and that this substantially impedes the optimal functioning of the health unit and the MOH's ability to direct health unit staff. This was described in the second interim Campbell Commission report.⁷ The vast majority of COMOH support Justice Campbell's recommendation that the *HPPA* should be amended to explicitly name the MOH as the chief executive officer of the Board of Health. A dissenting perspective is that there are other models of corporate leadership that should be available including those involving collaborative decision making. While public health professionals of many disciplinary backgrounds bring tremendous leadership and management skills and content expertise to the public health system, the critical question is who is ultimately accountable for the operation and functioning of the public health department. As described by the Naylor Report,¹⁴ single leadership is preferable and consistent with the Campbell report,⁷ it should explicitly be the MOH.

The CRC's terms of reference require it to comment on "organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks (LHIN)." This position paper will purposefully not address the opportunities and many challenges associated with public health integration in regional health authorities since there is no indication that this policy option is within the CRC's mandate. However, it is observed that many of the challenges currently experienced with embedding public health within municipal structures in Ontario have also been widely observed in regionalized health structures (e.g. fragmentation of public

health programs; diversion of public health resources; loss of executive role of MOH; lack of direct reporting to Board or Chief Administrative Officer).¹⁰

The LHIN boundaries have been established based on current referral patterns of the small proportion of the population that are cared for in acute care institutions. This contrasts with public health practice which is much broader, reaching people where they live, go to school, work and socialize. These two organizing principles do not align. While public health is strengthening its linkages with acute care institutions particularly for infection control purposes, public health also needs to work closely with many other local institutions such as municipal governments, school boards, child welfare organizations and non-governmental organizations. These organizations are almost all based on geopolitical boundaries. Similarly, public health must also have ready access to demographic, survey and health data that are almost exclusively available by local geopolitical boundaries. For these reasons, COMOHO is of the strong opinion that the proposed LHIN boundaries do not make sense as the basis of boundaries for local public health units.

Consolidating the number of local public health units has been a common recommendation of the Walker Panel⁵ and the Campbell Commission.⁶ COMOHO supports this recommendation in principle, although there are a number of factors that should be considered in its achievement. The Naylor Report states that “every local health agency across Canada [have] an adequate staff of highly skilled and motivated public health professionals.”¹⁴ A rational approach would be to identify the expected functionality and capacity of public health units and those health units unable to meet these expectations would be potential candidates for amalgamation.

The ability to respond to emergencies is an obvious function of local public health agencies and the first step in surge capacity is to re-allocate resources from within a health unit. This favours health units with larger overall staff contingents with greater capacity to reallocate internally before requiring outside assistance. Surge capacity beyond internal reallocations however, has little to do with the number of health units and more to do with pre-event planning for mutual aid. As described further in the human resources section, it is highly desirable that each health unit have at least 2 MOHs, which would be more feasible if there were fewer health units in the province.

Previous work has suggested that health units serving population bases of at least 200,000 achieve greater economies by having a smaller proportion of their budgets allocated to administrative purposes. Such analysis should be updated and reviewed. While population is a key determinant for public health unit boundaries, as population densities decrease, geography becomes a more important determinant. This is particularly important in northern locations where the logistics of travel and managing multiple satellite offices often require the need for public health units to have smaller population bases.

The final comment on the number of health units relates to the practical implications of achieving a reduction in their number. The need for change management should not be

under-estimated with a 2-year period of transition needing to be supported. Ideally, any amalgamations that are considered should strive to maintain existing boundaries versus splitting up existing health units. In addition, voluntary and opportunistic amalgamations should be supported and encouraged where possible.

Recommendations

COMOH therefore recommends:

1. The establishment of independent, sole purpose Boards of Health as the local governance body for public health units.
2. The majority of members of the Board of Health should be appointed from the community. These individuals should be selected based on their interest in public health issues and the fulfillment of specified competencies. An appropriate oversight mechanism should be established to ensure that the desired parameters for selection of community Board members have been fulfilled.
3. Shared funding between the province and municipalities should be maintained with the province responsible for at least 75% of overall funding.
4. Consistent with municipalities providing less than half of the funding, municipally appointed members would comprise less than half of the Board of Health membership.
5. The expectations for Boards of Health should be explicitly defined and their performance routinely assessed and supported.
6. The *Health Protection and Promotion Act* should be amended to make explicit that the Medical Officer of Health is the chief executive officer of the Board of Health.
7. The proposed boundaries of the Local Health Integrated Networks should not be used as the boundaries for Ontario's public health units.
8. The existing configuration of public health units be optimized:
 - a. Consider the critical mass of expertise required to achieve expected functionality of local public health units and minimize administrative costs
 - b. Voluntary and opportunistic amalgamations should be supported and encouraged
 - c. Simple amalgamations are preferable to the splitting up of existing health units
 - d. Change management be actively supported for a sufficient period of time (e.g. 2 years)

- e. Population base of health units cannot be viewed as the sole determinant of health unit boundaries and the logistical realities of large geographic territories must also be given significant consideration.

Public Health System Accountabilities

There is currently no formal accountability process in place for Ontario's public health system. The current mix of accountability-related strategies and tools for local public health units including the Mandatory Program Indicator Questionnaire (MPIQ), Program Based Budgeting, accreditation, and audit of financial records are inadequate.

The MPIQ is based solely on self-report without audit, which calls into question its validity. In addition, even if a health unit accurately completed the MPIQ and achieved high rates of compliance, it does not mean that that health unit is adequately addressing core system functions. Accreditation is currently voluntary with only a third of health units having participated. While some MOHs view that the accreditation process has been helpful to them as an organization, others are of the view that it was limited by its focus on administrative practices, although it is acknowledged that the revised accreditation standards include a greater programmatic perspective.¹⁵ Audits of financial records only establish whether there are financial controls in place to prevent inappropriate diversion of funds, but not the appropriateness, quality and effectiveness of the programming that is being purchased with those funds.

There is little doubt that accountability at both the provincial and local levels of the public health system must be improved. It is also apparent that no single instrument will fulfill all of the requirements for the required accountabilities. There are clearly many different dimensions that need to be captured as part of an overall accountability framework for the public health system including, but not limited to:

- Board governance
- Financial controls
- Administrative/management practices including continuous quality improvement
- Assessment of local needs and their use in priority setting and planning
- Collaboration and partnership
- Planning and delivery of effective and appropriate programming
- Client engagement/satisfaction
- Health outcomes.

These different dimensions need to be mapped to the range of tools and processes that will comprise the framework. The ability to assess many of these domains will be dependent on an on-site periodic "audit" or accreditation of local public health units. This should be conducted on an "arms length" basis. A key principle of the assessment needs to be its use to generate improvement in performance in the local health unit as well as throughout the system. The process therefore, cannot focus solely on gaps, but also must

recognize organizational strengths. Innovation needs to be recognized, rewarded and disseminated.

The extent to which health outcomes are included in an accountability framework requires consideration. The work of public health is founded on the goal of improving the health of communities and populations. However, as well described in a PHRED analysis published in 2000, “it is necessary to identify those activities and outcomes for which the local Board of Health can be held solely accountable.”¹⁶ For example, it might be reasonable to hold a Board of Health accountable for mobilizing, supporting and actively participating in a community coalition addressing social determinants of health. However, the participation of local partners and achievement of policy change on those social determinants implies accountabilities beyond the Board of Health. Consistent with this view, outcomes included in an accountability framework for local Boards of Health would need to focus on fulfillment of intermediate-level objectives versus long-term objectives that are clearly influenced by a wide variety of factors beyond the direct control of Boards of Health.¹⁶

Accountability and system performance should be intrinsic to any properly conceived system. As such, data necessary to support these tasks should be integrated with local management and information systems and the use of single purpose data collection and effort avoided. The Mandatory Health Programs and Services Guidelines (MHPSG) will need to be comprehensively reviewed and updated so that its role and content are consistent with the overall accountability framework. The Community Health Research Unit began work in this area as a follow-up to the PHRED accountability framework document.¹⁷

System performance and accountability issues are not limited to the local level of the public health system. The optimal functioning of the local system level depends on appropriate leadership, supports and funding from the provincial level. There need to be clear expectations for the provincial level of the system and an open and transparent process to assess its performance. This is why the U.S. CDC has developed state public health system performance standards that mirror local system standards while distinguishing the differences in expected roles and responsibilities.^{13,18}

The multi-dimensionality of accountability described in this section requires a mechanism to analyze and report them in a useful and coherent manner for a variety of stakeholders. The proposed public health balanced scorecard would support this intent by providing “insight into how well public health’s structure, resources and activities are aligned with its core functions.”¹⁹ The proposed scorecard measures performance in four quadrants: health determinants and status; community engagement; resources and services; and integration and responsiveness.

Recommendations

COMOH therefore recommends:

9. The development of a compulsory, multi-dimensional accountability framework for public health units that:
 - a. Holds local Boards of Health accountable for those activities and outcomes for which they can be held solely accountable
 - b. Ensures that basic financial controls are in place
 - c. Includes the performance of board governance functions
 - d. Includes a periodic, independent audit or accreditation of local public health system performance
 - e. Uses data and information that are simple to retrieve and preferably available from local management and information systems.
10. The development of clear performance expectations for the provincial level of the public health system and an open and transparent process to assess its performance.
11. The use of a balanced scorecard or similar mechanism to provide an integrated and comprehensive description of public health system performance.

System Funding

A previous section on system governance provided recommendations for a shared funding model between provincial and municipal sources. Historically, Ontario has had a combination of cost-shared programs and 100% funded programs. This has the potential of creating two-tiers of programming with the perception that 100% funded programs are more important. From an equality perspective, all programs should be cost-shared to the same degree. However, the reality is that some vital public health programs such as teen sexuality clinics are not universally supported by municipalities and 100% funding has ensured their availability across the province. A key challenge associated with many 100% funded programs is that they are not fully funded (e.g. Healthy Babies, Healthy Children) resulting in diversion of resources from existing programs.

Maintaining a shared funding model of local public health units must be accompanied by resolution of several related issues. Post-SARS, the province announced an increase in funding for public health that has suffered from a lack of clarity regarding the extent to which it reflects new dollars versus simply replacing a proportion of existing municipal expenditures. There is a significant danger of scarce public health system funding being diverted away from public health to other areas of municipal budgets. Having provincial and municipal funding sources with differing fiscal years creates undesirable complexity particularly considering the delays experienced with provincial budget approvals. While public health is expected to embark on multi-year strategies to address complex issues,

the funding structure continues to focus on one-year increments. Capital planning and investment need to be an explicit part of multi-year financial planning for system development.

Beyond these logistical funding issues, there are broader questions regarding the total level of system funding and its equitable distribution. The 2004 First Ministers' Meeting on Health Care acknowledged the importance of public health to achieve better health outcomes and contribute to the sustainability of the personal health services system. According to the Naylor Report, public health system funding in Ontario has tended to be 1.5-1.7% of overall health system expenditures over the past decade. The clear message from the various national and provincial reports is that this is insufficient. An increasing number of recommendations are being made on the level that funding needs to reach:

- Modelling conducted for HM Treasury in England found that doubling of the investment in prevention and promotion (£250 million) in the first 10 years of the model was associated with the lowest rise in health care costs in the subsequent 10 years.²⁰
- Full implementation of Quebec's public health program²¹ will require an almost doubling of Quebec's annual public health budget from \$265 million to \$506 million.²²
- The Legislative Select Standing Committee in British Columbia analyzed current direct and indirect health-related costs and estimated health savings from modest improvements in key risk factors recommending that funding for public health initiatives should gradually increase from 3% to at least 6%.²³
- The British Columbia Cancer Society recently recommended increasing disease prevention funding to at least 5% of the health care budget with a particular emphasis on chronic diseases.²⁴

There is a remarkable similarity in the conclusions of these various groups in recommending that the investment in public health needs to double and reach about 5-6% of governmental health system expenditures in order to achieve optimum results of prevention and promotion initiatives. There must also be transparent and consistent mechanisms to track system expenditures so that they can be compared against system performance.

Longstanding concerns exist regarding the distribution of funds among public health units. This was the subject of a project in the mid-1990s that led to the development of a preliminary equitable funding model.²⁵ While viewed as an important step, COMO members believe that there are many factors that should influence funding levels. This is an issue that requires further analysis and the following table is provided as a non-exhaustive list of suggested "need" and "cost" factors that should be given consideration in developing more appropriate funding mechanisms.

Needs	Costs
<ul style="list-style-type: none"> • Population (size, age distribution) • Deprivation (e.g. income) • Health status (e.g. premature mortality, disability) • Urbanization (e.g. number of restaurants, workforce, migration, industry) • Population fluctuations (e.g. daily or seasonal changes) • Rural factors (e.g. number of wells) • Higher risk populations • Presence/absence of other service providers • Service to First Nations communities 	<ul style="list-style-type: none"> • Geography (population density, transportation, managing multiple small branch offices) • Multicultural (e.g. multiple languages) • Cost of living factors

Considering the heterogeneity of the factors, it is not envisioned that all of them would be included within a single funding equation. Separate parameters might be required when considering specific programs (e.g. number of wells and environmental health program funding) and separate funding envelopes required to address specific issues (e.g. services to First Nations). Current macro level funding inequities are mirrored at programmatic levels. For example, some public health units possess OHIP billing numbers in order to bill for sexually transmitted disease-related visits while others do not.

Recommendations

COMOH therefore recommends:

12. Overall public health system funding growing in a sustained and long-term fashion in order to optimally address the range of public health issues facing Ontarians.
13. The funding of the public health system becoming open and transparent to allow monitoring of system expenditures and investments.
14. The funding of local public health units becoming more equitable by considering the many factors that affect relative needs for public health action and the relative costs of service delivery.
15. Providing clarity regarding the intent of the government's announced investment in public health to achieve strengthening of system capacity versus simply replacing existing municipal funding.

16. Addressing long-standing shortcomings of the budgetary process including differences in fiscal years between provincial and municipal governments, the need for multi-year funding and capital investment, and inequitable access to OHIP funds for sexual health service provision.

Public Health Human Resources

The Naylor Report emphasizes that “no attempt to improve public health will succeed that does not recognize the fundamental importance of providing and maintaining in every local health agency across Canada an adequate staff of highly skilled and motivated public health professionals.”³ Pre- and post-SARS, a number of reports have described that Canada is faced with a substantial set of challenges with respect to its public health workforce including:^{3,5,26}

- Vacant positions
- Poor and inequitable distribution within and among provinces/territories – particular challenges in rural and First Nations’ settings
- Aging workforce
- Insufficient training positions
- Little continuing education
- Academic and public health practice fields not well connected
- Limited data available to describe the public health workforce
- No strategy to comprehensively address these challenges.

The importance of having a strategic assessment and planning approach to workforce development has been a consistent finding from several sources. This includes an environmental scan of best practices in public health workforce development in Australia, England and the U.S.,²⁷ as well as a series of regional workshops on public health education held across Canada in early 2004.²⁸ Consequently, the F/P/T Public Health Human Resources Joint Task Group has been developing a framework for public health human resource development that is expected to be released later this year. A collaborative process will be required with key roles for national, provincial and local public health system levels to be involved in monitoring the current workforce and forecasting needs; ensuring competency based core and continuing education programs; and the provision of assistance and incentives to support training.

Ontario’s public health system needs to become actively involved in ensuring that academic institutions are producing the right numbers of professionals with the right mix of competencies and that there are a range of upgrade and continuing education programs for existing staff. This type of system leadership for workforce development is an explicit expectation within the U.S. public health system performance standards for state and local public health systems.^{13,18}

An additional area of focus at the regional public health education workshops was the need to develop career paths that are “attractive with opportunities to work in stimulating

and challenging environments with competitive remuneration...secondments and exchanges be supported...[with] consideration of the full life-cycle of careers paying attention to the recruitment of individuals to the field of public health and include a combination of part-time and full-time employment.”²⁸

Practicum settings are as critical in the development of public health practitioners as they are in the clinical health sciences. Ontario has a strong history of teaching health units and their evolution into the PHRED program.²⁹ The program however, has been handicapped by a shared funding model that expects the municipal tax base of selected municipalities to support a program that clearly is intended to meet regional and provincial needs. The PHRED program needs to be designed and funded to contribute to meeting the system’s balance of regional and provincial workforce training needs. The additional inter-dependent roles of PHREDS in applied research and program development also need strengthening and are addressed in the next section of the paper.

It also needs to be recognized that linkages between local public health units and academic settings are not limited to the PHREDS. Many non-PHRED public health units are involved with teaching of health professionals (e.g. nursing students) and research projects. In addition, there is a wealth of highly relevant academic expertise that is located outside the major health sciences centres including, but not limited to, the Universities in Guelph (e.g. veterinary epidemiology) and Waterloo (e.g. behavioural sciences).

Public health practice is inter-disciplinary by nature and the preceding discussion applies to the entire public health workforce. As a group of Ontario MOHs, COMOH wishes to identify some additional specific concerns regarding workforce development issues as they apply to MOHs within Ontario’s public health system.

A number of warning signs exist regarding the state of the MOH workforce. Ontario suffers from chronic vacancies in MOH positions and many highly experienced individuals have left the system over the past decade as they have pursued careers in other jurisdictions or sectors. Comments from a number of MOHs that are summarized in the Walker and Campbell reports indicate widespread disenchantment that may lead to further losses of experienced MOHs. Indicative of the current situation, a significant proportion of physicians completing specialist training in public health do not go on to practice in the formal governmental public health system.

The traditional training route for public health physicians has been through re-entry following an initial clinical career. However there are a number of financial and other barriers that limit this training path that has only recently been reinstated after a number of years of unavailability. Despite the existence of longstanding vacancies in MOH positions¹ and the important role of MOHs highlighted in recent reports and identified in legislation, a comprehensive strategy to address the current situation has not been forthcoming. As recommended by the Walker Panel, Ontario needs to develop a “Public Health Human Resource revitalization strategy...[including]...a review of recruitment

and retention strategies for Medical Officers of Health and Associate Medical Officers of Health, including remuneration.”⁵

We need to better understand why physicians are or are not attracted to this career path, why individuals train for years and decide not to work in the public health system, the barriers to recruitment and retention, and comprehensively address them. Some of the important factors are already known. Attraction and retention of MOH/AMOHs has been a long-standing problem owing to the following factors, which are listed in no particular order of importance:

- Limited exposure to and low profile of public health during medical school
- Poor remuneration relative to other salaried physicians and medical specialists
- Steadily increasing professional demands placed on the position
- Greater complexity in public health practice
- Poor public health governance
- Professional isolation
- Shortages and/or maldistribution of complementary public health professionals.

There is a widespread perception that compared with other physicians, MOHs are not highly valued and current rates of pay reflect this. There are systemic challenges and significant barriers in negotiating a fair compensation package for MOHs. In many settings such as municipalities and the provincial government, MOHs are slotted into job classifications that do not adequately consider the degree of academic preparation, scope of decision making, consequence of error and overall responsibility. In settings with independent Boards of Health, MOHs are often placed in a position of negotiating compensation with the same board to whom they report on a regular basis and whose support is essential to the success of the public health programs. As recommended by the Walker Panel, the current remuneration of MOHs must be addressed.

The MOH career ladder is exceedingly limited and narrow in scope. Many health units have only a single MOH requiring new graduates to assume the CEO role for which they are partially prepared and to practice in relative isolation of their colleagues. The system needs to provide positions for graded responsibility and skill development. The system also needs to recognize that not all public health physicians will wish to have or be appropriate to fill a CEO role. A greater number of AMOH positions would address both of these issues, as would attractive entry-level public health physician positions within the provincial level of the public health system. Greater employment flexibility with part-time AMOH and/or public health staff physician consultant positions would be much more attractive for qualified individuals with a range of interests. There are also roles in public health for physicians without formal training in public health. Quebec is an excellent example of a system that provides opportunities for physicians of varying backgrounds to contribute to program areas that are of interest to them. Such an approach also provides natural linkages between public health and the health care system.

There are currently several career and training paths to becoming an MOH in Ontario. The majority of MOHs have undergone specialty training and are certified by the Royal College of Physicians and Surgeons of Canada as Community Medicine specialists. It has never been possible to have all of the MOH/AMOH positions filled by physician specialists. Many MOHs who lack specialty certification have Masters of Public Health training frequently obtained from programs in other countries where they are more easily accessible. The overall lack of physicians in Ontario has prompted a policy to support more immigrant medical graduates to achieve licensure. Such individuals with previous public health training or an interest in the field provide another potential source of future MOH/AMOHs. Overall, there is a lack of clarity regarding the minimum acceptable set of competencies required to be an MOH/AMOH in Ontario, any limiting circumstances in which these would be applied, and the most appropriate training path(s) to achieve them. These issues must be addressed to ensure that all Ontarians have access to MOHs who have the necessary competencies to protect and promote their health.

Recommendations

COMOH therefore recommends:

17. Implementation of a comprehensive public health workforce development strategy at provincial and local levels.
18. In the context of an overall public health workforce development strategy, to provide specific attention to the recruitment and retention of Medical Officers of Health including:
 - a. Identifying and acting upon the incentives and barriers for physicians to acquire public health training, as well as enter and remain within the public health workforce
 - b. Developing a career path for MOHs with graded responsibility and mentoring following public health training:
 - i. Existence of at least one AMOH within each public health unit
 - ii. Provide training in management and associated skill development for AMOHs wishing to become future MOHs
 - c. Providing in partnership with other key stakeholders, a range of continuing education opportunities
 - d. Providing more consistent and competitive rates of remuneration:
 - i. Province-wide salary level for public health physicians
 - ii. Remuneration consistent with physician salaries in other sectors (e.g. Coroners)
 - iii. Include cost-of-living adjustments and benefits package
 - iv. Compensate for on-call responsibilities
 - v. 100% provincial grants to Boards of Health for MOH/AMOH compensation.

- e. Defining the minimum competency set for practice as a MOH/AMOH and any associated limiting circumstances for their application.

Note: recommendations for improving the PHRED program are included in the next section.

Applied Public Health Research and Knowledge Transfer/Translation

Applied research and translation of knowledge into practice are described in the Naylor Report as key support functions of the public health system. It is widely recognized that the investment in applied research is insufficient and that what is known is not being fully implemented.³⁰ It is expected that the proposed Health Protection and Promotion Agency will develop strong capacity in both of these areas in a collaborative fashion with academic institutions and the Public Health Agency of Canada and its six national collaborating centres. For example, the country only needs one portal and database for the effectiveness of public health interventions. While the evidence base for core program standards can be contributed to by a number of jurisdictions, it need not be duplicated by individual P/Ts. Many of the tasks for knowledge management and translation therefore need to be planned, coordinated and funded at the provincial and federal levels. Nevertheless, there are local and regional roles within an overall provincial research and knowledge transfer strategy.

The preceding section of this report highlighted the important role of regional PHREDs in providing education and training to existing staff, as well as practicum settings for public health students. Combining academic and practice-related skill sets make PHREDs ideal settings for applied research, program development and evaluation, as well as knowledge transfer. Just as clinical settings have clinician-scientists to perform a combination of applied research, training and service roles, comparable public health practitioner-researcher positions also need to be supported in public health settings.²⁸

Coordination of research priorities and projects should occur on a province-wide perspective with the proposed provincial Agency having lead responsibility. As articulated in a CIHR sponsored paper on public health research, there needs to be active communication between funders, end-users of applied research, and researchers to ensure that the research that is being conducted meets the system's needs.³⁰ The term "applied research" implies that the research being conducted is immediately useful to practitioners. It appears that there are a number of relevant research questions regarding system design and performance that could inform future decision making. For example, what is the relationship between size and capacity of public health units and the quality of public health programs? What are the best mechanisms to support the use of effective interventions at the local level? What are the most important incentives and barriers to achieve municipal engagement in local public health assessment and planning? What are the incentives and barriers to recruiting and retaining public health physicians and other skilled public health practitioners? These types of research questions clearly require

active participation of public health practitioners and the conduct of research at the local level that could be conducted by the PHRED program.

There is also a need for ongoing training in public health organizations so that they may access, consult and produce relevant research and to shift the culture of such organizations to value research as an integral component of policy and program design and decision-making.³⁰ Regionally-based PHREDs should have key roles in accomplishing these tasks.

A potential challenge with a PHRED model is that funding may appear to strengthen the host public health unit versus providing regional and provincial level capacity. This is exacerbated by the existing 50:50 funding model with local municipalities. In addition to reinstating a 100% provincial funding model, there must be a regional advisory/governance model to ensure that regionally focussed activities and resources meet the needs of that region. Considering the wealth of public health expertise, practicum opportunities, and the size of public health training programs in the greater Toronto area, the PHRED program needs to have a presence in this part of the province.

Recommendations

COMOH therefore recommends:

19. Supporting regional-based PHREDs to provide mutually reinforcing functions of training, applied research and service provision:
 - a. Be 100% provincially funded
 - b. Priorities and programming coordinated from a province-wide perspective
 - c. Have a regional advisory/governance structure to ensure regionally focussed services are appropriately and equitably delivered
 - d. Expand the number of PHRED programs with Toronto as the next obvious site.

20. Coordination of research priorities and projects through the proposed Health Protection and Promotion Agency be informed by a network of researchers and practitioners including individuals from local public health units to facilitate communication and priority setting.

Conclusion

The renewal of public health in Ontario will ultimately be measured by the extent to which local public health units are more appropriately structured, resourced, and supported to deliver effective public health interventions to the people of Ontario. COMOHE believes that the recommendations outlined in this paper address critical areas to achieve this desired outcome. The province's MOHs look forward to working with the CRC to inform the development of long-term strategies to enhance the capacity and functioning of public health units in Ontario.

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