SUMMARY OF THE NOVEMBER 2005 INTERIM REPORT OF THE CAPACITY REVIEW COMMITTEE

PART I: CONTEXT

On November 2, 2005, the Local Capacity Review Committee (LCRC) released its interim report. It is a summary of findings from the first of a two-phase initiative to formulate recommendations to strengthen local public health capacity. This first phase reports on data gathered from health unit staff and management surveys as well as written submissions (the majority of those identified in the report were from alPHa and its member organizations) to the Committee. It is a snapshot of the deliberations to date, and as such does not make specific recommendations. What it does do is identify issues and options under consideration for strengthening public health governance and structure; funding; accountabilities, human resources and research and knowledge transfer.

This summary is intended to be no more than a guide to the Interim Report. alPHa strongly encourages its members to carefully read the whole report, using this summary as a map to (and short description of) the various issues covered within it.

SECTION 1: PREFACE

The report begins by summarizing the growth in profile of public health functions and importance, in the context of the Walkerton e-coli outbreak, the arrival of West Nile Virus, the immense impact of SARS, and the collected conclusions of various examinations of the public health system that were precipitated by these events.

These conclusions were unanimous – that the system in place is not properly equipped to do what it is in place to do and is in need of revitalization and modernization in several areas of health protection and promotion.

The purpose of the LCRC is to focus on the health units, where the system meets the communities that it is mandated to keep healthy.

SECTION 2: ABOUT THE CAPACITY REVIEW

This section describes the LCR’s purpose, process and context, which is to examine the effectiveness of local public health delivery, management, governance and funding, and how they are integrated with the provincial public health system. It is not an assessment, but a collaborative review that is meant to identify strategies and practices to strengthen all of these aspects – i.e. how the system should be structured to fully deliver mandated public health services and how to best meet community health needs.

Recommendations will be made on core capacities, human resources issues; systemic obstacles and opportunities; legal obligations and compliance; financial and programmatic accountability;
alignments with LHINs / Family Health Teams, primary care and municipal functions; as well as transitional issues that will be dependent on the extent and nature of advised changes.

It is pointed out that the Capacity Review takes place in the context of wider systemic changes, including a federal strategy (anchored by the Public Health Agency of Canada), the modernization of primary health care in Ontario with the establishment of LHINs and FHTs, the establishment of an Ontario Health Protection and Promotion Agency, and the creation of new Ministries of Health Promotion and Children and Youth Services.

SECTION 3: METHODS AND APPROACH

This section elaborates on the approach taken during this first phase by the Committee to gather and analyze data that is the subject of this interim report, which will inform its final report.

It consists of literature reviews, examination of position papers and submissions from stakeholders, establishing a “Reference Panel” (an assembly of representative public health organizations); and an on-line health unit staff and board member survey. The distillation of this information will identify the key issues for discussion and analysis during Phase 2, leading to recommendations in the final report.

SECTION 4: PUBLIC HEALTH IN ONTARIO

This section describes Ontario’s unique approach to providing public health services to its communities, briefly covering the structural and legislative framework within which Ontario’s 36 disparate health units operate, and what they are expected to deliver. It also hints at the challenges that health units face in meeting a uniform set of basic expectations where a wide range of factors (geography, funding, staff levels etc.) limit their capacity to do so.

PART II: ISSUES AND OPTIONS

SECTION 5: PUBLIC HEALTH GOVERNANCE AND STRUCTURE

This section compares the three different models for Ontario’s 36 boards of health, briefly describes the legislative requirements for their composition and reports on the wide variations in their structure and leadership approaches as reported to the LCRC through health unit surveys.

Issues identified include: board instability due to vacancies and member turnover; quality of orientation in duties and responsibilities and variations in strategic plans. This led to an acknowledgement that any reform must include clearer expectations, more consistent training / support, and improved processes for selection and appointment of members.

After a brief comment that the regional models in other provinces offer no clear advantages, the report does hint that moving toward a single model of governance has clear benefits to improving system-wide effectiveness through integration and consistency. It is then a matter of deciding on a model that can be applied throughout the province but includes the flexibility necessary to account for the disparate local needs.

A key consideration is Ontario’s unique involvement of its municipalities in the public health governance structures. This has been the source of great debate and requires an examination of
the advantages of local political engagement in public health against its capacity to pay for it (and whether the two are mutually exclusive).

While it does not make specific recommendations, the CRC sets out some principles and markers for effective governance that will inform their recommendations on the subject. Local authority, clear competencies, roles and responsibilities, sustainability, linkages and accountability are among those mentioned. The CRC will also consider the requirements to improve support for boards of health, and will examine “critical mass” by analyzing health unit performance expectations in context of staffing, demographic, geographic, financial and other factors, as it evaluates options for health unit reconfiguration as a means to meeting them.

SECTION 6: PUBLIC HEALTH FUNDING

This section begins with the current funding approach, itemizing how it is shared between the province and the municipalities, including a list of which programs are funded entirely at the provincial level. It then examines the difficulties in the local budget setting process, which originate in differing provincial and municipal fiscal years, long delays before local receipt of the provincial share and uncertainty that prevents long-term planning.

In addition to the logistical difficulties, it is generally accepted that mechanisms to ensure adequate overall funding to deliver all mandated programs are absent, failing to account for costs such as administration, travel and service to populations with complex needs, leading to significant inequalities.

It follows with a list of principles to guide the development of a more effective, clear and predictable allocation model that provides overall capacity improvement, equal and complete delivery of mandated services, capacity to respond to unanticipated contingencies, and capital costs. It then lists considerations for strategies to achieve this, including suggestions of multi-year funding, more communication on budgets between the Ministry and the health units, and a larger provincial funding share (up to 100%).

In addition to being sufficient, the proposed funding model will need to be equitable. The CRC states that a per-capita model is not appropriate, and suggests indicators for a model that might be (valid and equitable proxies for health unit needs and service costs; stability; operational clarity). No specific suggestions for an alternative are made, though it does hint that novel approaches (e.g. 100% funding of Medical Officer of Health positions) could be considered.

SECTION 7: PUBLIC HEALTH SYSTEM ACCOUNTABILITIES

This section covers the lack of consistent and appropriate procedures to determine whether or not expectations for public health are being effectively met. Self-assessment tools used by health units are inadequate, not based on the most appropriate indicators, not consistently applied, not a staff priority and whose results are not verified by provincial assessments. In addition, it is suggested that the standards against which performance must be measured (i.e. the Mandatory Health Programs and Services Guidelines) may not provide the most appropriate indicators.

This results in difficulties in measuring system-wide performance, compliance and improvement (and therefore planning), because reliable comparators and standardized data sets are unavailable. The CRC therefore enumerates the elements of effective performance management, including a strong statutory framework, appropriate standards and monitoring, support for evaluation
activities and interventions for detection and remediation of failures. Details of what this might look like are offered in two graphics.

In short, effective performance management requires a range of accountability mechanisms with comparable measurements and consistent application that are linked together systemically to ensure ongoing performance improvement in public health. The section closes with an indication that the CRC is considering the benefits of the Balanced Score Card model as a public reporting tool for health units.

**SECTION 8: PUBLIC HEALTH HUMAN RESOURCES**

This section examines the challenges of recruitment and retention of skilled and motivated public health professionals and support staff in all disciplines. It begins with a listing of public health unit employees by position and then lists vacancies for each. Reporting an overall vacancy rate of 4.6% (with a range by position of up to 25%), issues of staff turnover, student recruitment and projected retirements over the next 5 years are being examined to set the context for filling future needs.

A specific mention is made of the Medical Officer of Health workforce, as almost 16% of the current complement is expected to retire within 5 years, and there are already approximately 15 vacancies for fully qualified A/MOHs in Ontario. The CRC has commissioned a study to review supply and demand issues for this group.

A listing of the challenges to recruitment and retention follows, which includes systemic issues (profile, attractiveness, stability, remuneration and progressiveness of public health careers), as well as quality of working life issues (recognition of value; management and leadership concerns; lack of support for professional development).

Recognizing that only some of these can be addressed with short-term solutions, the CRC will examine suggestions for strategies are made for the systemic (marketing public health careers, a more active and comprehensive provincial recruitment and retention strategy, competitive and equitable salaries, student scholarships, stronger public health education curriculum) as well as quality of working life issues (progressive leadership programs, provision of professional development and peer networking opportunities).

**SECTION 9: RESEARCH AND KNOWLEDGE TRANSFER**

Public health is by definition evidence-based. Information, research and knowledge are prerequisites for effective public health interventions. This section examines the current mechanisms that bridge the evidence with the practice.

The existing PHRED program (located in only 5 of the 36 health units) is cited as an important example, but as one that works at a disadvantage due to the absence of a solid, province-wide strategy to engage research communities while setting research priorities. Health units thus undertake extensive research, needs assessments, program development and evaluation and health status monitoring in relative isolation. A significant amount of this work is done by staff involved in direct program delivery.

Research and information priorities and needs are then listed, including best practice guidelines, continuing research skills enhancement, health indicator data, and access to specialist expertise. It is reported that there is a significant gap between these needs and their actual availability. Time
shortages, lack of system-wide coordination and communication, absence of appropriate skills, lack of access to relevant data and shortages in resources to respond to identified needs are cited as important barriers to conducting, sharing and effectively applying research.

Communication and coordination was identified as the major weakness in the current approach, one that might be solved with increased centralized functions, standardized processes and improved staff opportunities for training and access to useful information.

The expansion of the PHRED program is then considered, given that non-PHRED health units do value and make use of its services, and recognize its potential to address provincial and regional coordination issues for which the current PHRED model does not have the capacity. The Public Health Agency of Ontario is named for centralized roles in setting research priorities, developing tools and coordinating activities, as well as translating information into policy and practice priorities. Public Health Units would continue to play a key role in similar activities at the local level, which would benefit from enhancements to leadership, funding, partnerships and networks, training, and dedicated and skilled staff.

SECTION 10: PHASE II – NEXT STEPS

During Phase II (already underway), the CRC will engage a consulting firm to visit public health units to more fully explore the issues highlighted above in interview and focus-group format. Three Roundtables are also planned for late November and early December, one to discuss each of the following: public health accountabilities and performance management; strategies for public health funding; and linkages with academic institutions. The CRC will continue to review the commissioned research and results of the ongoing information gathering processes with a view to formulating recommendations in its Final Report. Written input is welcome and may be submitted at CapacityReview@moh.gov.on.ca