Response to Public Health Modernization Discussion Paper

Insufficient Capacity

1. What is currently working well in the public health sector?

There is no single answer that is valid for the whole of the Province of Ontario. Most health units are performing well – delivering programs and services, meeting the requirements of the Ontario Public Health Standards, maintaining and understanding population health and addressing the full range of health issues, as well as working to reduce inequalities in health status. Local partnerships, both within and without the healthcare system are strong, enabling achievement of goals, and there are timely responses to emerging issues. However, there is variability across health units. It is particularly challenging for some health units to attract and retain qualified public health professionals including a long-term fully qualified medical officer of health; to have sufficient expertise to undertake surveillance and/or health status assessment, or to control outbreaks; and to access and apply data and evidence or to evaluate programs.

There are many examples of collaboration with associations and within the public health system, including health units working together in Tobacco Control Area Networks (TCANs) and with the Ontario Tobacco Research Unit at the University of Toronto; and the Association of Public Health Epidemiologists (APHEO) engaging health units in the development of an extensive list of core indicators (including sources, definitions, analysis tips, methods of calculation, etc.) used by all public health epidemiologists. Partnerships with Public Health Ontario have enabled coordination and provision of evidence to support program and service delivery.

In terms of Toronto Public Health specifically, we continue to work to improve population health by providing health protection and promotion services that are timely and evidence-informed, in keeping with our mandate as outlined in the Ontario Public Health Standards. This is facilitated by an engaged Board of Health, as well as collaborations and good working relationships with other City Divisions. It is also facilitated by a public health system where each component has its own governance, structures, mandate, and funding stream (e.g. Public Health Ontario, Ministry of Health, local public health units).

Public health units regularly review their organizational structure to identify and implement approaches to further advance efforts to improve the health status of the population. For example, Toronto Public Health has recently undertaken a review of the organization with a view to ensuring it is optimally structured to adapt to potential
changes within the public health sector, along with the ever-changing needs of the population.

2. What are some changes that could be considered to address the variability in capacity in the current public health sector?

Configuration of Public Health Units

As mentioned in the Discussion Paper, there are several reports that provided recommendations related to the structure, organization and governance of public health. These include Learning from SARS (Naylor), the Walker Report (Expert Panel on SARS), Revitalizing Ontario’s Public Health Capacity (Capacity Review Committee), and Improving Public Health System Infrastructure in Canada (F/P/T Task Group on Public Health Infrastructure). Several important changes were made in Ontario as a result of the recommendations in these reports, including revisions to the Health Protection and Promotion Act to strengthen the role of the Chief Medical Officer of Health and to provide for more powers in an emergency, and the creation of Public Health Ontario. Some issues were not addressed – and the most important of these is the failure to ensure that all health units have the critical mass necessary to provide the staff, skills and organizational capacity which is seen in larger organizations. A report (Moloughney) in 2005 found that all health units that have not had a Medical Officer of Health for 5 or more of the previous 10 years had populations of less than 135,000, and health units of this size were also more likely to lack a full-time epidemiologist (a quarter that had no epidemiologist in 2014 still lacked one in 2017) and to have low achievement of the inspection of food establishments. Research from the US suggests that public health departments reach the most efficient size when the population served is about 500,000. If a restructuring of the boundaries of health units is to be undertaken then a minimum population served of up to half a million could be considered everywhere, except possibly the far north.

Provincial Support

Even with a new configuration of health units able to practice high quality public health, there will continue to be a need for support, provided by the provincial level, to all health units, so that they may continue to maintain and improve their infrastructure. By “infrastructure” we mean the workforce, organizational capacity, information and knowledge systems, etc. which reports have repeatedly identified as essential to an effective public health system. These may need provincial assistance because they require a degree of standardization, because they require highly specialized skills, because resources may be shared, or because development is very expensive. Some examples include:

i. Workforce Development – as Naylor said, “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”. Opportunities for professional development of staff is an important way to continue to build skills and capacity. At one time the Public Health Agency of Canada provided a number of programs, but these have largely been eliminated: provincial-level support is therefore important.
There are very clear needs for the development of skills in population health, evidence-informed decision making and evaluation, amongst others.

An assessment of staff competencies will assist in identifying the alignment between work requirements and competencies, and highlight areas for further development. A coordinated approach to continuing education has been identified as an important way to promote workforce development across the public health sector, for example, through tailored education strategies for a particular discipline using specialty standards. This coordinated approach could also include a harmonized workforce onboarding program, to provide skill development in public health competencies that are common across the sector.

ii. **Evidence** – ensuring that programs, services and policies have evidence of effectiveness, and translating knowledge into action are essential to public health practice. Building skills, providing access to evidence, and sharing evidence reviews are basic building blocks. A centralized repository (i.e. for evidence syntheses), along with knowledge exchange groups, and evidence-informed strategies (e.g. Best Practice Guidelines Evidence Informed Decision Making) will promote evidence-informed practice and can reduce duplication of efforts. A process and structure for identifying and making available evidence syntheses that apply broadly to the public health sector (e.g. rapid reviews developed by Toronto Public Health and Peel Region) would also facilitate the use of evidence more efficiently.

iii. **Information systems** – there will continue to be a need to expand the role of information technology in public health practice, and to improve the efficiency of current systems. This should be undertaken at the provincial level for reasons of cost and of interoperability.

iv. **Knowledge sharing** – creating a mechanism for collaboration and sharing resources among public health units will enable sharing of resources, information, ideas, skills, and campaigns.

There could be opportunities to designate and allocate funding to public health units to be centres for excellence in various areas so that individual public health units can draw on strengths and capacity of others. This could apply to areas of knowledge exchange, as well as areas of respective strengths and expertise.

**Role of Public Health Ontario**

Public Health Ontario (PHO) is the most important resource for the support of infrastructure. Much of its time and resources are taken up with communicable disease control and with short-term issues. There is a case to be made for expanding its capacity, especially in workforce development, evidence-informed decision making, and chronic disease and injury prevention. This expanded capacity could also include innovative structures where PHO has secondments or positions that specifically support set projects for smaller public health units. PHO’s work should not be confined to program-specific issues, but support the development of organizational capacity in general. There is a role for PHO in program planning and
implementation – this would promote the incorporation of scientific evidence into effective public health programming.

**Funding**

One cause in variable capacity across health units is the arbitrary nature of the distribution of funding. Historically, there has been a failure to account for population increases in the announcements of funding changes. This has resulted in the GTA and other fast-growing areas falling dramatically behind in per-capita funding. The MOH established a committee, with membership representing a wide range of interests, to develop a formula for needs-based funding. It reported in 2013, after three years of work, and the formula was accepted by government. Progress towards the implementation of this model has been slow. Government should review its commitment to a fair, needs-based distribution of the available funds.

**Leadership**

Gaps in leadership continue to occur during Medical Officer of Health transitions – a potential solution to this issue is to make it obligatory to have at least one Associate Medical Officer of Health in each board of health.

3. **What changes to the structure and organization of public health should be considered to address these challenges?**

The variability in capacity across Ontario could be addressed through a review of health unit boundaries in order to produce public health organizations with the critical mass to practice the highest quality of public health. This will involve changes in governance (addressed elsewhere).

It is important to avoid a simplistic approach to restructuring that involves only which programs and services are delivered at the local level and which at the provincial level and allow for nimble response at both levels. For example, this may include a centralization of some functions common across public health units, along with localization and specialization of others. Innovative methods that facilitate smaller public health units to access resources centrally or from neighbouring public health units will also strengthen capacity across the sector. The main contribution of the provincial level is to support the organizations which seek to improve health at the local level.

It will be important to maintain the structure of larger health units embedded in their municipal structure in order to advance public health work through collaboration with municipalities.

**Misalignment of Health, Social and other Services**

4. **What has been successful in the current system to foster collaboration among public health, the health sector and social services?**
There are many examples of successful (or at least promising) collaborations between public health and the health and social services sectors. They include web-based prenatal programs operated in collaboration with hospitals; hospitals referring high-risk postnatal patients to public health – e.g. Healthy Babies, Healthy Children; parenting programs for those receiving Ontario Works and the Ontario Drug Benefit, referrals to and involvement in prenatal nutrition programs; involvement in City initiatives – e.g. Investing in Families, involvement in a number of initiatives directed towards people experiencing homelessness, including screening for tuberculosis, and providing immunizations (e.g. pneumococcal pneumonia, influenza). Public health is involved with infection control committees in hospitals, and liaises with hospitals on tuberculosis control. There are also successful collaborations to provide smoking cessation with both community organizations and primary care.

Collaboration can occur at the patient/client level – in which, for example, a public health nurse and a hospital nurse and/or a social worker may each have a client/professional relationship with the same person or family, and will work together to help that person get what they need. The collaboration may also be at the program level; in this case, the collaboration may be aimed at establishing a new program, or expanding or improving an existing one. It may involve public health and health care operating different parts of a system which has been developed in collaboration: examples include the immunization system, in which public health advises on schedules, procedures and availability of vaccines, distributes the vaccine and collects data on doses administered and adverse events; and smoking cessation either in hospital or in primary care, in which public health assists with education, information, and sometimes follow-up or other support. Public health also provides proactive and on-demand general information to primary care physicians as well as advice on individual cases. Hospitals and public health also collaborate to support long-term exclusive breastfeeding.

More broadly, health sector collaboration works best when all parties understand their mandate and can bring important perspectives to an issue. Opportunities to continue to provide clarity regarding roles and responsibilities among various partners will help to support this collaboration.

In addition, greater alignment between various provincial levels of government will facilitate increased alignment at the municipal level. For example, greater alignment between the Ministry of Health and the Ministry of Education on topics such as immunization, would enable greater alignment with the municipality.

5. How could a modernized public health system become more connected to the health care system or social services?

While we recognize the need to work well with health care and social services, we respectfully disagree with the assumption that the problem is best stated as, “there is insufficient collaboration amongst public health, the health sector, and social services, so we should establish more connections”. It is essential to define the issue clearly – perhaps by asking these questions: What are the reasons for closer collaboration? Is it to serve individual clients better? How many individual clients does public health serve? How many of them would benefit from assistance from these other organizations? How
well are these clients being served by multiple sources at present? What sources of failure, dissatisfaction or inefficiency can be identified? How can these be mitigated? We can all agree that collaboration is not an end in itself – it should accomplish something better than an alternate approach. One likely scenario is that clients are identified and properly served by the right organization; but the effort required to arrange this and to overcome bureaucratic obstacles is a source of considerable inefficiency. There would appear to be several possible obstacles to the efficient operation of the system: obstacles or uncertainties caused by rule differences; inefficient referral systems, delays caused by mismatched capacity to handle the client volume, and incompatible or inefficient information systems, and misaligned boundaries, together with barriers related to privacy and confidentiality concerns. All of these must be addressed, both at provincial and at local levels.

Opportunities to assist health care institutions in the development of policies for health promotion are not consistently taken up. Examples include the identification of admitted patients who are smokers, offering pharmacological intervention whilst in hospital (e.g. according to the Ottawa Model), and follow-up by primary care or public health; strong and enforced policies on supplemental feeding in newborns, including strict compliance with World Health Organization guidelines; healthy food choices (and not providing unhealthy choices) in hospital cafeterias.

The ability to better integrate the flow of information across sectors is important for the system to become better connected (e.g. immunization where public health has information and clinicians also have this information).

Lastly it should be noted that some health units with city or regionally-based governance are already closely connected to social services, being part of the same organization. Disrupting this relationship would constitute a change away from the intended direction.

6. What are some examples of effective collaborations among public health, health services and social services?

Examples are provided in the answer to question 4.

At this point it is worth stating the supreme importance of collaboration with organizations outside of the health and social services systems. These are important (in terms of their impact, through the determinants of health – housing, food, transit to education and work, etc.) upon health status and inequalities, and constitute, for many health unit staff, a significant proportion of their time. The most obvious sector is education – all health units are engaged in schools, helping to produce policies and environments which support health, working to provide safe routes for travel to and from school, supporting the implementation of school food and beverage policies, etc. There are a host of other relationships – with libraries, food banks, homeless shelters, city departments, professional and academic associations, professional associations, workplaces, many NGOs both large and small, individual councillors, professional groups such as transportation engineers, city planners, architects, developers, and many others.
Duplication of Effort

7. What functions of public health units should be local and why?

There are roles for both the provincial and the local levels in undertaking the functions of public health. For example, many of the health protection, health promotion, and public health service functions are delivered locally as they require direct interactions with individuals. In addition, many of the health protection and promotion functions are informed by local information in order to be responsive to local needs and therefore be effectively implemented.

Most of the interactions between public health professionals and both clients and intermediaries (schools, health care workers, businesses, municipalities, etc.) take place “in the field”. The local level should assess local needs, epidemiologically in more detail than is being done, or could be done, at the provincial level, and by adding information from case management, complaints, hard to reach populations, and program administrative data.

Locally is where relationships of trust with health care institutions and professionals and multiple community partners are developed, and where the opinions of stakeholders and the public are taken into account. Since the birth of public health in this country, it has been locally governed and has ensured that the public has participated in deliberations about services and about legislation which protect their health and may affect their autonomy. Without the confidence of its citizens, public health cannot undertake its work successfully.

Some potential clients of public health programs may have high levels of need and/or be hard to reach. A strong presence at the local level is necessary if their needs are to be met.

Nearly all innovation in public health interventions has taken place locally. There is a pattern of one or a few progressive health units innovating, and then adoption elsewhere, and then progression into provincial law. In this way, efforts at the local level can mobilize and advance programs and policies at the provincial level. Tobacco control is an example – this has been driven by the local level for more than forty years. Even after the provincial legislation, health units continued to innovate restrictions which were later incorporated into the legislation. Toronto was the first to require the pasteurization of milk. Other examples are restricting the access of minors to tanning beds and requiring the posting of calorie counts on menus and menu boards of chain restaurants. Many program innovations also started at the local level. Recent work in the built environment and health was driven by health departments in cities across Canada. Without local initiative, progress in public health will stall.

Many important interventions could not function without leveraging the resources of other organizations, particularly the voluntary sector. This can only take place at the local level. Local partnerships facilitate the development of community capacity and resilience, and tend to be more relevant to the needs (including language and culture) of the local community.
Responding to small outbreaks, and inspecting food premises and responding to health hazards are two more examples of services which are facilitated by local knowledge and the ability to respond quickly. Planning for services—from the location of clinics to modifications to render services more culturally appropriate—requires local epidemiological data and local knowledge.

Targets and priorities for population health are appropriate at provincial levels to mobilize the broader public health sector to work towards a common goal. These goals can then be translated to the local context.

8. **What population health assessments, data and analytics are helpful to drive local improvements?**

There are a number of assessments, data, and analytics that are helpful to drive local improvements.

Population Health Status Assessments (PHSA) are an important source of local information, although they can be misunderstood: they should not be just a list of “indicators”. The role of the PHSA is to answer questions about the burden of disease, disease patterns over time, the relationships of determinants of health, risk factors and outcomes, the distribution of health and disease by various patterns of disadvantage, comparisons by person, place and time, what will happen without intervention, how much of a disease is accounted for by various risk factors and what would be the outcome if these were reduced to predetermined levels and so on - it is a detective story.

Similarly, a surveillance system does not exist in order to produce reports after the fact – its role is to spot problems as they develop, and to provide clues about the characteristics of these affected and likely sources of the problem. Because surveillance for communicable diseases such as the current novel coronavirus outbreak but also for diseases such as Tuberculosis or Lyme disease actually uses data directly entered at the health unit, and data aggregated across health units is important, both timeliness and standardization are vital. Coupled with the costs of technology, this points to provincial leadership.

Apart from the usual (Census, CCHS, mortality data, BORN, CIHI) data, each local health department must collect data, either through less well-known and/or non-health systems or directly by survey or from program data. These will provide information on determinants, risk factors, distribution of risk, use of /access to/satisfaction with services, opinions and others. These refer to local circumstances and are essential for local strategic and service planning.

The critical questions concern the distribution of these tasks amongst local and provincial players. The main provincial player in this respect is PHO. The following points should be considered:

i. For the reasons given above, local data and local epidemiological analysis are essential. Epidemiological staffing at a local level coordinated with provincial support is also essential.
ii. Some more support from PHO would be useful. For example, the ONBOIDS analysis of burden of communicable diseases has proven useful, and was too large and labour-intensive to be done locally, PHO would continue to produce specialized reports. Access to multiple sources of data is already available to health units through IntelliHEALTH. PHO could collaborate with APHEO to further develop and maintain the core indicators. Very large or difficult analysis might occasionally be required, and it might be more efficient for PHO to undertake this and produce reports for both the province and each health unit. PHO also has a role in disseminating changes in data systems (e.g. scheduling of surveys, changes in definitions, new surveys, new releases), perhaps through a regular online newsletter and in providing education at basic and advanced levels through workshops and webinars. PHO might also have a role in producing updated versions of tools such as ONMARG. Those health units which have not previously been active in producing PHSA reports might benefit from guidance documents.

iii. PHO lacks the capacity at present to undertake the kind of work performed by epidemiologists in health units. This capacity needs to be reviewed to ensure an adequate balance locally and provincially.

iv. Local work may be constrained by relatively small sample sizes in sample surveys such as CCHS. The MOH has occasionally purchased additional samples in the past – this should become a regular practice. There is also a role for the MOH in purchasing additional questions in CCHS.

v. There may be a need to purchase data sets not available through IntelliHEALTH, and PHO should coordinate this and/or share data.

vi. In future there will be issues which require urgent information. MOH should have the budget capacity to fund surveys within a short timeframe. The design should involve PHO, health units, and other relevant experts. With provincial investment in data collection across the population, it will reduce potential duplication across units and address the fact that some analyses are challenging at the local level and need to occur for larger populations.

9. What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority-setting for public health in the province?

Knowledge Exchange

One of the current challenges in the public health sector is ensuring mechanisms to share and exchange knowledge that has already been produced. This is important given that achieving evidence-informed decision making is a highly skilled and sophisticated process that relies on high quality and comprehensive evidence. One way to facilitate this knowledge exchange is through a central repository of high-quality evidence reviews produced by PHO and health units, as well as access to other sources of reviews, such as the National Collaborating Centres. There will also need to be a requirement for a health librarian service available to current and each newly-configured health unit, and for a substantial program in training staff in producing and using reviews. There must be criteria for quality of reviews being considered for the central database. It is also critical to understand that most reviews are undertaken elsewhere and are in the published literature, so the ability to search the literature and
access reviews is essential. Skills development could be the responsibility of PHO, or the National Collaborating Centre for Methods and Tools at McMaster University could also be of assistance.

**Research Capacity**

In the field of public health, research in the sense of disciplined investigation of health phenomena producing generalizable evidence is usually undertaken by universities and research institutes. Scientists at PHO produce some research of this type, but it has not been regarded as a suitable use of health unit funds. Nevertheless, some health units have teamed up with academics to obtain funds from funding agencies such as Canadian Institutes for Health Research (CHIR) to participate in this work. This research is usually highly applied, and the health unit may be designated as the “knowledge user”. The benefits of this to public health are obvious, and funders are now favouring this type of work. This approach works and should continue. A possible enhancement would be for Ontario’s Health System Research Fund to solicit more applications for research related to public health, and to set aside part of its funds for this purpose.

PHO should continue to cooperate with groups of health units to undertake applied research, and indeed should expand the input of health units into the planning of its research program.

“Research” is sometimes used to encompass other activities which involve the use of data but are concerned with specific information rather than generalizable knowledge. This includes needs assessment and evaluation. These must be performed locally, for reasons similar to those given above for PHSA, but again, there are supporting roles for PHO. Evaluation needs to be undertaken more frequently and its quality maintained at a high level. There should be an initiative, led by PHO, to improve performance. Spending the taxpayers’ money on programs of minimal effectiveness is to be avoided.

10. What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

At present MOH has a stewardship role, and is also responsible for F/P/T liaison, vaccine procurement and the vaccine program, for certain statutory duties, communications, advising the Minister, etc., PHO provides scientific advice and support to the Ministry, health units and the public, operates the Public Health Laboratory, and has a mandate for workforce development.

At present, MOH’s model for accountability is too detailed and onerous. Ontario is the only jurisdiction which takes this approach – others have abandoned it because of the work involved and the rigidity of the standards do not result in better accountability. MOH should consider the approach used in Quebec, which is discussed later. A set of standardized outcome measures for comparison rather than accountability would benefit local public health units.
Generally, PHO works well, but it is heavily tilted towards communicable disease issues and has to respond too often to short-term crises. Its capacity is quite modest in environmental health, and in chronic disease and injury prevention/health promotion. It bears repeating that the main function of PHO is to support public health activity in health units by providing expert advice and guidance, providing laboratory services, and building skills. It also provides technical advice to MOH. Neither MOH nor PHO are well-positioned to provide services directly to clients/communities. Although it is possible to contemplate shifting some supportive functions from health units to PHO, this is limited, as we have already seen how health units must retain basic means to undertake all six public health functions. In addition, PHO cannot undertake more work without additional resources. As surveillance systems develop, PHO’s role in surveillance may develop further, and it may be able to provide real-time surveillance products to health units. Possible PHO roles in a vaccine registry and in evidence-informed decision making are discussed later.

At present, PHO, the MOH and local public health units have a lot of data - PHO could support the sector through artificial intelligence and machine learning. Public health units would also benefit from methodology work (e.g. behaviour insights, use of big data) that requires expertise that may not be available at each public health unit.

A centralized resource for research ethics would be useful, and might be provided by PHO.

MOH might develop its communications functions so as to provide materials (text, visuals, infographics, etc.) to health units for their own use in support of shared priorities. This may also include social media strategies supporting healthy choice messaging.

Access to a centralized resource for IT development and oversight would support public health units who may face similar challenges in IT infrastructure development and implementation.

11. Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

Perhaps the greatest need is to further develop the Digital Health Immunization Repository (aka Panorama), especially to improve ease of use, and also to develop a true comprehensive immunization registry for all ages, with input from physicians. Additionally, the Ministry of Health should integrate consumer apps, e.g. CANImmunize into the Digital Health Immunization Repository Building. IT solutions should allow for near real-time data collection (client and public health unit) and analysis to enable faster response, as well as mobile health strategies.

Public health units are currently developing and implementing IT solutions for virtual care, e.g. e-referral, e-chat, virtual client services. These could be developed at the provincial level to support both local public health and the broader health system.
Real-time, near real-time, and frequently updated surveillance data, together with interpretive screens for communicable disease surveillance would be useful.

There are some services that could be delivered more effectively through greater use and integration of technology. For example, if the province were the custodian for health information related to immunization.

Finally, the MOH could work to support greening public health services such as including digital consent and shared platforms with partners (e.g. schools).

12. **What processes and structures are currently in place that promote shared priority setting across public health units?**

The premise of this section requires a careful examination. We respectfully ask that consideration be given to questions such as why priorities need to be consistent given that health needs vary across the province? Is shared priority setting the same issue as consistent priority setting? What should determine priorities?

Given that different areas of Ontario have different levels of health status, as well as both equity issues and special populations, if priorities are the same everywhere, we are concerned that there will be wasted effort, or a failure to address some health-related needs. For example, tuberculosis is a very serious health problem for those affected, with the added hazard of having the potential for spreading to perhaps hundreds of others. More than 90% of cases in Ontario are in the Greater Toronto/Hamilton Area, Ottawa, or among Indigenous people. These cases cannot be ignored where they do occur, yet this is not a priority for most of the province. Similarly, the North has an excess rate of mortality, especially among males, which is currently not explained by known risk factors or determinants; the 905 area has many immigrants from South Asia with an increased risk of developing diabetes and cardiovascular disease; many immigrant children have poor dental health; some communities have higher than average rates of smoking, and so on: these should all be local priorities where they occur, but may not be provincial priorities. Of course, it is helpful for health units to know about the priorities of neighbouring health units. Some of this information is already exchanged through a variety of regional and provincial meetings.

The Province will have certain priorities it wishes to have addressed - these can be part of a Provincial Public Health Plan. At present there is no inconsistency between provincial and local priorities because there is no clear and up-to-date statement of provincial priorities. The OPHS by its design implies that every standard is a priority.

Some health departments undertake proper PHSAs, engage staff and stakeholders, and produce multi-year strategic plans which identify priority needs and how to address them, including the necessary infrastructure development. Others do not accomplish this, in spite of the requirements of the Foundational Standards. From this perspective, there is inconsistency – but it is inconsistency in the standard of the process of priority setting.

13. **What should the role of Public Health Ontario be in informing and coordinating provincial priorities?**
14. What models of leadership and governance can promote consistent priority setting?

These two questions must be considered together – they involve a consideration of priorities and governance together: the question is whether there is a difference between the objective assessment of health and the setting of priorities; and whether there is a need for both provincial and local perspectives in the setting of priorities. The answer in both cases is yes, and fortunately there is a model which can accommodate all of these requirements.

The setting of priorities is a decision about putting certain needs before others, and about spending public funds. Although this should be based upon objective evidence, there are other factors such as public concern which should be taken into consideration. These are decisions which must be taken by representatives of the public, either elected or operating under delegated powers. Public Health Ontario should provide objective evidence of need, and of the likely effectiveness of interventions, but the final decision rests with the government. Likewise, at the local level, the medical officer of health will present objective information and recommendations, and the governing body will make the decision.

How are these provincial and local priorities to be linked? The system used in Quebec is well worth considering. In that province, the Ministry confers with the regions and with the Institute National de Santé Publique (INSPQ – similar to PHO) and establishes a 10-year plan for public health in Quebec (called the National Plan—this would be termed a Provincial Plan in Ontario) — This contains a limited number of goals which all regions are expected to adopt. There is also consultation concerning a limited number of outcome indicators. The plan is usually updated at the midway point. The regions each produce their own Regional Public Health Plan in response to the priorities set in the overall plan outlining local implementation of the priorities. The overall plan is usually of five years’ duration and is updated every two to three years. The Regional Plans must follow the pattern of the overall National Plan, but with more detail about implementation, and with some variation permitted if negotiated with the Ministry, after the provision of justification. These plans are approved by the Minister.

In Ontario, the local plans would be approved by the local governing body and then by the Minister. This system is feasible, has distinct roles for provincial and local levels, whilst allowing for flexibility and variation justified by local needs. It also allows for an appropriately longer-term perspective; in addition, it relieves the system from the heavy load of paperwork associated with the current OPHS system.

A new system of governance would allow for a consistent form of governance across the Province. In the past, boards of health have, by law, had a majority of municipal members (with different systems for Toronto, Ottawa and regional governments); this may have been justified by the municipal contribution, but it is worth reviewing. The new areas served will, in most cases, be much larger, rendering the representation of each lower tier municipality challenging. The direct relationship between public health staff and councils and their committees, as well as staff of other departments, has been a strong factor in the development of healthy public policy. Any new system of governance should preserve this as much as possible. Across Ontario, this might be
facilitated by maintaining the requirement for a majority of municipally-appointed members. For Toronto, the boundaries of which will remain unchanged, a continuation of the Board of Health should be considered.

Ensuring very large governing bodies are functional is very challenging. Local representation is important as part of this governance to reflect the local context and perspective. Employees should not be eligible for appointment. The current provision granting the MOH the ability to be present for meetings is a supportive feature.

The model of leadership which establishes the Medical Officer of Health as the CEO, reporting to the governing body has been successful and needs to be continued. It will be necessary to ensure that the newly appointed Medical Officers of Health have all of the necessary skills.

Also to be considered is updating the Health Protection and Promotion Act to reflect the majority of stable funding to come from the Province.

15. What has been successful in the current system to foster collaboration among public health and indigenous communities and organizations?

Responses to this issue have been developed locally, Toronto Public Health has successfully fostered collaboration with Indigenous communities and organizations through the following key initiatives:

i. Toronto Indigenous Health Strategy (TIHS)
   Since 2016, this has been successful in fostering collaboration between public health, primary care and the Indigenous community in Toronto. Toronto Public Health, the Toronto Central LHIN and Anisnawbe Health Toronto partnered to help establish the Toronto Indigenous Health Advisory Circle (TIHAC). TIHS embraces a community-led process to envision a thriving and healthy Indigenous community in Toronto by leading transformation in health programs and services. Each step in the development of TIHAC and TIHS was community-driven and culturally informed.

ii. Toronto Indigenous Overdose Strategy (TIOS)
   Toronto Public Health collaborated with Indigenous community partners to develop TIOS in 2019. Development of TIOS was led by an Indigenous facilitator in collaboration with an advisory committee comprised of Indigenous service providers and community members, as well as TPH staff. The TIOS is deeply rooted in the perspectives and advice received from a diverse range of Indigenous people who use/have used substances and who were the main group consulted for this strategy. It is grounded in Indigenous world views that seek to reconnect Indigenous people to their culture and traditions as part of improving health and well-being. TPH is committed to implementing TIOS recommendations directed to the health unit, and is pursuing diverse opportunities to work with Indigenous communities in Toronto to implement the other recommended actions in the strategy.
iii. Toronto Urban Health Fund – Indigenous Funding Stream
TPH’s Toronto Urban Health Fund (TUHF) provides funding for community-based non-profit organizations to build individual and community capacity that support HIV prevention, harm reduction, as well as child and youth resiliency. Based on community consultations, it was recommended that TUHF develop a new funding framework devised by and for Indigenous populations.

In fall 2017, TUHF co-developed a funding model with Indigenous community partners and in alignment with the principles outlined in the Toronto Indigenous Health Strategy. With the support of an Indigenous consultant, a TUHF Indigenous Advisory Circle (IAC) was established to promote Indigenous self-determination.

One SDOH PHN is currently dedicated to prioritizing Indigenous students, families and communities within a healthy schools approach by building relationships between TPH, school boards and Indigenous community partners in Toronto. The other SDOH PHN has helped establish partnerships between Indigenous organizations and TPH's chronic disease and injury prevention programs.

16. Are there opportunities to strengthen Indigenous representation and decision-making within the public health sector?

Indigenous governance models for public health should be developed, implemented and evaluated through Indigenous-led processes. To ensure success, the governance development process and resulting model would need sufficient and secure long-term funding. The Ministry could partner with Indigenous advisors to develop a province-wide ICS public health transformation strategy.

TPH staff have recommended that the Ministry work with Indigenous leaders to devise a knowledge transfer and exchange plan. This plan could outline a process for collecting, disseminating and adapting successful locally developed strategies that have strengthened Indigenous representation and decision-making within the public health sector.

17. What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?

The Ontario French Language Health Services Translation program has been essential for delivering written public health information to Francophone communities. The Ministry’s provision of this free service ensures that public health units do not face budgetary restrictions in meeting the needs of French-speaking Ontario residents. The Service’s expertise in translating health information instills confidence regarding translation quality.

In addition to French-designated public health positions mandated by the Province, TPH has created other French-language positions to meet the needs of Francophone communities. Designated positions support TPH in delivering programs in French and also assist in fostering partnerships with community organizations and school boards.
18. What improvement could be made to public health service delivery in French to Francophone communities?

The Ministry could provide funding for health units to hire additional French-speaking public health nurses. In order to increase the availability of French-speaking public health professionals, the Ministry might promote public health as a career path in Francophone communities.

Learning from Past Reports

19. What improvements to the structure and organization of public health should be considered to address these challenges?
20. What about the current public health system should be retained as the sector is modernized?
21. What else should be considered as the public health sector is modernized?

There were, in Ontario and nationally, several reports about public health both before and after the SARS crisis. There was a remarkable uniformity in the findings and recommendations. These latter included strengthening the capacity and competency of the workforce, developing better, and more interoperable information systems, and supporting evidence-informed decision making – all which imply increased expenditures. Ontario has implemented a number of reforms since SARS, including the creation of PHO, strengthened legislation, and the implementation of the Panorama information system for reportable diseases and childhood immunizations.

Some issues presented by these reports still require attention, however. These include stable and adequate funding adequate numbers of skilled staff in each health unit, a solid scientific basis for all activities, a clear, consistent and widely disseminated strategic planned approach and an effective yet simple system of accountability.

Structure is important – the current situation results in a number of health units which are challenged to function at the expected level of competence. However, where existing units are very large, they should be left as is and not be further amalgamated into extremely large units. The City of Toronto should continue to operate as a health unit with the same boundaries.

Structure, however, is not the most important factor in the success of public health. More important is that public health should:

i. Have a clear mandate and goals, expressed in terms of health status, health inequities, and preventing and managing outbreaks and emergencies. These should guide strategy, programs and services.

ii. Link to and cooperate with health care services, in particular primary care, to the extent necessary for the pursuit of its own goals. This will be most relevant to the prevention and management of communicable diseases.

iii. Seek to prevent chronic diseases and injuries with an emphasis on population-level interventions intended to change the environment in which choices are made, including the use of policy.
iv. To the extent possible, use approaches which have been shown by scientific evidence to be effective, and to evaluate the effectiveness of local implementation.

v. Engage the public and stakeholders, and be accountable to government, the local governing body, and the public.

vi. Work as a system comprised of local and provincial levels, with appropriate roles for each and where the whole system and the players in it recognize they are ultimately part of a system accountable to the public for their health.

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