alPHa

Moving Ahead Together

A Position Paper of
The Association of Local Public Health Agencies

August, 2005
INTRODUCTION

Operation Health Protection (OHP), Ontario’s three-year plan to renew and strengthen its over-extended and under-resourced public health system was launched just over one year ago. Over the last year, there have been many opportunities for members of the Association of Local Public Health Agencies (alPHa) to provide their perspectives on achieving the goals of this timely planning process.

Chief among the parallel processes under OHP that will benefit from alPHa’s members perspectives is the Local Capacity Review (LCR). Our members welcome this unprecedented opportunity to contribute to creating a sustainable public health system for the province. The input provided in this paper is based on first-hand experience of the successes and challenges of the system as it currently operates.

There is already a substantial body of analysis and recommendations that will inform the capacity review of the public health system. The Campbell and Walker reports are comprehensive documents that have also benefited from our members’ input, and many of the recommendations in those reports reflect alPHa’s members’ positions and opinions.

The intent of this paper is to complement these existing reports with the specific perspective of our members. Building on the general recommendations of alPHa’s March 2004 position paper, Creating a Sustainable Public Health System in Ontario, this paper represents a more focused articulation of positions on the five key areas being examined by the Local Capacity Review Committee (LCRC):

- Governance and Structure,
- Public Health Funding,
- Public Health System Accountabilities,
- Research and Knowledge Transfer, and
- Public health human resources.

PROCESS

alPHa’s membership is made up of Ontario’s medical officers of health, board of health directors, and management representatives from public health dentistry, inspection, business administration, nursing, nutrition, epidemiology, and health promotion. Following the announcement of the Local Capacity Review process and format, alPHa discussed the need for each of these groups to provide input to the areas under review.

The diversity of our membership suggested a strong likelihood of differences in opinion both within and among groups of members. Accepting that this reality reflects the diverse public health needs of Ontario’s communities and the approaches used to meet them, it was determined that alPHa would encourage each of its member organizations to develop its own positions and key messages to be submitted to the CRC as the input of those groups. alPHa would then analyze each for areas of consensus and submit them as positions representing the views of the Association as a whole.

In order to ensure some consistency in identifying areas of consensus and dissent, the Council of Ontario Medical Officers of Health (COMOH) agreed to share a set of questions it had developed for each of the five LCRC review subject areas with the other alPHa groups. The appendices to this document contain the position papers and key statements developed by alPHa’s members. Those that did not develop a position paper for input to the LCRC provided key statements in a question and answer format, using the
COMOH questions as a guide.

What follows is the synthesis of this process. In this document the term ‘members’ is used to denote the alPHA sections and affiliates that provided input into this process. Specifically, the member groups that participated in the creation of this document are:

- AOPHBA – Association of Ontario Public Health Business Administrators
- APHEO – Association of Public Health Epidemiologists
- ASPHIO – Association of Supervisors of Public Health Inspectors of Ontario
- BOH - Board of Health Section
- COMOH – Council of Medical Officers of Health
- OAPHD – Ontario Association of Public Health Dentistry
- OSNPPH – Ontario Society of Nutrition Professionals in Public Health

**GOVERNANCE AND STRUCTURE**

**Board of Health Structure**

The majority of alPHA members support the establishment of independent or autonomous boards of health for all public health units. Twenty-five (69%) health units have this governance structure in place today. In this model, the board of health is independent from local government, however, as stipulated in the *Health Protection and Promotion Act* (HPPA), each obligated municipality in the health unit appoints municipal members to the board. Municipally appointed members may be Councilors or citizens. Among the 25 independent boards, 20 have staff operations that are also independent of municipal administration (i.e., subject to their own policies and procedures), while for the remaining five health units with independent boards, staff fall under municipal operations. For all health units with independent boards of health, the Medical Officer of Health (MOH) reports directly to the board of health. The remaining 11 health units are governed by boards that are directly associated with a regional or municipal council, i.e., the elected council acts as the board of health or appoints a committee to act as the board of health.

alPHA’s Board of Health section does not support the recommendation that all health units should be governed by autonomous or independent boards of health. While there is some support for the independent board model among boards of health, the majority of boards emphasized that one model for boards of health can not serve all areas of the province with equal effectiveness. No clear preference emerged for any one board structure. Rather, the majority of boards feel that any structure can function well, given the appropriate membership and supports. Further, while supporting an independent board model overall, a number of alPHA’s members note that health units associated with regional governments may benefit from direct access to regional resources.

In considering appropriate governance structures, all of alPHA’s members are concerned with the ability of boards of health to act in the best interests of the health of the communities they serve. The majority of alPHA’s members believe that fully independent boards, those with independent boards and staff, will minimize the potential for competing priorities with other municipal services and will best ensure that the health of the public is of priority concern in decision-making. A recent survey of health units by alPHA supports this belief. A survey of 29 health units showed that fully independent boards approved budgets with higher per capita funding.

Using population estimates for 2003, based on 1996 Census data from Statistics Canada, the following per capita costs have been put forward in 2005 health unit budgets.
On average, fully independent boards approved 1.3 percent increases in the municipal share of health unit funding, while boards with municipal or regional structures approved decreases of 5.7 percent and 1.4 percent, respectively. It should be noted, however, that all board structures resulted in both increases and decreases to the municipal funding share on an individual health unit basis. 63 percent of the fully independent boards approved increases to their share of the health unit funding. This number drops to 33 percent and 25 percent for regional and municipal boards, respectively.

**Board Composition**

There is strong agreement among aPHa’s members that communities across Ontario can best be served by boards of health with a membership that is well versed in public health issues, as well as representative of the individual communities served. Regardless of the board structure in place, boards should include representation from the community (regular citizens), local elected representatives, and provincially appointed representatives. Some members also recommend that boards should include representation from major strategic partners such as school boards and community-based agencies. There are differences of opinion on the proportions of each (e.g. the BOH Section was very clear that provincial appointees should be kept to a minimum while COMOH recommends a minority of municipally elected members), but there is strong agreement that the composition and function of Boards of Health must always serve the outcomes of improved community health. There is also strong agreement that regardless of how board members are chosen, the significant majority should be appointed from the community and must demonstrate some expertise and a strong interest in public health. As expressed by OAPHD, “Whichever model of governance is chosen, the QUALITY of leadership provided by Board members and senior management is important” (see Appendix 6).

**Key Leadership – Boards and MOHs**

Clear roles and strong management are key components of a capable public health system. In regards to the role of the MOH, members feel that, “the local MOH should have autonomy and needs to be protected and have similar powers and authorities locally as the CMOH has been given provincially” (ASPHIO, see Appendix 3), and “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” (COMOH, see Appendix 3).
alPHa members clearly and repeatedly expressed the importance of board of health members having a strong commitment to and understanding of public health. The Board of Health section provided further insight into what is required of their members, as well as the broader governance environment:

Regardless of the board governance model, each board member must clearly understand the purpose and roles of the board of health, the legislation that defines them, and his or her roles and responsibilities. This requires not only an individual commitment, but also a stronger climate of clarity and mutual understanding and respect for the roles and responsibilities of the different players, i.e., the board members, the medical officer of health, municipal councils, and the province. (see Appendix 4)

Board Terms of Membership

Members identified the management of terms of service for board members as an important element in the success of board effectiveness. Multi-year terms are recommended and terms should be staggered to ensure better continuity through periods of high turnover, i.e., during municipal elections. The recommendation to keep municipally-elected representatives on boards to a minority level will assist with the issues associated with turnover of these board members.

Health Unit Alignment

alPHa’s members are unanimous in their positions that health units should not come under the jurisdiction of local health integration networks (LHINs). The following excerpt from the COMOH position paper reflects the input from alPHa’s members.

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. (see Appendix 5)

While agreeing with the principle that public health should not be coordinated by the LHINs, a number of alPHa members suggest that alignment with LHIN boundaries could be considered, but only where that structure makes sense due to close proximity or access to resources.

Most alPHa members, however, are open to change in the current structure and geographic distribution of health units. COMOH suggests that the current configuration of public health units should be optimized. They make the recommendations:

- Consider the critical mass of expertise required to achieve expected functionality of local public health units and minimize administrative costs
- Voluntary and opportunistic amalgamations should be supported and encouraged
- Simple amalgamations are preferable to the splitting up of existing health units
- Change management be actively supported for a sufficient period of time (e.g. 2 years)
- 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. (see Appendix 5)

These words are echoed in the recommendations of other alPHa members who, when considering how the
number and geographic locations of public health units should be determined, make the following recommendations:

Need to balance population with geography/travel requirements. Access to resources and specialized professional staff is a key element. (ASPHIO, see Appendix 3)

The number of units should be a function of the population size and geographic area and large enough to support a full range of public health experts. (OAPHD, see Appendix 6)

Use the current public health structure as a starting point and consider local agency boundaries including school boards, social services, LHINs etc. as well as population, geography, etc. Consider current geopolitical boundaries for both programming support and data. ….. More importantly, public health has to work with community agencies as well as with health care and the boundaries must make sense from the perspective of local agencies and organizations. (APHEO – see Appendix 2)

Where it is difficult to retain key resources, it is suggested by some alPHa members that regional structures similar to the PHRED program should be considered where centralized consultants could provide support to a number of health units within a defined region.

Recommendations:

1) Local boards of health should be independent of local government.

2) Board of health members should be drawn from the communities it serves, and should include municipally elected officials, as well as committed citizens chosen by the Board or appointed by the province.

3) Board of health members must have a strong commitment to and understanding of public health.

4) Health units should not come under the jurisdiction of local health integration networks (LHINs).

5) Realignment of health unit boundaries should be considered only in the context of optimizing human and financial resources, and ensuring equitable availability of public health expertise and technical requirements for full local delivery of public health services in all parts of the province. Any such consideration must be undertaken in full consultation with local boards of health, health unit management and their professional associations.

PUBLIC HEALTH FUNDING

There are many variable factors that must be considered when determining public health unit funding. The aim must be to ensure that the requirements in the HPPA can be met by all health units, including the ability to determine and address community-specific needs.

Three key principles are supported by alPHa’s members in terms of the overall structure of public health funding. These principles are:

a) Core Services. Fund a set of core public health services that apply across the province. This allows all health units to start with an even playing field.
b) Local Needs. Fund health units to determine and address community-specific public health needs. This allows for variable needs across communities to be addressed.

c) Multi-year Funding. Develop a three-year needs-based funding framework for health units. This will improve funding stability and long-term planning for health units.

Variables in the Funding Formula

When it comes to the specific components of a public health funding model, there is agreement on a number of important characteristics that impact the cost of service. alPHa’s March 2004 position paper, Creating a Sustainable Public Health System, stated that public health funding must include strategies related to geography, population dispersion, and the determinants of health. These characteristics continue to be seen as essential elements of a public health funding framework. Specific elements are:

Population Characteristics. Demographic factors have a considerable bearing on public health service delivery. For example, service to First Nations communities can have an impact in terms of population density, transportation and managing multiple small branch offices. Key population characteristics to be considered in funding public health are:

- Population size
- Population density
- Age distribution
- Population fluctuations (e.g., daily or seasonal changes)
- Health status
- Health Risk factors
- Diversity (e.g., cultural practices and languages)

Community and Geographic Characteristics. Health units in Ontario vary a great deal in the land mass they cover. Serving the people in geographically large health units can result in significant travel expenses, and equitable program access often requires larger investments in infrastructure, e.g., satellite offices. Community characteristics such as the number of employers, restaurants, and facilities have a large impact on resources needed for surveillance and inspection. Key community and geographic characteristics to be considered in funding public health are:

- Geographic size of health unit
- Number and geographic dispersion of communities
- Rural factors (e.g., isolation, numbers of farms and wells)
- Density factors (e.g., number and dispersion of regulated premises and facilities to be inspected)
- Concentration of industry (e.g., risk factors from pollution)
- Geographic hazards (e.g., bodies of water)
- Availability of other health and social service providers

Socio-Economic Characteristics. Determinants of health can vary greatly across health units. Key social and economic characteristics to be considered in funding public health are:

- Education levels
- Employment levels and employment security
- Food security
- Housing security
- Income levels (levels of poverty)

Health Unit Characteristics. Just as the characteristics of the geographically defined health units are variable, the organizations that manage the services provided to the health units have important
differences that need to be taken into consideration when providing them with funding. These characteristics are:

- Staff size
- Availability of skilled staff
- Organizational complexity (e.g., number of organizational levels, collective agreements, supply contracts, number of satellite offices)
- Local partnerships and network participation
- Program compliance

Other factors to consider are:

- Community infrastructure to support public health programming
- Inflationary factors
- Tax base (i.e., municipality’s ability to pay)

**Funding Issues**

While considering a comprehensive funding formula for public health there is an opportunity to address current issues. Two key issues are consistently identified by aPHa’s members. These are:

**Administrative Costs.** Where the Ministry of Health and Long-term Care funds a public health program 100 percent, administrative costs must be included. This will ensure an unintended financial burden is not placed on health units.

**Fiscal Year vs. Calendar Year.** As expressed in the COMOH position paper, “there is a need to address the long-standing shortcomings of the budgetary process including differences in fiscal years between provincial and municipal governments.” (see Appendix 5) While it is recognized that it will be difficult to have local or provincial levels of government change their fiscal year, moving to multi-year funding will greatly reduce the impact caused by the fiscal year differences.

**Funding Sources**

aPHa’s members fully support the current direction of Operation Health Protection to achieve a provincial/municipal funding split of 75%/25% by 2007/08. In The SARS Commission Second Interim Report SARS and Public Health Legislation, Justice Archie Campbell writes, “The burden of persuasion is on those who want to preserve the present system of split provincial-municipal governance.” (p. 61) aPHa’s members feel strongly that it is important to maintain a municipal role in the governance of public health. It is acknowledged that better supports and accountability mechanisms are needed for boards of health and health units to ensure all health units are strong organizations, well positioned to achieve their mandates. aPHa’s members believe that this can best be achieved working together with the municipalities that represent the communities health units serve. As expressed by the BOH, “There is a general agreement that funding for public health should be shared to ensure local decision making, central guidance, and a larger resource base.” (see Appendix 4)

Community engagement in the public health system is highly valued by those who work in the public health system. Community capacity building is an important part of developing healthy communities. Maintaining municipal involvement will build resources within communities that support public health efforts on an on-going basis. “Without municipal funding, it is perceived that municipal engagement on the board of health and in public health issues would be significantly reduced.” (COMOH p.2)

**Recommendations:**
6) The following three principles should be incorporated into the overall structure of public health funding:

a) Core Services. Fund a set of core public health services that apply across the province.
b) Local Needs. Fund health units to determine and address community-specific public health needs.
c) Multi-year Funding. Develop a three-year needs-based funding framework for health units.

7) Where the provincial government funds a public health program 100 percent, administrative costs must be included.

8) Continue the current direction of *Operation Health Protection* to achieve a provincial/municipal funding split of 75%/25% by 2007/08.

PUBLIC HEALTH SYSTEM ACCOUNTABILITIES

There is strong agreement among alPHA’s members that the existing accountability mechanisms in place for public health are inadequate. While different alPHA members focus on the utility of a variety of tools that could enhance board of health and health unit accountability, audits and balanced scorecards receive the most support. Universally supported are the principles that accountability should be built on standards that are applied at provincial and local levels of the public health system, and that standard data collection tools that are part of the everyday work of the health unit need to be developed.

The following excerpts from the COMOH position paper are representative of what many alPHA members support:

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 (App5, p.7)

COMOH goes on to recommend:

The development of a compulsory, multi-dimensional accountability framework for public health units that:
- Holds local boards of health accountable for those activities and outcomes for which they can be held solely accountable
- Ensures that basic financial controls are in place
- Includes the performance of board governance functions
- Includes a periodic, independent audit or accreditation of local public health system performance
- Uses data and information that are simple to retrieve and preferably available
from local management and information systems.

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.

The use of a balanced scorecard or similar mechanism to provide an integrated and comprehensive description of public health system performance. (App5, p.9)

Recommendations:

9) Accountability should be built on standards that are applied at provincial and local levels of the public health system.

10) Standard data collection tools that are part of the everyday work of the health unit need to be developed.

PUBLIC HEALTH HUMAN RESOURCES

Current Realities

Public health units employ approximately 6,000 people in Ontario today. Public health professionals are highly skilled and are committed to serving the communities in which they live and work. However, there are significant shortages of public health staff in Ontario, including MOHs, public health epidemiologists, public health dentists, health promoters, public health inspectors, public health nurses, and public health nutritionists. Rapidly declining enrolment and graduation numbers in post-secondary public health programs, and the loss of skill sets acquired in these programs to more lucrative careers indicate that these shortages could become even more significant in the near future. The field of public health has a relatively low profile in society. It is often said that when public health is doing its job well, it is invisible.

This invisibility was apparent following the SARS outbreak when there was little specific mention of the MOHs, communicable disease investigators, epidemiologists, and data entry staff that went well beyond the daily demands of their jobs to manage the crisis. If public health is to become an attractive career option for those who wish to contribute to the well being of the population, it should be promoted as something more than “other health care workers” when they are being publicly recognized.

Even though public health can be a very rewarding field in which to work, as a lesser known field in which to work, skilled staff experience professional isolation and lower professional status. Salaries are lower than comparable positions in other settings. Health unit staff in general works in relatively flat organizations where, for the most part, there is limited opportunity for career advancement. Some professional groups see their role as marginalized depending on the focus of the health unit. For example, APHEO states that, “not all health units have a culture that supports the need for evidence based planning, and so the epidemiologist may not be able to do their job.” (see Appendix 2)

Public health receives insufficient support from the education system. There are only a few post-secondary schools that offer professional training, student placement opportunities are limited, and professional schools where graduates could work in public health often provide little or no information about the field, e.g., medicine, dentistry, epidemiology, and nutrition.
Strategies for the Future

To achieve the renewal of the public health infrastructure that is being undertaken at this time, a full complement of qualified staff in each of the public health disciplines and the technical roles that support them is required. Careful consideration must be given to recruitment and retention strategies, to include specific attention to competitive pay, benefits, working conditions, educational incentives and professional esteem.

Recommendations:

11) The development of a strategy to address the immediate shortages of medical officers of health and public health dentists, epidemiologists, promoters, inspectors, nurses, and nutritionists.

12) The development of a comprehensive, long-term recruitment strategy that includes promoting public health service as an attractive career choice. This strategy should include input from institutions with a public health curriculum, the Ministries of Education and Training, Colleges and Universities, and alPhA and its Affiliate organizations.

13) The development of strategies to provide or facilitate the provision of ongoing education for public health staff and training opportunities for students including, but not limited to, job placements, secondments, tuition-for-guaranteed service arrangements and paid practicums.

14) The Ministry of Health and Long Term Care, in consultation with local public health agencies and relevant associations, must clearly determine core competencies, appropriate remuneration, and ideal numbers for public health staff to carry out public health services mandated by the province as well as those deemed necessary or desirable for a community by its board of health.

RESEARCH AND KNOWLEDGE TRANSFER

alPhA members support the need for a comprehensive and planned approach to research and knowledge transfer. A plan should be developed that encompasses provincial, regional, and local level requirements, including definition of how these levels interact. Current structures can play important roles in ensuring that research and knowledge transfer is developed to support the public health system as a whole. The existing regional Public Health Research, Education, and Development (PHREDs) programs need to be re-examined in light of the new Ontario Health Protection and Promotion Agency. The provincial agency with its evolving mandate to support public health research will be in a good position to coordinate the activities of the regional PHREDs. The central agency could establish research programs in various fields and co-ordinate research activities through the system. It can also co-ordinate collaborative program evaluations across health units.

As a model moving into the future, the PHRED program receives mixed reviews from those working in public health. The regional structure and work of the PHREDs is generally viewed as a strong support to health units, but a number of improvements are suggested. Most importantly, the PHRED program is seen as needing a clearer mandate and 100 percent provincial funding. Health units would also like to see more focus on developing community profiles, researching best practices, and Rapid Risk Factor Surveillance System (RRFSS) data analysis. They would also like to see RRFSS funded by the province for all health units.

A key element in the area of knowledge transfer is paying close attention to the accessibility of
information and the way it is presented. Health units are eager to use research and best practices in program development and evaluation, but the research must be distilled and communicated in ways appropriate to the health unit audience. One suggestion from OSNPPH (see Appendix 7) is for PHREDS to use a newsletter format with sections relating to public health programs, e.g., inspection, chronic disease prevention, etc.

APHEO (see Appendix 2) notes that PHREDS are not sufficient for epidemiologists who require biostatistical, research and evaluation expertise as well as a coordinating function between health units and with universities.

Another information need that has been identified by aLPHA’s members is a central health resource library. Ideally this resource would be electronic for ease of access to journal articles and other literature. The recently launched public health portal could be used to promote and disseminate public health research, best practices, benchmarks, and program evaluation.

Health units clearly want to have access to research that will help them to plan programs effectively. This will mean ensuring structures and processes are in place at provincial, regional, and local levels to support health units and, more broadly, the field of public health.

Recommendations:

15) Develop a plan for research and knowledge transfer that encompasses the provincial, regional, and local levels.

CONCLUSION

This position paper represents a synthesis of our members’ discussion of the five key topics under review by the Local Capacity Review Committee. It is meant to add to the current and comprehensive set of reviews underway by the Committee. The appendices contain the position papers and key statements developed by aLPHA’s members. Those that did not develop position papers provided key statements in a question and answer format, using the COMOH questions as a guide. This set of documents and their recommendations are largely consistent and complementary. Together, they form a strong foundation for strengthening the public health system to truly enable residents of Ontario to realize their fullest health potential.
INTRODUCTION

The Association of Ontario Public Health Business Administrators (AOPHBA) was provided with the Council of Medical Officers of Health (COMOH) discussion questions by the Association of Local Public Health Agencies (alPHa) with the opportunity to comment as an affiliate of alPHa. AOPHBA subsequently met in June and this paper provides some views espoused by the affiliate on the areas of:

1. System governance and structure;
2. Public health system accountabilities;
3. System funding;
4. Public health human resources; and
5. Research and Knowledge Transfer

System Governance and Structure

The key theme relating to various types of governance and structure was that there must be a consistent province wide model that focuses on and supports public health. There are obvious advantages and disadvantages to the different types of governance – autonomous, regional, and municipal. Regional government can provide massive administrative support to a health department that is not available to autonomous health units. There was general agreement that regions were generally supportive of the “must do” aspects of mandatory programs and that this, in many cases, was the crux of the problem – the ministry must be more definitive as to what standards are mandatory. At the same time, an autonomous board can be very supportive of public health issues and, while some autonomous boards can be pre-occupied with the cost of public health at the expense of program delivery and meeting mandatory guidelines, a recent alPHa survey shows that health units with autonomous boards fared better with respect to their 2005 budgets.

The AOPHBA supports an autonomous board governance model for public health units to permit a Medical Officer of Health to ensure local public health requirements are met. Service agreements can be put in place to share services with municipalities and to meet surge capacity on the administrative level. For autonomous boards to be effective, there must be firm direction from the province to boards of health on what the expectations are regarding the delivery of public health. Board membership also plays an important role in the process.

The majority of boards of health currently have municipal appointees and provincial appointees with municipal appointees being in the majority. There has to be an increased focus on public health issues as there are times when municipal councilors are required to concern themselves more with municipal funding issues rather than the issues pertaining to public health. With the change in municipal/provincial funding levels, the minimum requirements are that elected municipal representation on boards of health must more accurately reflect the municipal financial contribution.
Local autonomous boards of health and continuing municipal representation, albeit with improvements in candidate selection, determine that the public health funding mix should continue to be split municipally and provincially with the province paying a 75% as will happen by 2007. Were there to be further changes to cost sharing, care must be taken to ensure the municipal contribution remains large enough to maintain a municipality’s ongoing interest in public health matters.

AOPHBA does not believe health units should be aligned with LHINs. In determining the appropriate distribution of health units, consideration must be given to stakeholders served by the health units, e.g. school boards. Amalgamation of like organizations can be problematic – municipalities, school boards, hospitals are all examples where expected savings related to staffing reductions did not materialize, and the true cost of amalgamation tends to be underestimated.

In addition to stakeholders being served by health units, other criteria for consideration, if mergers/amalgamations are to occur, must consider geographic boundaries and the problem associated with servicing large areas, not only in the north but also in southeastern Ontario for instance. Consideration must also be given to the diversities in community needs and demands on large geographic areas.

PUBLIC HEALTH SYSTEM ACCOUNTABILITIES

Existing outcome measurement strategies and tools are not sufficient to track and report against the established accountabilities. AOPHBA considers accountabilities related to the financial side are more than adequate with the requirement for independent audits, provincial settlements, etc. The problem is determining if the money is being spent on the right thing and that is a program issue. Program Based Budgeting, in and of itself is not an outcome measurement tool. This was all too evident prior to 1998 when the PPB process was not only financial in nature but also attempted to establish goals and objectives and measure a health unit’s performance at the end of a year. In all likelihood, those goals and objectives were never even looked at. MPIQ was introduced as an assessment tool, but its effectiveness appears limited, and provincial feedback has not been timely.

Performance measurement outcomes are difficult to establish in many of the mandatory programs. How can one quantify and measure something that may only produce results five or ten years down the road. In order to determine health unit’s success, a measurement system needs to exist which includes a valid data capture process. Very few health units possess the resources to produce the required databases, and they have yet to be developed by the province. Standards are set by the province; the success of a particular program based on outcomes is set by the province; as such, the required information systems used by each health unit will use the same information and those systems, for the sake of efficiency and commonality, should be developed by the province.

Accreditation is not considered to be an effective tool to report against established accountabilities as it has no relevance to mandatory programs at the provincial level. It is an internal administrative assessment tool of value only to the health unit being accredited.
PUBLIC HEALTH FUNDING

Boards of health must continue to approve the budgets for their health units with the province providing the appropriate grants based on the applicable cost-sharing ratio. Grants must be approved earlier in the health unit’s fiscal year because many boards of health, notwithstanding provisions of the HPPA which empowers boards to approve budgets, will discourage new spending until both the municipal and the provincial approvals are received. AOPHBA does not see any requirement to synchronize the public health unit fiscal year with the MOHLTC as the ministry normally does exceptionally well in converting grants from April through March to January through December. The three month window is viewed as advantageous to both health units and the ministry. Occasionally, when new 100% funded programs are introduced, the ministry will respond to the suggestion to alter the fiscal year to a calendar year basis for the benefit of municipalities and health units.

There is a need to recognize local issues and population increases in specific areas when funding public health. Specific funding formulae applicable to all health units mandated by the MOHLTC are not considered workable. Having said that, there is a requirement to identify an equitable approach to funding unorganized territories.

100% funded programs must be fully funded so cost shared mandatory programs do not carry the brunt of administrative costs (Healthy Babies/Healthy Children is but one example). Currently the criteria for 100% provincial funding is direct program operating costs only and does not include administrative and overhead costs required to support the program. Progress is being made in providing allocated administrative costs to 100% funded programs as evidenced by the new Ontario Tobacco Strategy funding allocations.

There is an urgent requirement for the MOHLTC and the health units to institute long-term funding (three years?) forecasts which are needs based to create funding stability. Concern has been expressed over the ministry’s capability to provide ongoing sustainable funding, given the funding is changing to 75%-25%. This is of particular concern if health units are successful in maintaining the existing municipal funding levels, as was the stated intention when the ratio change was announced.

A consistent process is required for capital funding applications. The establishment of reserves (municipal and provincial funds) for major item replacement costs should be investigated.

Resource sharing and pooled purchasing can go a long way to help reduce public health costs. A prime example is resource material development at the provincial level. Some work is being done now, but an increased emphasis on the development and production of resources at the ministry level for distribution to all health units would provide for consistent messaging and time and cost savings for public health units. The key question is to ensure services across public health are optimized.

PUBLIC HEALTH HUMAN RESOURCES

The issues in recruiting and retaining public health staff are numerous and require serious efforts on many fronts. There must be a greater awareness of public health career opportunities at university, college and even high school levels of education. Links with educational institutions
must be established and maintained to increase recruitment. The MOHLTC working with the Ministry of Colleges and Universities should have a significant role in ensuring the supply of public health professionals graduating from the educational system is adequate enough to meet the staffing needs of public health unit across the province. Health units must actively recruit public health staff from educational institutions. The supply of some public health professionals is limited by the finite number of educational facilities for a particular professional group, as is evidenced by the dearth of Public Health Inspectors in the province. There is also a requirement to provide incentives to attract qualified staff to under serviced areas, such as the north.

Bursaries and grants may be one way of attracting individuals to the public health profession. Career advancement within health units is limited because of the relatively flat hierarchical structure. To overcome this, greater opportunities for secondments, even with the inherent risk of permanently losing staff as a result of the secondment, and the ability to work on collaborative projects within the ministry and between health units should be implemented. Opportunities for professional advancement must be encouraged.

Salaries and benefits must be competitive with the market. Even between health units, salary disparities exist that can make it extremely difficult to attract professionals to a particular health unit.

Apart from Public Health Inspectors, the greatest difficulty health units encounter is the ability to attract Medical Officers of Health. The association’s desire to comment on availability of Medical Officers of Health probably created the greatest controversy in the group as to whether or not AOPHBA should be offering comments. Compensation packages for MOHs need to be improved to make them competitive with other areas of the medical profession. Again, bursaries and other forms of financial assistance could be made available for medical students interested in pursuing a career in public health. There has been much discussion regarding the governance of a health unit with MOHs also being the CEO of the health unit, which is the norm, and is also being recommended by the Campbell Commission. However, discussion amongst AOPHBA members indicated that there may be MOHs who have little or no interest in the administrative aspects of a CEO’s position within a health unit (finance, human resources, etc) and would prefer to concentrate on health protection and promotion only, leaving the day to day chief administrative operations to someone else. This concept could be further explored as it is workable, does not detract from the MOH remaining as CEO, and could accommodate those physicians interested in public health who prefer to concentrate on only the medical aspects of public health.

Research and Knowledge Transfer

PHREDs should be re-examined in light of the new Health Protection and Promotion Agency. They should also be 100% provincially funded. Very few AOPHBA members were aware of what type of support their respective health unit received from their ‘neighbouring’ PHRED. Indications were that health units that availed themselves of the services of a PHRED found the cost to be bordering on excessive – hence the requirement for 100% provincial funding so the services of PHREDs are available universally.
QUESTIONs

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, existing measurements are not sufficient for tracking and reporting. New indicators and consistent interpretation of the indicators including definitions and data sources need to be improved. We recognize that it is not easy to develop indicators that are truly attributable to public health activities. A number of different strategies and tools are necessary, including input, process and outcome measures which are all important.

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

1. Scorecards?
2. Audits?
3. Questionnaires?
4. Accreditation?
5. Other?

Any of these would be useful, the significant issue is that whatever is done is standardized and consistent – it is also important that the reason for gathering the information is identified (i.e. scorecards are very different than audits). If scorecards are used, then the score card will need additional flexible reporting that will allow for explanations (e.g. during SARS other targets were not achieved). Any mechanism should have strong public health input and should be well documented, peer reviewed and evaluated once in place.

Optional Question

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

The general standard of Planning and Evaluation needs to be revised and is of specific interest to our Association. All of the Mandatory Guidelines need to be revised for different reasons- some have previously had extensive suggested revisions and therefore may be easier to update such as Chronic Disease.
Governance and Structure

QUESTIONS

Should the autonomous board of health model be adopted province wide?

Although there are many resources available to those health departments in regional governments, as a structure, boards of health should be autonomous.

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

There should be a mixture of local and provincial political representation and non-political public representation from non-political. Note that the short-term nature of most boards does not support long range planning.

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

Blend of provincial (highest percentage) and local (for local ownership).

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

No

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?

Use the current public health structure as a starting point and consider local agency boundaries including school boards, social services, LHINs etc. as well as population, geography, etc. Consider current geo-political boundaries for both programming support and data. Any changes need to be preceded by a needs assessment and have an on-going mechanism to assess effectiveness and efficiency of any changes.

Optional Question

(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?)

All these need to be considered – also taking into consideration other ways data is collected (for example census boundaries are used as denominators in many of the rate calculations). The boundaries need to make sense at a community level for several reasons. Reliance on postal codes for creation of boundaries will not give accurate information. County boundaries should be respected where possible. More importantly, public health has to work with community agencies as well as with health care and the boundaries must make sense from the perspective of local agencies and organizations.
Public Health Funding

QUESTIONS

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

Funding needs for public health require both a base funding approach (i.e. you need the basic staff regardless of population size), some population size factor (specifically for client based service components) and then some other dispersion factor for travel and costs related to distance (i.e. need for satellite offices in large geographic health units to have some sort of Presence). Multi-year budgeting would facilitate planning.

Base funding should be simple and transparent, based on population size, transportation issues (mostly rural issue), and service delivery needs (e.g. hubs of HIV, restaurants etc in urban areas). In addition funding and resources should be available for innovative public health programs or programs based on evolving or specific local needs (e.g. measles outbreak, SARS, mental health programs, parenting programs, new surveillance initiatives) and have, as part of all of their designs, a strong evaluation component. These resources should be available to all health departments.

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

A key issue is "stable funding" so that health units can count on regular increases for cost of living etc. Also need to hear about funding earlier to allow for hiring of allocated human resources (rather than waiting to year end to know that budget has been approved).

Public Health Human Resources

QUESTIONS

What are the challenges and issues in recruiting and retaining epidemiologists?

- Not enough new people entering the public health.
- No specific training and apprenticeship program for public health epidemiology.
- Differences in salaries.
- Contract positions are not as desirable and should only be used for special projects.
- Geography – can be difficult to recruit in rural or northern areas.
- A variety of different job functions and understanding of the skills of epidemiologists across the province.
- Epidemiologists who are the only epidemiologist in the health unit are often overstretched and feel isolated.
- Not all health units have a culture that supports the need for evidence based planning, and so the epidemiologist may not be able to do their job.
- Epidemiology is not a mandated position in a health department unlike most other professional positions.
- Career advancement limitations.
What are the challenges and issues in recruiting and retaining public health staff in general?

**Key Human Resource Issues**

In March 2005, APHEO conducted a member survey to identify our key human resource issues. The following ten issues represent the most pressing human resource needs identified by our members; most of these identified needs are applicable to all health unit professionals:

1. Achieve a minimum staffing level of qualified epidemiologists in each local health unit in Ontario.
2. Complete the identification of discipline specific core competencies for public health epidemiologists and standardize credentials for public health epidemiologists.
3. Enhance epidemiological resources at the provincial level including specialized epidemiological resources as well as staff to perform routine centralized "data" functions.
4. Increase funding for "decision-support" teams at the local and/or regional level that includes epidemiologists, data analysts, evaluators and administrative support.
5. Ensure a broad range of ongoing continuing education opportunities to keep skills up-to-date.
6. Provide support for public health professionals to obtain advance formal education, while still in the workforce.
7. Provide opportunities for career growth potential.
8. Ensure competitive compensation and reasonable equity in compensation across health units and other regional/provincial structures.
9. Increase the understanding of the use of epidemiology and the role of epidemiologists among other front-line and senior management staff.
10. Adequately resource a supportive network to facilitate ongoing training and collaboration of local public health epidemiologists and other decision support staff from across the province.

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

- Coordinated recruiting strategies.
- Equitable and competitive salaries.
- Better continuing education opportunities.
- A critical mass of epidemiologists, health analysts and evaluation specialists in each health unit.
- Support of APHEO and other networking capacity through teleconferencing (and other technological resources).
- Central epidemiologist support available to provide extra capacity locally if needed.
- Sufficient resources to allow student placements.

Optional Question

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

At least one epidemiologist in each health unit.

From the epidemiology context: epidemiologists, evaluators, data analysts, GIS capacity.
Public health units are mandated to ensure that local programs address the health needs of the community, with cost-effective, efficient evidence-based approaches. To assist with this standard, most public health units in Ontario have at least one Master’s prepared public health epidemiologist on staff and may also employ a continuum of specialized knowledge workers including data analysts, evaluators and other decision-support staff. Yet, there continues to be a number of smaller health units that are either unable to recruit an epidemiologist or have not elected to use their resources to employ an epidemiologist. In addition, there is a shortage of experienced epidemiologists and other decision-support staff that work on a part-time or short-term contract basis to support specific projects. Although work environments have slowly changed over the past decade, many epidemiologists continue to work in relative isolation from their professional peers within the health unit environment. Networks, such as APHEO and the now dissolved Health Intelligence Unit (HIU) system, play a key role in supporting individuals as they carry-out their day-to-day work.

In addition the following centralized resources for local health units should be considered:

a) Centralized timely, output of results by health unit and province for a short list of “core” indicators as identified in the APHEO core indicators project, this would go beyond what is currently available through Statistics Canada and would include additional public health indicators from RRFSS or other sources.

b) Development, support and coordination for provincial wide evaluations that are common to all health units (e.g. Tobacco, ECD projects etc.)

c) Human resource and knowledge transfer resources to carry out specific tasks of general use to public health such as: leading and conducting public health specific effectiveness reviews, maintaining and updating indicator’s on APHEO’s website, supporting the development of RRFSS across the province, including web maintenance.

d) Human resources to secure, disseminate to the field, and support our use and interpretation of those "harder to get" data sets for example mental health and OHIP billing.

e) Human resources to provide support to the field or carry- out and conduct those "harder to do" analysis or analysis that one does not often have to do (such as cancer cluster investigations...). This type of support might include having someone to call when one has specific epidemiology questions and would like a second opinion.

Specifically, centralized core indicator pre-packaged analysis of databases such as morbidity, mortality, natality data sets is required at minimum. The HUI’s took us a step closer to this vision of automated data analysis systems - there is a lot of work there that can be taken and built upon.

There needs to be more evaluation support available to HU’s. There have been many opportunities for centralized evaluation of Heart Health, ECD and now Tobacco programs and the resourcing and support for evaluation appear to get missed.

In my opinion, the demands made on HU epi’s to support PH program planning, evaluation, research and information needs has grown exponentially and competing demands are an issue.

In addition, a central resource for biostatistical and senior epidemiological expertise to communicate with public health epidemiologists, which has experience of public health, is very necessary. This person would need the time and flexibility to respond to respond to local issues.

With reference to iPHIS, we should be ensuring that while the cognos people are still here they should continue to work on canned reports that would be used by all or even a portion of HU’s to minimize the number of complex reports we might have to create; and 2) when the cognos people leave, there should be a mechanism whereby we have access to someone who is expert at report studio who could create ad hoc complex reports when we need them. Since we are going to have little need to create these complex reports, then when the time comes that we do, let’s say during an emergency situation, we are not going to remember how to create them or at least not without a lot of hassle and
Moving Ahead Together: A Position Paper of the Association of Local Public Health Agencies

Research and Knowledge Transfer

QUESTIONS

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

Local health unit capacity to access on-line journals, but not to do systematic literature reviews.

We need centralized resources of expertise – biostatistics, research design and evaluation

We also need a co-ordination mechanism so that we can do collaborative program evaluations, etc.

Critical mass of people and resources centrally to ensure delivery of data and resources and issues centrally.

Is the PHRED Program sufficient to meet this purpose?

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

No. The PHRED program supports evidence based planning for public health programming and education and training of public health professionals particularly nurses. Epidemiologists need additional centralized support for epidemiologists and evaluators such as biostatistical, research and evaluation expertise and a coordinating function between health units and with universities. Systematic literature reviews, benchmarking, are not appropriate at the health unit level. The challenge arises as the PHRED program mandate is not driven by those units within its area (such as occurred with the HIP’s). The mandate of the PHRED program has been confused over the years, and a clear mandate and 100% provincial funding is needed.

An environmental scan and needs assessment of current strengths of our system.

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

Not necessarily – however a plan needs to be articulated (for provincial, regional, and locally).

ii. Other mechanism(s)?

Recommend HIP structure. One option would be the HIP structure. However, it is necessary to identify needs, analyze options, implement a process and be open to change based on the evaluation.

Optional Question

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

- Establish a process (assess through to evaluation).
- Have all levels involved in process (local, regional, provincial, etc.).
- Base decisions on best practices.
Our comments are summarized under the following headings:

- Public Health System Accountabilities
- Governance and Structure
- Public Health Funding
- Public Health Human Resources
- Research and Knowledge Transfer

**Public Health System Accountabilities**

- The existing systems are not adequate.
- Agree that MOHLTC audits must be conducted.
- Accreditation is a useful tool but less than ½ of the PHU are accredited.
- Accreditation process may provide the tool/process to measure local PHU against a standard or accepted level of practice.
- The current MOHLTC databases such as CISS, IRIS, etc are outdated and need to be replaced. Better data management can assist PHU in measuring and reporting compliance with reportable standards.
- Many PHU have either replaced CISS or in the process of replacing CISS with other databases such as Hedgehog (Decade Software), etc. The MOHLTC should support these initiatives through the current or future funding formulas and build on the databases being implemented by local PHU by either adopting the same or enabling PHU to report results in a format that can be easily prepared/converted by the PHU databases.
- A standard software platform for all health units should improve accountability, efficiency, overall reporting and communication efforts among health units/ministry in day to day functions as well as responding to surge capacity events.
- Safe Water, Food Safety, Tobacco Control MHPSG require immediate re-writes, particularly in light of new legislation.
- Health Hazard Investigation and Emergency Response/Management should be separate programs with measurable outcomes and deliverables for PHU.
- The Mandatory Program Indicator Questionnaire needs to be revised or replaced by some other reporting tool to more accurately measure compliance and reflect the accomplishments of PHU.
**Governance and Structure**

- Autonomous BOH structures are generally supported comprised of both local citizens and local elected officials. Appointments by MOHLTC should also be considered.
- The local MOH should have autonomy and needs to be protected and have similar powers and authorities locally as the CMOH has been given provincially.
- Needs to be a process where public health funding is directly related to meeting all provincial standards and guidelines (MHPSG) and to address local needs and/or issues. Currently, many politicians have cut PHU funding on the principles that something less than 100% compliance is fine. Particularly, when there is little accountability or auditing by the MOHLTC. “Pay for say principle”, e.g. if no local municipal funding then local political appointments may not be necessary for the BOH to be functional.
- When determining how many PHU, must incorporate the size of the population, demographics, local needs and the geography of the area. Travel times and access are very different in rural areas than urban areas, particularly for the northern communities where unorganized townships are serviced by remote field staff. Need to balance population with geography/travel requirements. Access to resources and specialized professional staff is a key element.

**Public Health Funding**

- Support 100% Provincial Funding provided PHU can implement additional programs and/or services to meet local needs.
- A review of the current wage structure within PHU to ensure that positions with similar educational requirements and responsibilities are compensated equitably, e.g. Public Health Nurses and Public Health Inspectors – wages may vary considerably is some PHU.
- Whatever funding formula is finalized need to ensure that the northern and rural PHU unique challenges are sufficiently addressed to ensure a level playing field across the province of “minimum” public health programs and services (MHPSG or equivalent).
- Would also support a model with some local funding (<25%) however, an autonomous BOH would set the budget, etc and the local municipalities would be required to pay their portion with legal processes in place to ensure they contribute their assigned percentage.
- Critical elements/criteria include; access to resources, population and geography.
- Synchronization of local PHU and MOHLTC budget years (fiscal versus calendar) or timely funding of approved local BOH budgets.
- Recognition for local needs for communication materials in both French and English and other languages based on local demographics. Costs may vary significantly depending on translation needs.

**Public Health Human Resources**

- Competitive salaries continue to be a driver for attracting not only MOH but also other public health professionals and specialists.
- Investigate and implement bursaries and/or hiring incentives to assist PHU to attract and retain professional staff which includes providing internships /placements to recruit new
staff.

- The requirements for 24/7 on-call/emergency services eventually burn-out local MOH and middle/senior management.
- Support the OPHA – Core Competencies March/04 document. Environmental health practitioners can better apply in practice the health determinants associated with environmental health, especially those related to the physical environment.
- In addition suggest reviewing the draft set of Core Competencies proposed by F/P/T Public Health Resources Joint Task Group and the Core Competency Steering Committee of the Canadian Institute of Public Health Inspectors (CIPHI).
- Supportive of the five core functions of the public health system: population health assessment, health surveillance, disease and injury prevention, health protection and health promotion.
- Need also to identify the requirements of support staff and non-professional staff (outreach workers, etc).
- Need to strengthen and enhance the linkages between academia and public health practice and research in environmental public health practice.
- Additional resources are required for public health laboratories.
- Public health informatics is essential to move forward in managing the volumes of data and personal health information at a local PHU level.
- A collaborative approach to public health resource planning should be investigated to enhance the ability of local PHU to: manage their day to day business, share specialized resources, reduce duplication and ensure existing and future public health staff obtains the skills and training to meet public health challenges.
- Ensure the MOHLTC have the technical expertise to provide guidance and assistance to local PHU, particular in specialized roles such as environmental health specialists, toxicologists, data management, program evaluators, risk communicators etc.
- Sufficient management staff is essential to support the growing list of complex programming that has high levels for consequence of error, to provide focused oversight.

**Research and Knowledge Transfer**

- If PHRED is the model, then need a system to ensure that information is more accessible and shared between local PHU.
- Environmental Health Specialists/Practitioners can provide the evaluations and assessments needed to propel current environmental health practice beyond the present regulatory paradigm into innovative environmental health practices.
- If PHRED, then more focus on public health program evaluation, researching of best practices/benchmarking of public health programs and RRFSS data analysis and developing community profiles.
- PHRED should be centralized with the MOHLTC or ensure processes in place for accessibility to PHRED staff and reports/studies
- MOHLTC and other agencies such as the MOE, OMAF, and CFIA consultants should be available to provide guidance and technical expertise to local PHU.
- Linkages between academia and local PHU should be strengthened.
STRENGTHENING PUBLIC HEALTH
GOVERNANCE, FUNDING, AND ACCOUNTABILITY

alPHA Board of Health Section
Submission to the Local Capacity Review Committee

July, 2005
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INTRODUCTION

This paper summarizes the input of the Board of Health Section of the Association of Local Public Health Agencies (alPHA) to the Ministry of Health and Long-term Care’s Public Health Capacity Review Committee. The content focuses on those areas that fall under the purview of boards of health, namely:

- governance and structure;
- public health funding; and
- public health accountabilities (programming and financial).

The Board of Health Section is pleased to support the work of the Capacity Review Committee.

BACKGROUND

In Ontario, there are 36 local boards of health. The Health Protection and Promotion Act (HPPA) lays out the specific membership requirements of each board in regulation 559. Boards of health can be divided into three types:

Autonomous

The Board of Health is independent from local government, e.g., Grey Bruce and Porcupine. However, as stipulated in the HPPA, each obligated municipality in the health unit appoints municipal representatives to be directors of the board. Municipally appointed directors may be councilors or citizens. Staff operations are independent of municipal administration (i.e., subject to their own policies and procedures). The Medical Officer of Health reports directly to the Board of Health.

Municipal

The Board of Health is separate from council; however, staff operations are integrated with the municipal administrative structure, i.e., staff and health unit operations are subject to municipal policies and procedures. Examples are Chatham-Kent and Toronto. Like independent or autonomous boards, each obligated municipality in the health unit appoints municipal representatives to be directors of the board. Municipally appointed directors may be councilors or citizens. The Medical Officer of Health reports directly to the Board of Health.

Regional/Single-Tier

For 9 health units in Ontario (e.g., Niagara, Halton), the regional council or a standing committee of regional council acts as the Board of Health. Regional governments have a Chief Administrative Officer who is responsible to the regional council for all administrative matters. The Medical Officer of Health reports to the Chief Administrative Officer.

Local boards of health are the governing bodies of Ontario's health units. Their role is to set policy and provide strategic direction for the health unit. Directors of local boards of health are appointed and generally fall into one of the following categories:
Elected Municipal Official  An elected representative of municipal council who is appointed to the board of health by municipal council.

Municipal Appointee  A Board of Health director who is not an elected member of municipal council and is appointed by municipal council.

Provincial Appointee  Appointed by provincial Cabinet by Order-in-Council under Section 49 of the HPPA. The HPPA requires the number of provincial appointees to be less than the number of municipal representatives.

Citizen Appointee  A Board of Health director who is not an elected member of municipal council and is appointed as a citizen representative (Toronto only).

GOVERNANCE AND STRUCTURE

The purpose of a board of health is to provide strategic direction and leadership, while ensuring that its community’s public health needs are serviced in a well-managed way. In order to accomplish this, directors of the board must periodically examine and discuss each of the following elements of stewardship:

- principles of governance and board accountabilities,
- roles and responsibilities of the board of directors,
- roles and responsibilities of individual directors,
- guidelines for the selection of directors,
- a range of specific skills and expertise, and
- board standing and ad hoc committees.

If a board takes the time to examine these principles of governance and formulate strategies on how best to govern, it will develop a strong infrastructure of polices from which to work. This by definition builds in a process of becoming informed on the processes and desired outcomes that the board wishes to achieve. It also ensures that each board director is clear on his or her roles and responsibilities.

A director’s primary role is to ensure that the duties of the board of health, as set out in law, and the board’s own strategic direction, as designed to meet the public health needs of the community, are carried out. Municipally-elected directors of boards of health must separate their perceived duty to reduce taxes from their statutory duty to protect the health of the community. Public health is sometimes seen as one of a slate of municipal programs that can be prioritized in the interest of servicing the electorate’s expectation to keep taxes low. Negligence of the statutory requirements for public health services is not an option for any board of health director.

A board of health must also understand and respect the difference between governance and management. A board of health has no role in the day-to-day management of the affairs of the health unit. Boards are responsible for appointing medical officers of health (MOHs) to ensure that the management level is in place for the health unit. A good relationship between the board and the MOH is critical to the success of any board and any health unit.

Throughout Ontario, boards of health function with varying degrees of success regardless of their formal governance structure. An argument can be made that success has more to do with variables other than the structure itself. The majority of board of health directors believe that one model for boards of health cannot serve all areas of the province with equal effectiveness. Furthermore, the financial and human transition costs of moving to one model across the province will present significant challenges, and will have a detrimental effect on boards of health that are already functioning well if they have to align to a
new model of governance. Boards of Health that are working well now, need to be allowed to continue with their current structures.

Regardless of the governance models in place, each board must share common features to ensure they are all effectively serving the same purpose. These features include:

- directors with appropriate skills and expertise,
- directors with commitment that translates into active participation and attendance,
- continuity of membership,
- a strong policy framework to guide the work of the board,
- a strong local emphasis, and
- regular communication with municipalities and other stakeholders.

There is a strong consensus that first among these features is ensuring that directors have a strong commitment and possess the right skill sets that are relevant to the goals of public health and the health unit. A standard orientation program for new directors with a focus on public health and the board of health’s role is needed. The orientation program should be easily customizable so it can be adapted as necessary. On-going board development is equally important for boards with new and experienced directors. Resources need to be put in place to ensure effective orientation and on-going development of boards of directors.

A minority opinion among board of health directors is that the autonomous board governance model should be adopted across the province. This model would see boards of health made up of directors from the community through municipal and provincial appointments, with a requirement that each director have the prerequisite expertise. Some believe that an autonomous board is less likely to be conflicted in its role and is more likely to act according to its natural mandate. The municipal representation (citizens and councilors) ensures an understanding of the community and a responsibility to the electorate. The provincial appointments ensure accountability to the province’s standards and policies.

The main rationale for the majority opinion of allowing different governance models is that local needs must be the driver for public health programs and services. These needs are best understood by local individuals and agencies, and are best served by structures tailored to meet them. While a basic, universally-applicable framework of standards for local service delivery is needed, enough flexibility must exist within it to ensure that boards of health can set the most appropriate policies to respond to local priorities. These strategies may extend to their own structures.

The Board of Health Section supports the current model of blended membership on boards of health. The presence of locally elected officials on boards of health builds in democratic representation, advocacy, and influence, with the understanding that each must serve the primary purpose of the board. Elected officials who are well-informed about the needs of their communities can be valuable voices for public health at their municipal councils. They can keep public health issues on the agenda and lead the translation of board of health strategies into by-laws where necessary.

Provincially-appointed representatives can be effective as a reflection of the shared responsibility for public health service delivery. As the province has accepted responsibility for the largest share of the policy and funding framework for public health, provincial appointments to the local boards that oversee the delivery of its programs and services are justified. Regardless of the size of the provincial funding share however, provincially appointed representatives should be kept to a minority. Provincial appointees must come from the community, demonstrate a willingness to serve, be appointed in a timely fashion, and be chosen for competencies that will serve the best interests of the community and public health. It is noted that a perception currently exists that provincial appointments are biased based on any known political affiliations of applicants. Efforts should be made to ensure that the provincial appointment process is transparent and unbiased.
This model of blended membership is the best means for a local board of health to maintain direct relationships with key stakeholders and to establish reporting and accountability structures with its funding partners and community. Building in standards, including requirements to be well informed on board of health governance, responsibilities, and processes will increase overall board effectiveness. Continuity of membership is a key element of successful board performance. One way to achieve better continuity is to stagger consecutive terms of service to ensure that “corporate memory” is maintained through periods of turnover, e.g., loss of directors during municipal elections.

Regardless of the board governance model, each director must clearly understand the purpose and roles of the board of health, the legislation that defines them, and his or her roles and responsibilities. This requires not only an individual commitment, but also a stronger climate of clarity, mutual understanding, and respect for the roles and responsibilities of the different players, i.e., the board directors, the medical officer of health, municipal councils, and the province.

RECOMMENDATIONS

1. Introduce a package of governance standards for local Boards of Health.

2. Introduce a universally-applicable framework of standards for local service delivery with enough flexibility to ensure that boards of health can develop the most appropriate policies to respond to local priorities.

3. Put resources in place to ensure effective orientation and on-going development of Boards of Health.

4. Ensure Boards of Health that are working well now continue with their current structures.

5. Continue the current model of blended membership on boards of health.

6. Keep provincially appointed representatives on boards of health to a minority, regardless of the size of the provincial funding share.

PUBLIC HEALTH FUNDING

Funding Considerations

There is no simple formula to determine the ideal funding mechanism for public health units. For example, a straight per-capita allocation would fail to take critical variables into account such as geographic size and demographic characteristics. This is further complicated by the shared municipal/provincial, and in some cases, federal, responsibility for underwriting public health programs and services. It is important for the process of determining health unit budgets to remain flexible to ensure both the budget process and the budget itself can reflect local needs.

The following factors are important interrelated considerations when determining levels of health unit funding.

- Geography. Health units in Ontario vary a great deal in the land mass they cover. Furthermore, geographic size and population density are often inversely proportional. The larger the geographic size, the more spread out the population. Serving the people in physically large health units can result
in significant travel expenses, and equitable program access often requires larger investments in infrastructure such as vehicles and satellite offices.

- **Demographics.** Population characteristics can have a considerable bearing on public health service delivery. Many of the Mandatory Programs and Services are age-specific (e.g., 0-19 age group, women of childbearing age, seniors, etc.) and the public health needs of a community will be dictated by the distribution of these and other groups. Data about health status, disease prevalence, and risk factors, as well as the mix of rural, urban, and seasonal populations are also important factors to consider when determining funding levels.

- **Socio-Economic factors.** Socio-economic characteristics vary a great deal in both number and nature from one health unit to the next. Education levels, employment levels, employment security, food security, available health and social services, housing, income levels, and social networks are all important determinants of health that must be closely examined at the local level to help determine service and funding requirements.

- **Optional health programs and services.** Section 9 of the HPPA allows for a board of health to determine that additional programs or services are required to address community health needs specific to the area it serves. The determination of additional programs and services must be supported by the funding model.

Given the set of defined minimum standards that all health units are required to meet (i.e., the Mandatory Health Programs and Services Guidelines and provincial programs such as Healthy Babies, Healthy Children and the Universal Influenza Immunization Program), the above factors must be taken into consideration when determining the funding and resources required to develop and deliver programs to meet these requirements. It is worth noting that this includes the necessity for on-going resources and funding dedicated to gathering and analyzing these variable factors.

**Funding Challenges**

Every recent review of Ontario’s public health system reiterates the significant inadequacy of funding from all levels of government. Because of this, there has been a significant shortfall in the delivery of public health services, many of which are mandated by the province. Notable investments have been made by the federal and provincial governments over the past two years in response, but it is clear that more is required. As an example, a recent article in the Toronto Star pointed out that food safety checks have increased since 1998 from 21 percent to 72 percent province-wide. While this increase is extremely positive, there is still a 28 percent gap to be filled.

Several other challenges exist, many of which are closely related to the shared funding arrangement.

- **Budget approvals timing.** The timing of budget approvals has been an on-going problem for local boards of health and their obligated municipalities. While the municipalities are legally responsible for 100 percent of the board of health budget as submitted, they rely on receiving the promised provincial grant portion in order to keep their accounts. Delays of a year are not uncommon, which becomes more significant where the amount of the grant is subject to conditions and not guaranteed. In the case of program funding such as West Nile virus, the timing issue can create additional problems. The spraying of mosquito larvae must take place in the spring and summer, but health units usually do not know the amount of their funding for this program until the fall.

- **100% Provincial Programs.** Programs announced as 100 percent funded by the province (e.g., Universal Influenza Immunization Program) often fail to account for the administrative costs incurred by health units to deliver them. The net result is a further strain on already tapped health unit
resources.

- **New programs without resource commitments.** Where implementation of new programs is expected without a clear commitment of resources, it is difficult for health units to hire personnel before the resources required to do so are in place. An example of this was the expectation to fill 180 provincially-funded communicable disease investigator positions without any guarantee for provincial funding beyond three months. While the timing was eventually extended, successful hiring and responsible management of resources and expenditures were difficult in a climate of uncertainty.

- **Local requirements.** Where overall funding is insufficient and local variables do not receive adequate attention, it is difficult to take advantage of the flexibility built in to the HPPA to commit resources to optional health unit-specific programs as allowed under Section 9. It is also difficult to build in “surge capacity” to deal with local contingencies. Expanding services to unorganized areas and First Nations communities is also a consideration for many health units that are frustrated by inadequate funding to provide needed services.

- **Program development.** In some cases, significant health unit resources are committed to developing programs leaving insufficient resources to deliver them. While the focus on program development is necessary to ensure that programs are designed to meet local needs, an enhanced central role in determining best practices and developing universally applicable elements should be explored.

**Funding Responsibilities**

There is strong consensus that local decision making authority should be guaranteed, and the best way to do that is to maintain some level of municipal funding contribution. There is also consensus that the larger funding portion must come from the province, as it mandates the programs and services, and has a much larger revenue stream from which to draw. It is also fair for municipalities to contribute to funding given their mandate to address local needs. An idea put forward to further balance municipal and provincial responsibility is for medical officer of health and associate medical officer of health compensation to be 100 percent funded by the province.

75/25 and 80/20 funding splits have the most support from boards of health. This is based on the assumption of the continuation and enhancements of 100 percent provincially-funded programs. Programs that are 100 percent funded by the province must ensure that the funding includes program administration to stop the drain on health unit resources.

Maintaining a certain degree of local funding responsibility will not only protect local decision making authority, but it also maintains local interest and commitment to public health, most notably by ensuring a working relationship with the municipal and regional councils. It also increases the likelihood of implementing the optional, locally tailored programs that will address community-specific health needs.

Considering the province’s recent pledge to take on 75 percent of the shared public health programs and services by 2007, there is less interest in debating the ratio as there is in gaining a clear understanding of the “real” costs” to both the province and obligated municipalities. Further clarity about what is expected of local funders during the transition period is also needed. Given that the province has agreed to pay 75 percent of “approved costs”, there needs to be a clear definition of “approved costs”.

Finally, there is the fundamental issue of what the funding is meant to pay for. The Mandatory Programs and Services Guidelines have not been reviewed in almost a decade, and a thorough examination of their effectiveness is needed.
There is general agreement among boards of health that funding for public health should be shared to ensure local decision making, central guidance, and a larger resource base. Public health services cannot be sustained by local revenue streams, i.e., property taxes, but they must be locally directed. There should be a blend of authority and funding responsibility that best serves clearly identified needs-based standards that are designed to improve community health. With the province providing a clear policy framework and a well-defined majority share of the funding there is no reason why health units cannot continue to govern themselves locally and ensure accountable structures and services within the community.

RECOMMENDATIONS

7. A budget model must be developed that takes into consideration the geographic, demographic, socio-economic, and community-specific optional factors for each health unit.

8. Programs that are 100 percent funded by the province must ensure that the funding includes program administration.

9. Funding for public health should be shared by the province and local municipalities to ensure local decision making, central guidance, and a larger resource base. The current Ministry direction to 75/25 should be continued.

10. The Mandatory Programs and Services Guidelines have not been reviewed in almost a decade, and a thorough examination of their effectiveness is needed.

PUBLIC HEALTH SYSTEM ACCOUNTABILITIES

As the previous sections have illustrated, Ontario’s public health system is made up of a unique mix of centralized and local policy, planning, and delivery structures. There is a notable absence of effective accountability mechanisms among them, and those that exist are either insufficient (e.g., self-evaluation questionnaire) or underutilized (e.g., enforcement provisions in the HPPA). Strengthening accountability of the components of the public health system to each other, as well as that of the whole system to the public is required.

All boards of health, regardless of their structure, would benefit from stronger relationships with provincial government, beginning with clearer expectations of performance standards and external auditing. Mechanisms must be in place to ensure accountability with the province, obligated municipalities, and the local community. Enhanced communications will play a strong role in accountability processes, especially between the board and obligated municipalities, and between health unit staff and the community.

Health Unit Accountability

Provincial Audits. Audits by the Ministry of Health and Long-Term Care are needed to monitor health unit performance. The audits should be based on legislated, enforceable, results-oriented standards. Standards should go beyond measuring compliance and include a strong focus on health outcomes in the community.

Third Party Accreditation. It is recognized that the Ontario Council on Community Health Accreditation serves an important purpose. It provides health units with the tools for independent, voluntary, peer evaluation of the administrative and operational aspects of local public health agencies, including a review of program planning, implementation, monitoring and evaluation. However, there is no consensus
among boards of health that accreditation in its current form should be mandatory.

**Reporting Mechanisms.** Standardized tools should be developed that facilitate the evaluation of financial performance, public satisfaction, staff satisfaction, compliance with standards, and health outcomes, e.g., scorecards, surveys, a Mandatory Programs Indicator Questionnaire (revised to more accurately reflect local realities). Standardized tools will facilitate aggregation of data and comparisons across various categories of health units. In particular, reporting mechanisms can ensure that any service gaps are identified, examined, and addressed by the health units.

These tools should be built on comprehensive, transparent, easily accessed, computer-based data capture processes. The raw data should be captured as part of the everyday work of the health unit. This will facilitate local management of the data and its application to self-evaluation, strategic planning, policy and program development, risk management, and continuous improvement.

**Communication Focus.** Health units must communicate regularly with their community and government stakeholders. Health unit staff can provide program outcome updates to the Board of Health to demonstrate the effectiveness of programs and to facilitate the role of boards as advocates to local council and the general public. Public presentations and newsletters should include full disclosure of health units’ performance against mandatory standards. This transparent approach to communication will assist in highlighting the importance of the services provided by the health units.

**Board of Health Accountability**

**Board Selection.** Board recruitment and selection processes need to be transparent and ensure that individuals representing the community with appropriate knowledge are participants on the board. Board directors must be advocates for public health in the community.

**Board Development.** There is a clear consensus among board directors that training and orientation in board of health governance, roles, and responsibilities are needed.

**Board Evaluation.** Meeting processes should be evaluated with a tool designed to encourage adequate preparation and active participation in meetings, as well as to assess the value of the meetings and the effectiveness of the board in carrying out its purpose. Examination of this information will be required to demonstrate that the board of health remains accountable to the public, obligated municipalities, and the province.

**RECOMMENDATIONS**

11. Develop legislated, enforceable, results-oriented standards for boards of health and health units.

12. Require by law the regular monitoring and auditing of local health units.

13. Public presentations and newsletters should include full disclosure of health units’ performance against mandatory standards.

14. Standardized data collection tools are needed to support the requirement for health units to be accountable to the province and to the people they serve. Data should be captured as part of the everyday work of the health unit.
AFTERWORD

The Board of Health Section of alPHa welcomes this opportunity to provide insights to the Local Capacity Review Committee. This unprecedented review of Ontario’s public health system and all of its components represents a commitment to making the improvements to the system that are so urgently needed to better protect the health of all of Ontario’s citizens. Enhancements are needed at all levels of the system, and the local boards of health are no exception. The entire provincial system of health protection and disease prevention depends on clear understanding and performance of primary roles and responsibilities of each board of health and its directors. It also requires a clear framework of standards and accountabilities within which boards operate and against which they are evaluated. Finally, a sustainable, adequate and predictable flow of resources must be available to ensure that boards can effectively facilitate the delivery of public health programs and services that meet the needs of their communities.
Enhanced Local Public Health Capacity in Ontario

Position Paper of the Council of Ontario Medical Officers of Health

Presented to the Capacity Review Committee
June 2005
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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. 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.” 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.” 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 Diseases (Walker report) and the SARS Commission (Campbell report) indicate a need to address these municipal roles. The second interim Campbell report in particular, provides substantial discussion of this issue.
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. 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.

Consistent with these observations, COMOH 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%. COMOH 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. At its most extreme, municipal officials in some Boards of Health have acted with the sole interest of controlling public health expenditures. 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. 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. 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. 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,
The 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. 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, single leadership is preferable and consistent with the Campbell report, 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). 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, COMOH 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 Panel and the Campbell Commission. COMOH 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.” 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:

- The establishment of independent, sole purpose Boards of Health as the local governance body for public health units.
- 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.
- Shared funding between the province and municipalities should be maintained with the province responsible for at least 75% of overall funding.
- Consistent with municipalities providing less than half of the funding, municipally appointed members would comprise less than half of the Board of Health membership.
- The expectations for Boards of Health should be explicitly defined and their performance routinely assessed and supported.
- 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.
- The proposed boundaries of the Local Health Integrated Networks should not be used as the boundaries for Ontario’s public health units.
- The existing configuration of public health units be optimized:
  - Consider the critical mass of expertise required to achieve expected functionality of local public health units and minimize administrative costs
  - Voluntary and opportunistic amalgamations should be supported and encouraged
  - Simple amalgamations are preferable to the splitting up of existing health units
Change management be actively supported for a sufficient period of time (e.g. 2 years)

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. 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:

- The development of a compulsory, multi-dimensional accountability framework for public health units that:
  - Holds local Boards of Health accountable for those activities and outcomes for which they can be held solely accountable
  - Ensures that basic financial controls are in place
  - Includes the performance of board governance functions
  - Includes a periodic, independent audit or accreditation of local public health system performance
  - Uses data and information that are simple to retrieve and preferably available from local management and information systems.

- 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.

- 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.
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.  
- Full implementation of Quebec’s public health program will require an almost doubling of Quebec’s annual public health budget from $265 million to $506 million.  
- 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%.  
- 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.

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. While viewed as an important step, COMOH 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

- 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

### Costs

- 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:

- **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.

- **The funding of the public health system** becoming open and transparent to allow monitoring of system expenditures and investments.

- **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.

- **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.
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.” 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:

- 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., as well as a series of regional workshops on public health education held across Canada in early 2004. 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.

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…[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.”

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. 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 positions 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.”

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:

- Implementation of a comprehensive public health workforce development strategy at provincial and local levels.

- 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:
  - 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
  - Developing a career path for MOHs with graded responsibility and mentoring following public health training:
    - Existence of at least one AMOH within each public health unit
    - Provide training in management and associated skill development for AMOHs wishing to become future MOHs
  - Providing in partnership with other key stakeholders, a range of continuing education opportunities
  - Providing more consistent and competitive rates of remuneration:
    - Province-wide salary level for public health physicians
    - Remuneration consistent with physician salaries in other sectors (e.g. Coroners)
    - Include cost-of-living adjustments and benefits package
    - Compensate for on-call responsibilities
- 100% provincial grants to Boards of Health for MOH/AMOH compensation.
- 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. 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.

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. 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. 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:

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

- 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. COMOH 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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Public Health System Accountabilities

QUESTIONS

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 they are woefully inadequate. Until we have evidenced-based programs we will always have emotion controlling programming. We need hard documentation of program strategies and outcomes and impact as well as demonstrated need and capacity in public health.

Current indicators (with the exception of accreditation) are one-dimensional (focusing mainly on resource consumption, not outcome). There is little incentive to be innovative or improve performance, because outcome is not defined.

Quality improvement philosophy suggests that it is wiser to focus on three areas – input (resources), processes and outcomes, to get a true picture of what is going on. (At least accreditation has roots in QA)

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

Probably need several tools are to explore different aspect of performance

Scorecards?

Only if there are audits. The balance scorecard concept has the potential to overcome some of the difficulties outlined above

Audits?

Absolutely. Since the original accreditation system was supported by the provincial Government and is seen to be confidential, peer driven, etc., why not adapt the OCCHA organisation to provide the audits necessary to evaluate compliance with standards? Why would one want to reinvent another system that would be similar if not identical to the OCCHA model? Some audits should be by notice and some by random visit. Outcome and impact would need to be assessed too.

Questionnaires?

Only if there are audits

Accreditation?

Accreditation is good but it requires an awful lot of work. When even weak organizations
can get accredited a lot of the benefit is lost.

Other?

We need the Province to be accountable first and foremost and to stay the course. Accountability is a two-way street.

Provincial, on-line, reporting systems into which health units input data weekly. This could possibly include program management systems.

Standardized performance reports on a variety of outcome and process indicators, reported to the public on a regular basis (same tools used to collect and report data across the province, e.g. benchmarking)

Mechanisms for public consultation on the performance of health units.

Establishment of Health Goals for Ontario and regular reporting of performance of individual health units in meeting these goals, i.e. outcome measurements.

Optional Question

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

All programs need to be put on a best practice, evidence based research protocol. Some are in more urgent need of review than others e.g. Child Health, emergency preparedness, water safety, food safety and infection control.

GOVERNANCE AND STRUCTURE

QUESTIONS

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

The Ontario Association of Public Health Dentistry (OAPHD) recommends a hybrid model of governance; autonomous Boards of Health with strong MOHLTC representation.

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

Boards of health should be composed of, one third provincial appointees, one third municipal appointees and one third community members who are appointed by senior management of the health unit and who have exhibited an interest in public health. The composition should be an odd number
with a minimum of nine members. The mandate of the board of health must not be politically motivated but focused on the implementation of the Health Protection and Promotion Act. All board members should receive orientation by the Ministry of Health and Long Term Care and the local health unit. Terms of appointment should be for three years and should be staggered.

Whichever model of governance is chosen, the QUALITY of leadership provided by Board members and senior management is important. The current literature of excellence in governance suggests that the following factors are likely to be important:

- Clear understanding of the roles and responsibilities of a board of governors (vs. roles and responsibilities of staff).
- Ability of members to detach themselves from outside interests during Board activities.
- Excellence in leadership. Deliberate and intentional process for selection, orientation and ongoing training of board members are more likely to produce high quality outcomes than no processes or processes which just "happen".
- An interest in public health with some expertise related to public health e.g. an understanding of water quality issues, the environment, child development, health care, education, social policy, as well as some business expertise. Variety of backgrounds among board member.
- Understanding of local community needs.
- Ongoing training in emerging public health issues- technical and liability aspects.
- Clear mechanisms of accountability to wider community for decisions made.

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

The OAPHD could support a funding system whereby the Ministry of Health and Long-Term Care is responsible for 75% of the cost of mandatory programs and local municipalities provide 25% of the funding. However, the following factors must be taken into consideration:

- Funding must be tied to standards, deliverables, accountability, compliance and governance.
- Sufficient funding must be available to support the implementation of those standards.
- Consideration could be given to other funding partners, for instance the Ministry of Children and Youth for programs for children 0 to 6 years of age.
- Adequate funding must be made available to support mandated programs including recruitment and training of public health personnel.
- Since the provincial tax base is greater than the local one, it probably makes sense for the bulk of funding to come from the provincial level. Some element of local funding appears to allow greater community participation and appears to ensure that the program offered by the public health system better reflects local needs and priorities.
- However money is raised, it should flow to health units in a predictable, timely fashion. The one-year time frame currently employed is not conducive to sensible, long-range planning. It is difficult for health units to make the sort of investments in infrastructure (e.g. in IT or staff development) that are necessary to improve organizational performance when there is no guarantee that money will be there for the next phase of the project (the following year). The current "use it or loose it" yearly funding cycles mean that there is little incentive for health units to save money since the saved money cannot be offset against future goals.
- The current budgeting, forecasting and accounting tools used in public health tend to be very simplistic and do not easily show the true costs of delivering services. Multi-dimensional assessments might provide greater insights and enable better decision-making. This may mean a change in public health culture to regard business skills/processes as equally valuable as medical/clinical expertise. It probably also means an investment in business technology and in-ongoing training for managers in business administration. Currently these are often regarded as “frills” and therefore lower in spending priorities.
- If 100% provincial funding is considered it must be accompanied by regulations to protect that funding. As it could be considered as part of the provincial health care treatment program, the
Children In Need of Treatment (CINOT) program could be considered for 100% funding but it must be protected by regulation with an equitable fee schedule and accommodation for a systematic review of the fee schedule.

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?**

   It would be short sighted not to attempt to align health unit boundaries with LHIN boundaries although one LHIN may well cover more than one health unit. It should also be recognized that the LHIN boundaries suit the hospitals service areas and not the natural administration of other social systems (municipalities, commerce, education) that the rest of the world works on.

   A match up may be beneficial but public health must be kept out of LHINS since the hospital-dominated model will swallow-up all financial resources.

   The number of units should be a function of the population size and geographic area and large enough to support a full range of public health experts.

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

   An actual number is difficult to determine without a comprehensive analysis. They should service the natural/historic, administration systems of municipalities, school boards and commerce.

**Optional Question**

*(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?)*

An appropriate economic unit needs to be determined that will support a critical complement of staff committed and dedicated to one health unit eg epidemiologist, policy analyst, dental director etc. In addition, accommodation must be made for factors including geographic location, cultural issues, burden of illness and population density.

With fewer health units with, for example, a minimum of 500,000 population catchment (except across the north) they would need/warrant a full complement of qualified senior staff offering career opportunities both within and across the system.

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**Public Health Funding**

**QUESTIONS**

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

Match the funding to an appropriate planning model with evidence of population need and effective strategies.
The key factor is that health is the responsibility of the province. While the province may be able to contract or delegate, accountability, for the operation of the system, remains with the Ministry of Health. If one is accountable then one needs to have control and to have control one needs to regulate, enforce and be responsible for the majority of its funding.

Specific factors should include:

- Population size (seasonal and permanent)
- Demographic composition of population (age, ethnicity, immigration, education, employment)
- Distance staff/clients have to travel to access services
- Existing physical infrastructure (transportation, communication networks, food distribution networks etc)
- Accessibility of primary care
- Tax base
- Economic conditions in the area (employment, industries)
- Particular physical/environmental hazards that may affect health of population
- Unique health conditions that may be specific to that population

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

The issue of fiscal year versus calendar year versus school year comes into play. The simplest would be to go for a Calendar Year with the facility to make adjustments. The biggest challenge will be to provide enough funding to redo all the information technology requirements at the provincial and health unit level as soon as possible. Without the data, accountability and stewardship are impossible.

The tradition of slow budget approvals of ongoing, base programs needs to be fixed.

There is also a requirement for “surge capacity” needs to be addressed. Who is responsible for funding the “extraordinary?” Should health units be obliged to maintain “contingency funds” so that they can pay for additional expenses e.g. overtime or additional staff as needed, or should there be a clear stream of provincial funds dedicated to “crisis” management?

Public Health Human Resources

QUESTIONS

What are the challenges and issues in recruiting and retaining medical officers of health?
Likely the same as for other scarce senior staff although the pay differential from medical
Moving Ahead Together: A Position Paper of the Association of Local Public Health Agencies

Appendix 6 – Ontario Association of Public Health Dentistry

GPs may not be as wide as it is for the public health dentist.

Recruitment:
- Public health requires an unusual skill set (technical and personal)
- Limited opportunities to develop these skills in undergraduate training. Specialty does not enjoy high prestige.
- Salary not as high as for some other specialties
- Many physicians who are attracted to lower paying areas of clinical practice because of the opportunities for social good (e.g. family medicine, psychiatry) are uncomfortable about moving out of areas of medicine which are also underserved.

Retention:
- Burnout
- Some enjoy technical aspects of community health but are uncomfortable with the administrative/political aspects of the job
- Strain of responsibility without resources and authority

What are the challenges and issues in recruiting and retaining public health staff in general?
- Lack of career paths
- Uncompetitive salaries compared to comparable alternatives
- Diminished/marginalized role of some professions within public health (dentistry)
- Impact of the above on attracting students into public health specialty training
- Lack of financial support (bursaries) for specialty training

What strategies should be used to promote and retain public health staff?
- Competitive salaries
- Province wide human resource strategy
- Career opportunities
  - Mobility
  - Financial support programs for students in specialty training

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

Epidemiology, health promotion, policy analysis, service (preventive and cure) delivery and critical appraisal skills at all levels are key. Although the organizational structure adopted by a number of health units does not reflect the traditional, public health professional silo concept, each health unit and its decision making structure, must still contain the professional capacity to meet the mandated programs and the public health challenges of its community. For most disciplines, a master’s degree reflects the accepted level of education.
necessary to provide this professional capacity and most disciplines have a number of representatives at this educational level within the complement of staff. However, to provide the required capacity in medicine and dentistry, the accepted level of education are the qualifications of Medical Doctor (MD) and Doctor of Dental Surgery (DDS) and each health unit should be required to have this level of professional expertise within its management structure. Issues of technology and management are important means to the end but not ends themselves.

The 10 functions that are attributed to Rollins School, Georgia (WHO/CDC)
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.

Research and Knowledge Transfer

QUESTIONS

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

There needs to be a central health resource library available to service the needs of the professionals in the health units. At present it is impossible for any one unit to provide all the journals necessary for sound evidence based planning. There also needs to be some central agency responsible for the promotion and dissemination of public health research, supported by epidemiological services in individual units. This agency should establish targets for research in various fields and co-ordinate research activities through the system.

An equivalent of ICES for public health could do the job. Investigators need to be responsive to the needs of front line staff and not the reverse. All MOHLTC funded research units should be involved in this capacity review process.

The question seems heavily biased towards advocating the continuance of PHRED programs. The PHRED programs are valuable and those working in them often demonstrate a good understanding of knowledge transfer principles but the literature shows that a variety of diffusion mechanisms are necessary, in order to reach different target groups. Therefore, relying only on the PHRED programs as the sole mechanisms for knowledge transfer in public health seems shortsighted at best.

Is the PHRED Program sufficient to meet this purpose?

No, need alliances with universities and colleges too

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

No, but need access and commitment to work on issues on a regional basis.
Should this function be centralized in the Ministry of Health/Ontario Health Protection & Promotion Agency?

Possibly, but all the options need to be investigated including what would be the relationship of the Agency to the health units.

Other mechanism(s)?
   aLPHA’s list-serve and library capacity, some elements of the e-health strategy e.g. the proposed physicians portal, The Health Communication Unit’s workshops and the Health Canada Skills Enhancement distance-learning project are all examples of existing knowledge transfer strategies which currently incorporate “best practice” in knowledge transfer and should be encouraged

Optional Question
(What are the strategies to get the right mechanisms in place?)
APPENDIX 7 – OSNPPH KEY STATEMENTS

Public Health System Accountabilities

QUESTIONS

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, for the following reasons:

a) MPIQ – too vague a measurement tool for the parts of the programs where nutrition content is captured in Reproductive Health (RH), Child Health (CH) or Chronic Disease Prevention (CDP) programs. In Public Health our programming is often to get a “tick”, just as a teacher teaching to the provincial test! It needs refinement. The MPIQ has never been validated. The Mandatory programs are not written in a logical way with clear indicators that align with activities.

b) Program Based Budgeting is only a financial measure, a program may incur more costs however another may be lower in cost but produce a greater impact/outcome.

c) As for accreditation, unless it is mandated, it cannot be an effective nor universal measurement tool. At this point, there is no perceived benefit in participating in accreditation.

Note: None of these measure outcomes only processes.

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

• Scorecards? Some members think that the balanced scorecard concept that looks at all areas – is a more accurate reflection of accountability. Financial, Programs, People and Client Satisfaction. This is a possibility but could not just adapt the framework used by hospitals, as their measures are more clinical in nature. More data needs to be collected before a scorecard could be generated.

• Audits? Yes, this would be helpful for every health unit on a rotating schedule. Criteria would need to be developed and field-tested.

• Questionnaires? MPIQ would require improvements. For example, more open-ended questions, less prescriptive, more requirements for providing a rationale for responses (which could include local needs), training from the province re: requirements, more useful feedback from the province re: MPIQ (sometimes we receive no comments). The MPIQ needs to be validated.

• Accreditation? Would need to be mandated, but could certainly assist in improving accountability.

• Other? We need more effective tools to better capture the work that we actually do. Perhaps logic models would assist in showing accountability re: outcomes. Funding of RRFSS for all health units could aid in this as well. We need to evaluate our programs as an accountability mechanism.
Optional Question

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

With the role of the Ministry of Children and Youth in HBHC and school nourishment funds and with the growing concern over childhood obesity and need for comprehensive school health, we would recommend the review of the Child Health (include assessment of violence prevention – need, impact, capacity and appropriateness of topic areas such as anti-bullying programs in schools/communities), and Reproductive Health programs in order to define the core business for children and youth in the province. The next program to be reviewed would be the Chronic Disease Prevention program (including healthy eating/healthy weights strategy which includes food security), for the above reason as well as a need to make it more succinct, reflect best practices and be more measurable. The next priority program should be food safety.

Additional suggestion: Let’s first get the 5 most recently revised adopted (Child and Youth Health, Chronic Disease Prevention, Injury and Substance Abuse Prevention, Prenatal Health). Then we can go on from there to Food Safety, Water Safety, and Infectious Disease Control.

Governance and Structure

QUESTIONS

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

Public health could be most effective as an autonomous entity with a local board of health. It creates most local and provincial accountability and support. We also believe this would reduce the potential for competing priorities with other municipal services and help ensure the health of the public is of priority concern in decision-making. As well, this would be consistent with the newly created dept of public health headed up by Sheela Basrur. In this model our MOH’s should be directly accountable to her and her associates.

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

A mixture, with perhaps a 2/3 local and 1/3 provincial split. Or, it could be based on funding formula.

From the local representation portion, the Board members should consist of a couple of local politicians/councilors, community reps, university/school reps and health professionals - individuals who have a background in health and a vested interest in public health specifically.

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

Note: there is not consensus on this question

A mixture again, in order to keep a local connection and accountability for the funding, a 75% provincial and 25% local split. Having split funding perhaps ensures that any given government cannot change public health at a whim. May want to maintain status of some programs jointly funded others 100% funded.

The Ministry of Health, MCYS, and the Ministry of Education should all, collectively, contribute 100%.
funding for all programs in public health. Having said this, public health programming should be revised to be made much more simple to better reflect current public health issues i.e. forget offering X number of grocery store tours, etc. as communities can figure that out.

It is a misnomer that there exists true 100% provincially funded programs (e.g. HBHC) since local health units pick up hidden costs such as operating cost increases.

One member recommends that the Ministry critically assesses the Ontario hospital system since they are 100% provincially funded and have locally run Boards that have strategic plans to meet local/regional needs.

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

No, we believe we need more health units than the number of LHINs.

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?

We would recommend a number somewhere between the current 36 and the proposed 14. Health units need a certain capacity/size of staff and local population in order to justify, attract and hire a diverse staff group, especially nutrition staff, Epidemiology, health communication experts etc. Health unit boundaries can be aligned with a LIHN when it makes sense to do so.

There are pros and cons of having fewer larger health units versus numerous smaller health units. If we go with fewer health units then we become more like Alberta, BC and Nova Scotia where the focus is more on advocacy, policy development and environmental supports. Larger health units can pool resources and focus more on the above mentioned areas and can be a resource to smaller health units/satellite offices. However, if we create a few larger health units, we run the risk of ignoring rural and other local issues and not providing effective service in smaller communities. Examples of this can be seen in other amalgamated agencies such as the Ontario Ministry of Agriculture, Food and Rural Affairs and in the school boards, due to a small portion of local reps on Boards who make service and staffing decisions.

Having smaller more local health units allows them to better determine community needs and attempt to act on issues. However, this works only if there are enough human resources to do so which historically has not been the case.

Essentially, the number of health units should be determined by what makes sense based on size of geographic region, make-up of the population, what the flow of health care to the population is – i.e. linking with hospitals in area. For example, it does not make sense to have one or two health units for Northern Ontario. As a second example, the amalgamation of Toronto was very disruptive and Toronto is still trying to figure out how to work effectively; so avoid huge amalgamations and don’t now break up Toronto.
Optional Question

(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?)

All as already stated in the question plus, cultural diversity, health status, health needs that are particular to an area, coverage of other “merged services” e.g. school boards, rural/urban mix and health determinants. See those listed on page 13 under the Walker Report, first paragraph. Geographic boundaries that consider how people access health services followed by population size. One suggestion is to prepare several scenarios with full pros and cons of each scenario.

Another suggestion is to consider a regional model with centralized consultants that provide support to X number of health units within its region (e.g. regional PHRED program where each PHRED has a region that encompasses 5 to 7 health units.

Public Health Funding

QUESTIONS

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

This needs to start with a determination of what are the core businesses for public health in our province. Once this is defined then one can determine the requirements to meet these core businesses. The requirements include defining program components (both for the local and provincial level), staffing/capacity requirements and then costs. We need an equity funding formula that actually works.

Does health promotion fit within this model? If so, we need to fund all areas of health promotion adequately in order to meet best practices, to do the ongoing implementation and research on changing best practices and be able to monitor behaviour change over time.

Need a funded nutrition strategy for the province. In fact, there should be more centralized resource and campaign development and implementation, along with coordinated strategies.

Health unit funding should be based on need within the community to address key public health issues (based on health status (e.g. in the north, there is often higher morbidity and mortality and lower life expectancy even though it has the smallest population proportion), epidemiological evidence, geographic spread, cultural diversity (i.e. costs for training staff, translation), recruitment challenges, etc), capacity to meet these needs, and community infrastructure to support public health programming.

Many health units need to provide services over wide geographic area and this should be considered. Need for standard basket of services delivered by standard professionals e.g. dietitians provide nutrition programming, etc… There should be per capita funding with adjustments for geographical challenges and socioeconomic status of the population.
What other funding issues or challenges (outside of the allocation methodology or formula) exist? (i.e. funding or disbursement timing, synchronizing fiscal years, etc)

Timing of funds - they arrive far too late in the year, such that some planned items cannot be implemented, particularly if additional staffing is required.

We require more funds for broad nutrition promotion campaigns (i.e. social marketing etc.) for both the local and province wide levels.

Need increased funds for PHRED (to do nutrition focused research) and the Nutrition Resource Centre (in order to expand it’s role to cover all ages and stages and to do some innovative and new projects).

Our most important challenge is lack of funding to support resources to implement chronic disease programs. Funding is almost always more readily available for communicable disease and environmental health because there are tangible, measurable outcomes. Time to get smart about the prevention of obesity, heart disease, diabetes, etc. and actually come up with good program goals with measurable outcomes and then provide adequate funding to implement these programs.

Lack of recognition of need for administrative and staffing dollars. For example, heart health funding will not fund staffing but does require a full-time coordinator that we have to find in our existing staffing complement. In terms of HBHC, some health units do not have adequate administrative funds to run the program.

Public Health Human Resources

QUESTIONS

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

A need for strong administrative skills (strategic planning, personnel issues, and leadership skills) and clinical skills, as well as broad interests in all major public health issues in the one role can be frustrating to medical students who are only interested in a specific area of public health. Do MOH’s need to be the CEO of health units or should others be given this responsibility to free up the MOH to handle health-related issues rather than administrative.

In some cases, lack of authority, and a low salary when compared to other physician salaries.

The ongoing threat of mergers, in which an MOH may have to cover a large territory and/or be accountable to more than one Board.

The lack of respect for this role within the medical profession – i.e. public health is for retired doctors. Larger health units would require more MOHs in each unit and offer more peer support among MOHs.

Not enough opportunities to train MOHs.
What are the challenges and issues in recruiting and retaining public health staff in general?

For nutrition personnel, wide variations in salary across the province (would make it more attractive to relocate in a neighboring health unit), not enough candidates, hard to recruit in some areas, and nutrition staff moving into management means a loss of qualified nutrition personnel. At the same time some management positions may be closed to a nutrition professional so that in some cases there is little room to take on other roles. Other issues include - training/professional development funds are often inadequate in some health units, frustration with outdated core programs, limited leadership, red tape associated with differing types of governance, no clout to change the system, and not enough staff to plan, deliver and evaluate programs.

In some health units, they have not been able to take any students (unpaid) or interns due to insurance reasons. This can make it difficult for these individuals to complete the practical experience components of their training. Such opportunities also increase recruitment possibilities.

The ongoing threat of mergers also discourages some candidates from applying in smaller health units.

Often difficult to recruit to more isolated parts of the province. In the North, there is a lack of access to undergrad and graduate public health programs/courses (e.g. community nutrition).

There is limited career trajectory within public health when at a local health unit located outside the Toronto catchment area.

A critical mass approach is needed (e.g. regional model where specialists/consultants are available for local health units to access.

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

Increase student numbers and put in place a process so that students can receive practical training experiences at health units and receive some funding. Provide paid placements for Dietetic Interns.

Reduce salary variations across the province and between other public and private sector employees.

Provide adequate professional development dollars and provide regional training opportunities.

Establish opportunities for advancement within public health.

Make graduate degrees more accessible.

To improve retention, particularly in the North, we need distance education for rural/Northern public health professionals (e.g. for Dietitians to become Public Health Nutritionists at present, they need to relocate to Toronto for 2 years in order to obtain a Masters at U of T.)

In the North, broaden academic and practice partnership model that PHRED emulates.

We suggest that each PHRED have a paid Community Nutrition Education Coordinator.

Core competencies for all public health staff – perhaps a certification program should be considered.

Professional and public health association fees should be funded through work.
**Optional Question**

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

We should address population groups from all ages and stages. The focuses could be determined locally as to how much is spent with seniors for example.

Heart Health funding needs to be clearly defined as Chronic Disease Prevention funding.

Nutrition promotion programs provided by Public Health Dietitians and Public Health Nutritionists. Use of such specialists is required in other areas too; for example, for physical activity promotion, the use of staff trained in kinesiology.

Every health unit should have the capacity to:
- meet mandatory programs and services
- respond to emergencies (not necessarily through ongoing staffing but access to additional provincial and regional staffing)
- respond to major public health issues and threats, such as obesity, smoking
- meet media demands
- effectively train and coach program staff
- work with municipal planners (i.e. may need a planner on staff or at least a regional planner to work with on issues such as traffic calming, green space planning, bike paths, etc.)
- work with and sustain local partnerships
- work with local communities to make changes (i.e. work on community development)
- support comprehensive school and workplace health
- support best practice work (e.g. small group support programs for weight loss, breastfeeding, parenting, etc.)
- evaluate programs and services and conduct needs assessments
- conduct monitoring and surveillance

Key personnel capacity should include:
- Public Health Nutritionists and Dietitians
- Public Health Nursing
- Public Health Inspection
- Epidemiology
- Health Promotion specialists – including communication
- Finance, human resources
Research and Knowledge Transfer

QUESTIONS

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

We need more frequent and improved communication from the PHRED sites. When we do get information (twice per year) it can be overwhelming so time is not taken to read through a whole annual plan or report (50 to 120 pages). What about a newsletter type of update that is tailored to the different core public health businesses such as inspection, chronic disease prevention etc. These could be sent quarterly. In this way we are not overwhelmed with information once or twice a year but instead when PHRED information comes it is targeted to our particular program focuses.

Full funding of the Rapid Risk Factor Surveillance System for all health units, with the appropriate funding for analysis.

Provincial leadership in setting public health student and ongoing professional education opportunities.

Provincial leadership in setting research agenda and priority of research initiatives.

Regionally-based model with critical mass of specialists/consultants that provide support to all health units in the region.

Ideal PHRED model (if regionally mandated) works because there are formal affiliation agreements with local academic institutions which partners with those in the field who are “grounded in practice” with those who bring the academic expertise.

Is the PHRED Program sufficient to meet this purpose? Yes, if it is regionally funded or 100% provincially funded as at present its mandate is narrow (i.e. provincial and local health unit only) and the number of sites expanded.

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

No, but rather each health unit has a PHRED contact person(s) and access (which would be located at the central health unit, which has a formal affiliation agreement with a local academic institution). Only health units that have the capacity to support a research unit should be given PHRED funding. In addition, they need to align with an area university/college (that has a health research component). There could be a satellite subunit that is a link to a PHRED site in some health units.

However, there should be some capacity for research and for education at each health unit.

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

No, as this will not allow for the capture of the local input and crafting of the research which is very important as the province is generally not as informed/detached from the local issues.

However, PHREDs will need some sort of accountability to a central agency.
Centrally coordinated at OHPPA but regionally based using the existing provincial PHRED structures – with expansion (e.g. 5 to 10 regional PHRED sites). Leadership from OHPPA is needed to develop and prioritize public health research priorities.

Other mechanism(s)?

Establish RRFSS in every health unit, with central coordination through PHREDs. Have PHREDs work with all health units in their area, as opposed to just the one who funds them. To make this work, PHRED would need to be 100% funded from the province.

General comments: we need more public health research to be done in many areas of our work. This will help to determine best practices, to confirm these best practices, to monitor behaviour change and support new program development.

There should be grant funding that is accessible by all health units.

Capitalize on e-health technological infrastructure to build the regionally based model.

Provide dedicated stable funding to PHREDs to attract and retain critical mass of specialists/consultants.

Optional Question

What are the strategies to get the right mechanisms in place?

Have PHREDs 100% provincially funded to serve a cluster of health units.

The Provincial PHRED program has the history and vision of success elements, just not the stable funding and regional mandate required in order to truly be as “successful” as it could have been to date. Becoming centrally located at the OHPPA and regionally based with stable funding would allow PHRED to meet its long-term goals listed below.

PROVINCIAL PHRED STRATEGIC DIRECTIONS/GOALS:
1. Provide evidence to support effective and efficient public health practice and improve accountability in public health practice (e.g. effective public health practice project which conducts systematic reviews of effective interventions, benchmarking partnership)
   - Knowledge generation and brokering as to what works in public health and to inform MHPSG revision and assist in determining best practices when hot and emerging public health issues occur
2. Increase capacity within the public health system by providing Leadership in the education of future public health professionals.
3. Provide leadership in research and education through strategic partnerships.
Creating a Sustainable Public Health System in Ontario

A Renewal of Health Protection, Health Promotion, Disease Prevention and Surveillance

A Position Paper of the Association of Local Public Health Agencies

March 2004
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A Position Paper of the Association of Local Public Health Agencies (aPHa)  
March 2004
The national, provincial and local structures that deliver public health programs and services in Canada have been under close scrutiny in the wake of last year’s outbreak of Severe Acute Respiratory Syndrome (SARS). Most notable among several, the Naylor, Kirby and Walker reports present detailed recommendations for the renewal of the public health system at all levels. This paper complements that body of work with the perspective of Ontario’s public health service providers, as represented by the Association of Local Public Health Agencies (alPHa). It is the result of broad input and discussion by alPHa’s membership, which includes medical officers of health, board of health trustees and management representatives from public health administration, dentistry, epidemiology, inspection, nursing, nutrition, and promotion. Recommendations are presented for five topics: provincial health goals; public health funding levels; capacity of the Public Health Division and role of Ontario’s Chief Medical Officer of Health; local public health agency (also known as “health units”) capacity and role; and public health human resources.

**EXECUTIVE SUMMARY**

The national, provincial and local structures that deliver public health programs and services in Canada have been under close scrutiny in the wake of last year’s outbreak of Severe Acute Respiratory Syndrome (SARS). Most notable among several, the Naylor, Kirby and Walker reports present detailed recommendations for the renewal of the public health system at all levels. This paper complements that body of work with the perspective of Ontario’s public health service providers, as represented by the Association of Local Public Health Agencies (alPHa). It is the result of broad input and discussion by alPHa’s membership, which includes medical officers of health, board of health trustees and management representatives from public health administration, dentistry, epidemiology, inspection, nursing, nutrition, and promotion. Recommendations are presented for five topics: provincial health goals; public health funding levels; capacity of the Public Health Division and role of Ontario’s Chief Medical Officer of Health; local public health agency (also known as “health units”) capacity and role; and public health human resources.

**Provincial Health Goals**

Political, economic and social factors are just as significant to community and individual health status as disease control and healthy lifestyle choices. A renewed emphasis on prevention must therefore acknowledge the health impacts of policy decisions that do not fall under the purview of public health agencies. Broad health goals that bind all departments within government must be established to improve the public’s health. Therefore, alPHa recommends:

1. That the Government of Ontario establish a process to develop a broad set of population health goals, with requirements and standards that bind all government ministries and government-funded agencies that are comprehensive, complementary and effective in promoting and protecting the health of Ontario’s residents.

**Public Health Funding**

Governments at all levels must make a much stronger commitment to ensure the timely availability of sustained and adequate funding for the optimal delivery of public health programs and services in all communities. Every recent review of the public health system reiterates the significant inadequacy of funding from all levels of government for health promotion, health protection, disease prevention and surveillance programs and services. Careful thought must be given to devising a system that guarantees a sustainable source of funding that is protected from cuts due to economic and political pressures unrelated to the delivery of public health programs and services. Therefore, alPHa recommends:

2. That the province devise a strategy to increase overall funding to ensure:

   a) optimal and sustainable delivery of all mandated and recommended health promotion, health protection, disease prevention and surveillance services in all health units;
   b) the capacity for any optional public health programs and services to address local needs;
   c) the ability to respond to public health contingencies; and,
   d) coverage of all related administrative and support costs.
Personnel Recruitment and Retention

There are significant shortages of public health staff in Ontario, including medical officers of health, public health epidemiologists, public health dentists, health promoters, public health inspectors, public health nurses and public health nutritionists. Rapidly declining enrolment and graduation numbers in post-secondary public health programs, and the loss of skill sets acquired in these programs to more lucrative careers indicate that these shortages could become even more significant in the near future. Therefore, alPHa recommends:

3. That as part of its review of Ontario’s public health system, the Ministry of Health and Long-Term Care, in consultation with local public health agencies and relevant associations, clearly itemize core competencies, appropriate remuneration and ideal numbers for public health staff to carry out mandatory and recommended public health services.

4. That the provincial public health agency, in consultation with alPHa and its Affiliate organizations devise a strategy to address the immediate shortages of medical officers of health and public health dentists, epidemiologists, promoters, inspectors, nurses and nutritionists.

5. That the provincial public health agency, in partnership with local public health agencies, devise a comprehensive, long-term recruitment strategy that includes promoting public health service as an attractive career choice. This strategy should include input from institutions with a public health curriculum, the Ministries of Education and Training, Colleges and Universities, and alPHa and its Affiliate organizations.

6. That the provincial public health agency and local boards of health devise strategies to provide or facilitate the provision of ongoing education for public health staff and training opportunities for students including, but not limited to, job placements, tuition-for-guaranteed service arrangements, and paid practicums.

Provincial Public Health Agency Capacity and Role of the Chief MOH

In Ontario, the central health promotion and protection functions of the Ministry of Health and Long-Term Care are overseen by its Public Health Division (PHD) and by the province’s Chief Medical Officer of Health. This is where many of the funding and policy decisions for public health programs and services are made. The primary focus of these decisions must always be the health promotion, health protection, disease prevention and surveillance functions of health policy. Therefore, alPHa recommends:

7. That an extensive review of the province’s centralized public health functions be undertaken, with a view to the establishment of an independent and effective provincial public health agency headed by the Chief Medical Officer of Health.

8. That the provincial government commit to ensuring that this agency has reliable sources of technological, human and financial resources to undertake its advisory, monitoring, analysis, coordinating, liaison, enforcement and response functions.
9. That the provincial government put in place the liaison, reporting and consultative mechanisms that will make the provincial health agency the focal point for monitoring and reporting on progress toward provincial health goals, as endorsed by all government agencies.

**Local Public Health Agency Capacity and Role**

A close examination of local public health agency capacities and community needs will be critical to the success of renewed strategies for funding, recruitment and retention, and central oversight. Local public health agencies are in the best position to assess the needs of their communities, and must retain the autonomy to make decisions about the locally appropriate planning and delivery of public health programs and services.

As demands on local public health agencies have increased, so have discussions of expanding local capacity for highly specialized public health expertise, such as epidemiologists, additional medical officers of health and legal counsel. As this may not be presently practicable for all health units, more detailed and creative capacity-enhancing strategies may need to be considered for some. These will require a detailed examination a wide range of local characteristics. Therefore, alPHa recommends:

10. That the province, in partnership with local public health agencies, undertake a comprehensive and detailed review of capacity and community needs to inform the development of long-term strategies to enhance local public health agency capacity to plan and implement optimal public health services.

11. That the goal of such strategies is to optimize human and financial resources, public health expertise and technical requirements for local delivery of public health services.

12. That the province fully consult with the Association of Local Public Health Agencies when evaluating strategies to optimize local public health agency service capacity, including but not limited to those under which realignments or amalgamation are considered.
INTRODUCTION

Until recently, most of the public discussion of health in Canada has focused on the treatment-oriented health care system. Public policy debates on hospital bed shortages, crowded emergency rooms and doctor/nurse shortages have taken precedence over addressing the needs of the public health system that is responsible for the health protection and promotion, disease prevention and surveillance programs and services whose goal is to keep people well. Examples of these include disease outbreak control, food safety inspections, smoking cessation programs, and healthy lifestyle education. These prevention-based activities, as part of a sustainable and strong public health system, ultimately relieve those very pressures on the acute care system.

It has been said that an efficient and successful public health system is invisible. It is impossible to itemize the number of cancer cases, obese individuals, adolescent pregnancies and disease outbreaks that were avoided because of effective prevention programs. When funding, personnel and policy deficiencies reduce the effectiveness of these programs, such adverse health outcomes invariably increase to expose those deficiencies. The E. coli gastroenteritis outbreak in Walkerton, Ontario in May of 2000 and the SARS outbreaks in the spring of 2003 are two notable examples of this, each exposing significant gaps in the public health system, precipitating a restored recognition of its importance, and demanding an unprecedented effort to review and reinvigorate it.

A substantial and detailed body of reviews of the public health system and recommendations for its renewal has been generated in the wake of these and other public health urgencies. The Walker, Naylor and Kirby reports1 in particular contain in-depth discussions and detailed recommendations for comprehensive systemic improvements. The purpose of this paper is to build on and complement these with the perspective of the members of the Association of Local Public Health Agencies (alPHA), which include medical officers of health, board of health trustees and representatives from public health administration, dentistry, epidemiology, inspection, nursing, nutrition and promotion within Ontario.

What follows is the result of broad input and discussion by alPHA’s membership on four topics: public health funding levels, public health human resources, capacity of the Public Health Division and role of Ontario’s Chief Medical Officer of Health, and capacity of local public health agencies. Specific recommendations are offered for each that represent the consensus of the diverse public health professionals that make up the Association.

BACKGROUND

Ontario’s Health Protection and Promotion Act (HPPA) provides a strong legislative framework for the provision of programs and services to maximize community health. The Mandatory Health Programs and Services Guidelines (MHPSG) set out standards for the prevention of chronic diseases and injuries, the prevention and control of infectious diseases, and programs supporting family health. These are the minimum standards for programs that are to be delivered by all boards of health in Ontario. The intent of the legislation and the goal of these standards is to promote health and quickly identify the potential causes of adverse health outcomes and reduce or eliminate them.

1 The NAYLOR Report: Learning from SARS: Renewal of Public Health in Canada, released by the National Advisory Committee on SARS and Public Health on October 7, 2003; The KIRBY Report: Consultation Report, presented by the Coalition for Public Health in the 21st Century to the Senate Standing Committee on Social Affairs, Science and Technology, on October 21, 2003; The WALKER Report: For the Public’s Health, Interim Report by the Ontario Expert Panel on SARS and Infectious Disease Control, December 15, 2003

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This requires a broad range of activities – education, communication, investigation, inspection, enforcement, screening, and specific prevention measures such as immunization, to name just a few. These activities, alone or in combination, are effective tools in preventing food borne illness, infectious disease outbreaks, sexually transmitted diseases, low-birth weight babies, premature deaths from cancer, and many other preventable negative impacts on health.

In addition to regular programming, boards of health are faced each year with demands on already-scarce time and financial resources by unforeseen outbreaks of unusual diseases, new risks, and participation in environment and health-related local political debates (tobacco control, air pollution and pesticide regulation are pertinent examples). There may also be community-specific needs for additional public health programs that are not required of all health units by the province.

All local public health agencies in Ontario must have the financial and human capacity to meet minimum mandated standards, engage in the political process, address community needs and respond to public health emergencies, absorb unforeseen cost-increases and implement new mandatory programs. The success in carrying out these duties will come from the authority and expertise of public health professionals to make independent and informed decisions about the health of their communities, in combination with strong support and guidance from the province, and an adequate and sustainable source of funding.

A GUIDING PRINCIPLE: PROVINCIAL HEALTH GOALS

This paper will discuss topics as ways for optimizing the public health programs and services that contribute to the health and well being of all Ontarians. The MHPG set standards for “promoting improved health, preventing disease and injury, controlling threats to human life and function, and facilitating social conditions to ensure equal opportunity in attaining health for all”2. These standards bind only local boards of health, which alone cannot enable residents of the community to realize their fullest health potential. Such a broad purpose is an equally broad responsibility.

As such, aPHa believes that it is essential for the province to establish a set of health goals and to secure commitments from all government ministries and government-funded agencies to following standards that are binding, comprehensive, complementary and effective in achieving them. This would create a much stronger foundation for a healthy population by requiring health impact considerations and statements in all public policy decisions.

RECOMMENDATION:

1. That the Government of Ontario establish a process to develop a broad set of population health goals, with requirements and standards that bind all government ministries and government-funded agencies, that are comprehensive, complementary and effective in promoting and protecting the health of Ontario residents.

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2 Mandatory Health Programs and Services Guidelines, December 1997, published by the Minister of Health, pursuant to Section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7
PUBLIC HEALTH FUNDING

Overall Funding Levels

Health promotion, health protection, disease prevention and surveillance are effective and cost-beneficial strategies to keep people healthy. At a fraction of the cost of treating disease, they reduce morbidity and mortality by preventive means. Their value was clearly illustrated in the response to the Walkerton and SARS outbreaks, yet their funding levels remain inadequate. Most local boards of health are unable to deliver their minimum mandated programs, let alone contingency responses and additional, non-mandated services that would benefit their communities. Ontario will remain vulnerable to public health threats until governments at all levels commit to ensuring the timely availability of sustained and adequate funding for the optimal delivery of public health services in all communities.

In order to accomplish this, careful thought must be given to devising a system that guarantees a sustainable source of funding that is protected from cuts due to economic and political pressures unrelated to the delivery of public health programs and services. It must be reliable enough to allow for long-term planning and staffing. It must account for possible inequities that arise from disparities in population distribution and characteristics, and health unit size. Mechanisms must be built in to guarantee surge capacities to deal with contingencies such as outbreaks, unexpected cost increases and new mandatory programs. The goal of increasing funding for public health in Ontario must be to ensure that the health protection, health promotion, disease prevention and surveillance resources meet the health needs of all of Ontario’s communities.

Funding Sources

The current practice for funding public health in Ontario is unique in Canada. In all other provinces, public health funding is entirely provincial. In Ontario, Section 72 of the HPPA clearly obliges municipalities within a health unit to pay the costs of public health programming, though the Minister is empowered by Section 76 to make grants as he or she sees fit. The current agreement, based on those sections, is a 50 percent grant for “approved costs” made by the province, to match the amount paid out locally. This grant is not guaranteed, is conditional and often untimely.

While this situation in practice is not ideal, it does reflect principles that our members believe should be maintained. As the province mandates and sets the standards for the core local services, it has a responsibility to ensure that the resources and guidance are available to carry them out. As the local authorities have the expertise and knowledge to tailor these services to the needs of their communities, they must retain a certain degree of decision-making autonomy. There may be several ways of achieving this, but it is clear that the administrative dysfunction in securing the necessary funds for public health needs to be addressed.

Funding Ratios

The major practical difficulty in the cost-shared system is that municipal funding must be in place before the provincial share is even requested. This means that boards of health must approve, present and justify their budgets to their obligated municipalities, leaving them to contend with a complicated, conditional and untimely reimbursement process. This is compounded by the fact that public health must compete

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for severely limited property tax revenues with more visible services such as solid waste disposal, transit, and public works. This has created a climate where too much caution must be exercised when boards of health are setting budgets, especially where there is significant membership overlap with municipal councils.

There is a case to be made for total provincial funding as a solution to the above difficulties. It would ease the burden on municipalities, eliminate many of the administrative complications and allow medical officers of health to focus on the delivery of effective services rather than justifying their budgets in political and economic debate. The perceived drawbacks, however, are significant, including a loss of local health agency autonomy and the vulnerability of a single source of funding to political pressures.

An argument could also be made to have the province securely and consistently fund the basic mandatory public health functions, with a stronger mechanism for the local planning, funding and delivery of community-specific programming. This would give more weight to Section 9 of the HPPA, which provides the legal authority to do so, while transferring the largest financial burden for public health to the province’s broader tax base.

The Interim Report by the Ontario Expert Panel on SARS and Infectious Disease Control (the Walker Report) has made a specific recommendation to “restructure the present municipal-provincial cost-sharing agreement so that the province pays 75 percent to 100 percent of public health expenditures within two to five years.” The obvious reason for the range presented is that there was no consensus on a precise ratio, but a general feeling that an increase in the province’s portion would eliminate many of the above-mentioned obstacles to adequate investment in public health services.

The existing administrative problems outlined above would not change with such a restructuring. Boards of health would arguably be faced with even greater difficulties if their municipalities were still required to front 100 percent of the costs for public health and await a 75 percent conditional reimbursement. The provincial share must therefore be guaranteed, timely, and well defined. It must also include equity strategies related to geography, population dispersion, and determinants of health, and be focussed on the standards that are expected in all regions.

The greatest perceived advantage of local responsibility for a portion of public health funding remains that of autonomy. It is a widely held assumption that financial support for programs is closely related to the amount of local influence and debate over decisions made on their provision. It is also seen as a built-in protection during times of fiscal restraint at the provincial level. The current 50/50 cost-share arrangement remains attractive to some of our members for those reasons, subject to significant modifications to the timing and conditions of the provincial portion.

Regardless of funding source and ratio, the funding of core capacities (delivery of mandated programs, health surveillance and monitoring, response to small-to-moderate contingencies) in every local public health agency must be reliable. The Government of Ontario must accept a larger role in guaranteeing timely and sufficient financial resources for the delivery of health promotion/protection and disease prevention activities that it mandates. This increased role must not interfere with local decision-making autonomy over the delivery of community-based public health services.
RECOMMENDATION:

2. That the province devise a strategy to increase overall funding to ensure:

   a) optimal and sustainable delivery of all mandated and recommended health promotion, health protection, disease prevention and surveillance services in all health units;
   b) the capacity for any optional public health programs and services to address local needs;
   c) the ability to respond to public health contingencies; and,
   d) coverage of all related administrative and support costs.

PERSONNEL RECRUITMENT AND RETENTION

The professions related to health promotion, health protection, disease prevention and surveillance are currently enjoying unprecedented visibility due to the recent scrutiny and planned revitalization of the public health system. By extension, there is a greater understanding of their importance, which underscores the need to address significant shortages of qualified and willing individuals to fill these roles.

The shortage of doctors and nurses in the primary care sector is well known, and has often been called a crisis. A similar crisis exists in the public health sector, one that is compounded by the fact that it must compete with primary care for medically-trained individuals such as doctors and nurses. These shortages are just as significant for public health dentists, public health epidemiologists, health promoters, public health inspectors and public health nutritionists. Rapidly declining enrolment and graduation numbers in post-secondary public health programs, and the loss of skill sets acquired in these programs to more lucrative careers indicate that these shortages could become even more significant in the near future.

Attention must also be paid to support roles that are critical to the effectiveness of the public health system. These include (but are not limited to) program evaluation, curriculum development, social marketing, paralegal skills, environmental studies, database management, and communications. While shortages of these skill-sets may not be as significant, attracting them to the delivery of public health services must be part of the strategy to address human resources.

To achieve the renewal of the public health infrastructure that is being undertaken at this time, a full complement of qualified staff in each of the public health disciplines and the technical roles that support them is required. Careful consideration must be given to recruitment and retention strategies, to include specific attention to competitive pay, benefits, working conditions, educational incentives and professional esteem.

Core Competencies and Staff Levels

Before devising a recruitment and retention strategy for public health, a review of essential functions and core competencies must be undertaken. Beginning with an analysis of the essential public health services, skill-sets required to carry them out must be itemized. Following this analysis, desired service levels must be considered in order to estimate the staffing requirements for them.

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3 These are itemized in alPHA’s August 2003 Board of Directors Discussion Paper, The Future of Public Health in Ontario. 
Public Health Definition and Profile

As with funding, there are clear immediate needs to address existing personnel shortages, but sustainability will depend on a reliable, renewable source of qualified and dedicated professionals. This will be an ongoing challenge if public health does not clearly define itself with a view to becoming more visible and attractive as a career choice.

At the foundation of this is reinforcing the importance of prevention for achieving broad health goals and identifying related professions. Where young children are introduced to police officers, firefighters, doctors and systems analysts in early education, it would be reasonable to include public health nurses and promoters, public health inspectors, nutritionists, and medical officers of health in this curriculum. Elements of health promotion and disease prevention theory must become a permanent part of education at all levels and taught in more detail in the health care disciplines.

If this fundamental understanding of the functions, roles and importance of the public health system becomes a part of societal common knowledge, there might be more interest in exploring this type of work with high school guidance counselors, at job fairs, and during school-hosted career days. This will, of course, require input from public health professionals and government agencies that are capable of clearly defining what the system is, and itemizing available careers and their necessary qualifications.

Once students begin to enter post-secondary training for careers in public health, opportunities must be created to foster a closer relationship between the learning institution and potential employers. Health units, with assistance from the central agency, must foster a learning environment and demonstrate increased involvement in educational programs both for staff and for students. Mentorships, job placements, bursaries, tuition-for-guaranteed service arrangements and paid practicums are mechanisms that work very well in other professions.

Retention is the other part of this equation, and job satisfaction is essential for ensuring that qualified public health professionals remain dedicated and effective. Much of this comes from a positive workplace environment, but the perception of the job itself is also significant. Following the SARS outbreak, there was little specific mention of the medical officers of health, communicable disease investigators, epidemiologists and data entry staff who went well beyond the daily demands of their jobs to manage the crisis. If public health is to become an attractive career option for those who wish to contribute to the well being of the population, it should certainly be promoted as something worthy of a better designation than “other health care workers” when they are being publicly recognized.

Training and Education

Financial issues are a significant part of any career choice – not just what the job pays, but what one must pay to get the job. The cost of post-secondary education has increased to prohibitive levels for many students, which makes financial incentives to follow a particular career path significant. Because public sector careers are not generally as lucrative as private sector jobs, other types of incentives must be considered.

Grants and bursaries from boards of health would be useful to help attract students to public health
programs. Subsidized education in return for a period of service upon completion of studies is a mechanism that works very well in other disciplines. Paid practical summer placements should also be encouraged as an important mechanism for hiring permanent staff.

Compensation, Benefits and Employment Conditions

While it is true that many people choose careers in public health to serve their communities and contribute to the greater good, it is not enough to rely on this type of goodwill to keep a competent staff in professions where pay is relatively low and expectations are extremely high. This is especially true if there are specialty education requirements in addition to the basic professional degrees, as is the case for medical officers of health and public health dentists.

There is a need for recognition of the value of public health work and a re-evaluation of appropriate compensation by governments for the public health professions. It may not be possible for the public sector to pay rates that are comparable to the acute health care sector or private industry, but higher baseline salaries are necessary to attract and keep good candidates. Attention should also be given to competitive wages for underserviced areas.

Job perks such as medical benefits, affinity programs for insurance and investment, and no-cost opportunities for further education may also be effectively used to supplement comparative discrepancies between private and public sector incomes. Work-hour flexibility and subsidized services such as on-site day care are additional examples of considerations that attract workers to a place of employment. These and other creative strategies to benefit the employee should be evaluated for inclusion in the funding envelope that is dedicated to the delivery of public health services.

Recruitment and Retention of Medical Officers of Health

Section 62 of the HPPA requires that every board of health appoint a full-time medical officer of health. This position has become far more prominent, demanding and complex, and its importance was clearly underscored by the very first recommendation from the Walkerton Inquiry:

The Health Protection and Promotion Act should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant Medical Officer of Health position with a full-time Medical Officer of Health.

At present, there are nine vacancies within the defined terms of the legislation, with at least two retirements pending and very few new community medicine graduates entering the field. This represents an increase in vacancies since the above recommendation was made. Filling these vacancies is going to require finding not only qualified, but also willing candidates.

A subcommittee of alPHA’s Council of Ontario Medical Officer of Health (COMOH) is carefully addressing this issue, and more specific details are forthcoming, but an initial report has been submitted to the Walker Panel for inclusion in its final recommendations. The following considerations for MOH / AMOH recruitment and retention have been drawn from the work of that committee:
• Remuneration for MOH and Associate MOH positions is low relative to the other medical professions, especially considering the relative demands of the job. Salary improvements are essential to attract and retain them.
• Enhanced support for the statutory powers under Section 67 of the HPPA that optimize the abilities of A/MOHs to fulfill their statutory duties, preserve their independence and protect them from political and administrative interference;
• The presence in each local public health agency of at least one AMOH to share duties, including after-hours coverage, and to provide medical advice, assistance and support;
• Opportunities and support for continuing medical education, maintenance of professional certifications and establishing linkages with local colleges and universities; and,
• Strengthening relations between A/MOHs and their local public health agencies with the Chief Medical Officer of Health and the Public Health Division (or central provincial health agency) such that constructive collegial relationships, collaboration, and cooperation are restored.

RECOMMENDATIONS:

3. That as part of its review of Ontario’s public health system, the Ministry of Health and Long-Term Care, in consultation with local public health agencies and relevant associations, clearly itemize core competencies, appropriate remuneration and ideal numbers for public health staff to carry out mandatory and recommended public health services.

4. That the provincial public health agency, in consultation with alPHa and its Affiliate Organizations devise a strategy to address the immediate shortages of medical officers of health, health promotion officers, and public health nurses, nutritionists, epidemiologists, inspectors and dentists.

5. That the provincial public health agency, in partnership with local public health agencies, devise a comprehensive, long-term recruitment strategy that includes promoting public health service as an attractive career choice. This strategy should include input from institutions with a public health curriculum, the Ministries of Education and Training, Colleges and Universities, and alPHa and its Affiliate Organizations.

6. That the provincial public health agency and local boards of health devise strategies to provide or facilitate the provision of ongoing education for public health staff and training opportunities for students including but not limited to job placements, tuition-for-guaranteed service arrangements and paid practicums.

PROVINCIAL PUBLIC HEALTH AGENCY CAPACITY AND ROLE OF THE CHIEF MOH

Of equal importance to funding, human resources and local autonomy is a strong central system for the development of effective, evidence-based public health policy, the provision of leadership, advocacy and expert advice on public health issues. It is also necessary for the continuous and effective exchange of information between the local and central levels and across government sectors. Like the local public health authorities, this central agency must be sufficiently independent to act in the best interest of the public’s health.
In Ontario, the central health promotion and protection functions of the Ministry of Health and Long-Term Care are overseen by its Public Health Division (PHD, formerly the Public Health Branch) and by the province’s Chief Medical Officer of Health (CMOH). This is where many of the funding and policy decisions for public health programs are made, and where the above functions ought to reside, as long as their health outcomes take precedence over political and economic pressures.

**Characteristics**

To ensure effective public health policy, the central public health body must receive its authority through legislation, but remain independent of political influence. This agency must be carried out by a well-resourced staff with appropriate specialist expertise to carry out the functions that are itemized in the next section of this paper. It must be responsive to the needs of the local public health agencies while being aware of the political and economic climate within which it must function. Its primary purpose must be to support the goals and objectives that are designed to promote and protect health.

The Ontario Expert Panel on SARS and Infectious Disease Control has recommended the creation of a new Ontario health protection and promotion agency, which would also include an Ontario public health laboratory and a new division of infection control. Many of our members support this idea, and believe that this agency should be an arm’s length from government, or at the very least enjoy legally guaranteed independence to act in the interests of public health, similar to that of Ontario’s local medical officers of health.

This central agency, with the Chief Medical Officer of Health (CMOH) at its head, should be adequately staffed by readily available experts familiar with current and emerging issues in environmental health, public health nursing, public health law, public health dentistry, nutrition and health promotion. A robust research and review function should keep the agency abreast of best practices and new developments in all of these areas, and must always provide well-informed, politically independent leadership in public health that will influence public health practice and policy at local, provincial and federal levels.

This leadership must also be a resource to the government as a whole, and should have effective linkages to the acute care sector, emergency planning agencies and to ministries that deal with other determinants of health (e.g. Education, Labour, Social Services and Children’s Services). It should also be the authority on the proposed provincial health goals, empowered to evaluate and report on progress.

**General Functions**

First and foremost, a centralized health agency should set, monitor and revise provincial public health priorities and their minimum standards, in consultation with relevant agencies. It is our vision that these would include standards for the provision of public health services (i.e. the MHPSG) as well as those under the broader provincial health goals. Clearly established communication mechanisms and linkages would be utilized to ensure inclusive and iterative consultation.

In order to support this function, this central body must be well equipped to carry out and monitor public health-related research, have strong program planning and evaluation functions and an efficient strategy to ensure clear communication of results of these activities and meaningful response to them from key stakeholders.
stakeholders. The net effect of all of this should be strong support, clear direction and good advice for the delivery of public health services.

The continuous and timely exchange of effective and consistent information is essential to the proper functioning of a strong public health system. Its absence was identified as a significant weakness in the provincial response to SARS, and has been a regular source of frustration for our members in the recent past. With the proper enhancements to staff, practical expertise, resident knowledge and clarity of purpose, effective communication could easily be strengthened.

**Monitoring Functions**

In order to maintain control over consistent and effective information, it is extremely important to ensure that the best possible supports are provided for its collection and analysis. The collection of data on reportable diseases and immunization records are existing examples of activities that are meant to identify trends and inform reports on health status. However, they would benefit from improvements in data management systems. An ongoing investment in appropriate, up-to-date information technology resources (infrastructure, support and training for users) for both the provincial and local levels will facilitate the monitoring and follow-up of infectious diseases and tracking of chronic diseases throughout the province, with links to national databases serving similar aims.

Consideration should also be given to centralizing and strengthening the collection, analysis and reporting data for the periodic *Report on the Health Status of the Residents of Ontario* as undertaken by the province’s Public Health Research, Education and Development (PHRED) health units. This Report takes a broad approach to health status, accounting for the impacts of age, poverty, education, mental health, environment, violence as well as more direct health impacts such as disease and injury. This type of report should be based on solid and complete information as gathered by the central agency in consultation with local and other government agencies; its conclusions should be presented in context of progress toward the proposed comprehensive provincial health goals.

**Response Functions**

Disease outbreaks are the clearest illustration of the reality that political borders are not effective tools for the prevention of their spread. SARS, West Nile virus, and influenza are ready examples of situations where collective public health expertise and authority must be rapidly mobilized and efficiently coordinated.

Where local public health agencies should have the capacity to respond to local public health contingencies of small to moderate size in their areas, a similar, more centralized capacity must exist at the provincial level to respond to larger ones. A series of detailed contingency plans should be developed and communicated to the local agencies that will provide the ground level services, and should be regularly evaluated.

It should be stressed that an overemphasis on communicable disease control in renewing Ontario’s public health system would be wasting a tremendous opportunity to reinforce the idea that public health is essentially about prevention. Better outcomes for the public’s health can be predicted if the prevention activities are sufficiently upstream. Primary prevention (i.e. activities designed to identify and minimize risk factors) must remain the focus of public health system if it is to be successful. A strong
communication function should also be built in to ensure that effective and consistent messages about health promotion, health protection and disease prevention are delivered to the public where appropriate.

**Relationship with Local Public Health Agencies**

It is important that the primary interest of this central entity remain the delivery of clearly defined health promotion, health protection and disease prevention services. As such, the stakeholders of primary interest must remain the boards of health that deliver them. It has already been made clear that those agencies must retain significant autonomy to make decisions that will serve the health of their communities, but the provincial body must still be a reliable source of information, expertise, guidance and other resources. A strong co-ordination role and central development of province-wide campaigns on public health issues that can be locally adapted should be expected.

Assuming that this central body remains responsible for setting the standards to which these local agencies are held, it should also be responsible for ensuring the proper resources to carry them out. Funding is certainly of primary importance, but so might be providing ongoing opportunities for consultation, providing services for training and professional development, and devising strategies to recruit and retain public health professionals in all of its disciplines. It must also be responsible for monitoring and enforcing mandated program delivery as an accountability function. These will be complementary functions, where the evaluating body also has some capacity and responsibility for addressing any identified service gaps or inefficiencies.

Finally, should this agency be responsible for the central administrative functions of public health in Ontario, it should retain oversight of the allocations of the provincial portion of health promotion, health protection disease prevention and surveillance expenditures.

**Relationship with Government**

Given the impending renewal of the public health system at both the provincial and federal levels, the advisory capacity of the renewed provincial agency cannot be limited to support for the local public health agencies. It must be very active at the policy-making and governance level, with input to the new national public health strategy (as overseen by the new Minister of State for Public Health), and serving as a focal point for a renewed and comprehensive provincial system.

In light of the proposed provincial health goals, we believe that a critical function of this central public health agency will be to oversee their development and progress on them. It must have the requisite capacity to evaluate a broad range of health protection, health promotion and disease prevention strategies including environmental and socio-economic ones, the political clout to secure commitment to them and the capacity to give expert advice on them.

**Chief Medical Officer of Health**

In order to achieve the objectives of these roles, we believe that the position of the chief executive officer for the agency must have the appropriate independence, credibility, expertise and political clout to be a leading voice for public health in Ontario. It would stand to reason that the province’s Chief Medical Officer of Health position already possesses this combination of competencies, and should therefore be
that voice.

The expertise of the person filling this position must be such that his or her recommendations are a respected source of strong, consistent and credible advice to the government, to the public health service providers and to the public. He or she must be an effective liaison between the policy makers and public health professionals. He or she must also be an effective and respected voice for health perspectives on the business of all government ministries. He or she must also retain the legally guaranteed responsibility to make decisions that supersede political motivations when they are made in good faith and in the best interest of protecting the health of the province’s residents. He or she will provide leadership for the many functions of the renewed central public health authority as itemized above.

RECOMMENDATIONS:

7. That an extensive review of the province’s centralized public health functions be undertaken, with a view to the establishment of an independent and effective provincial public health agency headed by the Chief Medical Officer of Health

8. That the provincial government commit to ensuring that this agency has reliable sources of technological, human and financial resources to undertake its advisory, monitoring, analysis, coordinating, liaison, enforcement and response functions.

9. That the provincial government put in place the liaison, reporting and consultative mechanisms that will make the provincial health agency the focal point for monitoring and reporting on progress toward provincial health goals, as endorsed by all government agencies.

LOCAL PUBLIC HEALTH AGENCY CAPACITY AND ROLE

The purpose of the above discussions of funding and personnel shortages is to examine immediate needs to improve public health service delivery. There has also been discussion about increasing requirements for highly specialized public health expertise (e.g. epidemiologists, legal counsel), which might not be presently practicable for all health units. The fact remains that the required financial and human resources may not be immediately available to accomplish both. This has led to discussions of more creative ways to improve public health unit capacity and performance.

Considerations

The evaluation of new strategies for optimum delivery of public health programs and services will require a careful and thorough examination of a wide range of local processes and outcomes. The ultimate goal of any strategy will be to increase overall public health capacity and solve existing program and service delivery difficulties for all of the province’s communities. It cannot be implemented as a short-term measure to save money or achieve simple compliance with statutory requirements such as that of a full-time medical officer of health in each board of health. It must be a forward-thinking process aimed at the sustainable provision of optimum levels of health protection, disease prevention, and health promotion and surveillance activities in each of Ontario’s health units.

As such, improving local capacity must be evaluated in the context of the funding, human resources and governance strategies already under review. It will also require an analysis of Ontario’s diversity of
communities and a detailed examination of existing and ideal characteristics of the health units that serve
them. Only after this is achieved can service delivery improvement strategies be identified, with local
public health agencies given full opportunity to participate in discussions to influence any process that
leads to implementation.

Strategies to optimize the functions of public health units must be informed by the specific characteristics
of the individual communities served by a given health unit, as well as those of the health unit itself. If
different communities have different health needs, then it follows that their health units should have the
appropriate expertise and resources to address them. The considerations listed below are meant only as
examples, and should by no means be interpreted as complete:

Community Characteristics: total population; total land area; seasonal variation of population;
population density pattern; economic and cultural factors; special needs areas; transportation
systems; communication systems and media; educational opportunities; research facilities;
administrative boundaries of other political agencies (provincial, federal, municipal);
governance structures (e.g. relationship of board of health to city councils); health status
broken down by statistical indicators; emerging health issues, etc.

Health Unit Characteristics: staff levels; program compliance; collective agreements; local
partnerships and network participation; recruitment success rates; relative expenditures;
number of satellite offices; supply contracts; number and types of regulated premises;
existing agreements with neighboring health units and their success, etc.

Outcomes

Enhancements to local service delivery

First, assuming that public health costs continue to be shared, the local ability to plan, fund and
implement community-specific public health programs should be strengthened. Second, all local public
health agencies should have access to focused public health specialties (e.g. legal, toxicology,
epidemiology, etc.). Third, consideration should be given to strategies to increase purchasing power
based on deeper discounts for bulk orders of various goods and services.

Organizational improvements

New strategies should also be aimed at addressing communication, collaboration and administrative
obstacles. If we continue to insist that public health services are closely linked with other activities that
promote health and prevent disease, it would make sense that any strategy to enhance horizontal
integration should be endorsed. Closer and more integrated communication and collaboration with other
health services (e.g. hospitals, district health councils), as well as provincial administrative ones (e.g.
school boards, ministry of environment areas), is certainly necessary. While realignments of health unit
boundaries with those of other administrative and subjective jurisdictions could facilitate this type of
lateral integration and collaboration, we do not see it as a prerequisite.

Elimination of inequities
There is ongoing concern about the difficulties faced by Ontario’s northern health units because of their size and population characteristics. Issues of transportation, overhead for satellite offices, service accessibility and ability to recruit staff are significant ones. Forward motion on issues where several decision-making entities (e.g. municipal councils) exist is another. Of further concern is that larger jurisdictions alienate community members from the services that are supposed to be based on their particular needs. This is also true of related agencies that need to be consulted on program and governance issues. Larger areas make it much more difficult to assemble them. Specific attention must be paid to solving these problems in Ontario’s larger and more remote communities.

**Health Unit Amalgamation**

The idea of realigning the jurisdictional boundaries of boards of health to optimize services in the above context has been variously suggested as a possible strategy to which the above considerations might be applied. There have even been some concerted, though unsuccessful efforts by health units to enter into agreements and processes to merge in the past. This idea was recently brought back into the dialogue about improving public health capacity in the Walker Panel’s interim report in the form of the following recommendation:

“The Ministry should review, in conjunction with the Medical Officers of Health, the Association of Local Public Health Units (sic) 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”

(Recommendation 6, page19).

In the absence of a clear rationale for this idea, alPHa members do not support the idea that the number of health units in Ontario is in and of itself the greatest obstacle to service improvements. alPHa’s members strongly believe that merging health units should not be considered as a cost-saving or compliance measure. If a clear rationale for mergers as a means to enhance public health capacity does present itself, it must be undertaken with full consultation and close attention to the difficulties of such a process.

Amalgamations and realignments are complicated, politically contentious processes. Health units that have attempted it and boards of health in areas that were subjected to municipal amalgamations some years back have very negative views of the procedure, articulating that there are too many obstacles in the course of achieving its desired objectives. In the short term, mergers are energy intensive and would require large amounts of valuable human resource dollars for years to deal with merger issues. This is not an appetizing thought where resources to deliver the services themselves are already alarmingly scarce. Harmonizing collective agreements, restructuring goods and services contracts and maintaining pre-existing collaborative partnerships are all part of an enormous logistical exercise that may not be a wise use of resources at this time.

**RECOMMENDATIONS:**

10. *That the province, in partnership with local public health agencies, undertake a comprehensive and detailed review of capacity and community needs to inform the development of long-term strategies to enhance local public health agency capacity to plan and implement optimal public*
health services.

11. That the goal of such strategies is to optimize human and financial resources, public health expertise and technical requirements for local delivery of public health services.

12. That the province fully consult with the Association of Local Public Health Agencies when evaluating strategies to optimize local public health agency service capacity, including but not limited to those under which realignments or amalgamation are considered.

CONCLUSION

This position paper represents a synthesis of our members’ discussion of four topics that cover many, but far from all, of the required considerations in reviewing and improving the delivery of health protection and promotion and disease prevention services that are such a critical component of the overall health system. They are meant to add to the current and comprehensive set of reviews and recommendations contained in the various reports that were precipitated by public health crises such as the Walkerton E. coli and SARS outbreaks. Taken as a whole, this set of reports and their recommendations are consistent and complementary, and should form a strong foundation for strengthening the public health system to truly enable residents of Ontario to realize their fullest health potential.