



Report: PHE-19-07

Region of Waterloo

Public Health and Emergency Services

To: Chair Elizabeth Clarke and Members of the Community Services Committee

Date: August 13, 2019

File Code: A16-40

**Subject: Region of Waterloo's Response to Provincial Public Health
Restructuring and Funding Changes**

Recommendation:

That the Regional Municipality of Waterloo take the following actions in response to the Province's Plans for Public Health Restructuring and Funding Changes:

- a) Advise the Premier and Minister of Health that the Region of Waterloo supports the current fully-integrated approach to Public Health delivery in Waterloo Region;
- b) Request the Premier and Minister of Health that, if the Province proceeds with the implementation of one common structure and governance model within the Public Health Sector, the proposed entity including Wellington-Dufferin-Guelph, the Region of Peel, Halton Region and the Region of Waterloo, be reconsidered with a goal of reducing both the total population size and geographical scope of the current proposed entity;
- c) Request the Premier and Minister of Health that, if the Province proceeds with the implementation of autonomous boards of health for all Regional Public Health Entities, that municipal representation (either through elected representatives and/or representatives selected by the municipalities), should make up a majority proportion of the boards.
- d) Request the Premier and Minister of Health that any transition impacting the structure, governance and funding of the Public Health Sector, be carried out within appropriate transition periods, with attention to both effective change management and ensuring the important work of public health continues

- uninterrupted;
- e) Request the Premier and Minister of Health reconsider the planned changes to the provincial-municipal cost-sharing formula for Public Health programs and services, to maintain the current 75%-25% funding ratio.
 - f) Endorse Report PHE-19-07 as the Region of Waterloo's response to information known as of August 9, 2019 regarding planned provincial changes impacting Public Health structure and changes across the province (the Region may choose to comment further if or when the Province undertakes consultations later this summer regarding their planned changes); and
 - g) Forward a copy of this report to the Premier of Ontario, the Minister of Health, all local MPPS, the Association of Municipalities of Ontario (AMO), the Association of Local Public Health Agencies (ALPHA), and the other 35 Boards of Health in Ontario.

Summary:

In April 2019 as part of the provincial budget, the government made announcements that will significantly change both the funding and structure of Ontario's public health sector. If implemented as planned, the changes will be as follows:

- there will be 10 new Regional Public Health Entities governed by autonomous boards of health effective April 1st, 2020 (as opposed to the current 35 Health Units operating under various forms of governance)
- provincial funding within the sector will be reduced by \$200 million annually by April 1st, 2021 and the cost-sharing arrangements will be adjusted, with municipalities expected to pay a greater portion

Region of Waterloo is in a proposed public health entity that includes the current Health Units of Wellington-Dufferin-Guelph and the Regions of Peel and Halton; population wise, it would be the largest public health entity in the province. The total annualized loss of provincial funding related to public health programs in Waterloo Region is estimated to be \$5.4 million; the full financial impact to Waterloo Region resulting from the transition to a regional public health entity is not known at this time.

The province has committed to consultation processes with stakeholders including the Association of Municipalities of Ontario, the City of Toronto and the Public Health field; the focus of the consultations is expected to include geographic boundaries, governance and leadership of the new Public Health Entities.

The province's planned changes to both the structure and funding of the Public Health system, will have broad implications provincially and locally. The report includes observations and feedback that are presented in the interest of maintaining a strong system throughout Ontario and building on the strengths and success of the Public Health service delivery locally in Waterloo Region; they are summarized as follows:

- changes to the Public Health Sector should maintain and preserve the mandate of Public Health, and be evidence based;
- current structure, organization, governance and accountability for public health programs in Waterloo Region is working effectively; any structure changes should be better or at least equivalent to what currently exists locally, in order to justify the disruption and risk to effective public health service delivery;
- the proposed public health entity that includes the current health units of Wellington-Dufferin-Guelph and the Regions of Halton, Peel and Waterloo is too large; consideration should be given to modifying the size of this proposed grouping;
- the proposed changes will have significant impacts on funding and accountability for municipalities and have the potential to create barriers and weaken collaborations with other municipal functions and local partnerships;
- the province's proposed timeline for implementation of the changes is extremely ambitious; the government should consider a phased approach with a longer transition period if their vision of a strong, effective, nimble and locally connected public health system in Ontario is to be achieved.

Report:**Provincial Restructuring and Funding Changes of Ontario's Public Health Sector**

In April 2019 as part of the provincial budget, the government made announcements that will significantly change both the funding and structure of Ontario's public health sector. Details released following the budget confirmed that:

- Ontario's current 35 public health units will be consolidated into 10 new Regional Public Health entities, with one common governance model i.e. autonomous boards of health.
- Total provincial funding for public health will be reduced by \$200 million by the provincial fiscal year 2021-22.
- Beginning April 1st, 2019 cost-sharing arrangements with municipalities were to be adjusted; municipalities in more populous regional public health entities were expected to pay a greater portion and programs that were previously funded 100% by the province were to shift to cost shared.
- On May 27th, Premier Ford announced a pause to cost sharing changes that would have taken effect retroactively to April 1st this year. To date, there has been no formal correspondence confirming 2019 funding levels for Public Health Units, although we are assuming that the eventual provincial public health funding reductions to provincial funding levels will not occur in calendar year 2019.

- According to original announcements following the budget, transition of governance to the 10 new Boards is planned to occur April 1, 2020.

Funding Implications for Region of Waterloo Public Health

The financial impacts of the change in cost sharing arrangements vary depending on the population size of each new regional entity. As a result of Region of Waterloo's proposed inclusion in a grouping that has more than one million in population, the scheduled changes from the current 75% and 100% provincial funding envelopes were as follows:

- 2019-20 (April 1st – March 31st) – 70% provincial: 30% municipal
- 2020-21 (April 1st – March 31st) – 70% provincial: 30% municipal
- 2021-22 (April 1st – March 31st) – 60% provincial: 40% municipal

As indicated previously, the planned cost sharing change that was to take effect on April 1st, 2019 was deferred by the province; it is not known at this time when the change to 70% provincial/30 % municipal will take effect.

Depending on each health unit's historical base budget increases relative to the availability of additional provincial funding, significant variability exists in actual cost sharing ratios among health units, up to and including 2018. Depending on whether local health units maintained the 75% - 25% ratio for cost shared programs (or alternatively if the local municipal share exceeded 25%), the recently announced changes will have more, or less, impact. For example, health units where the municipal share was already more than 30% on cost shared budgets would have virtually no impact to their funding until the final change to 60%/40% cost sharing. Similarly, Health Units where the municipal share already exceeds 40% would experience no impact of the funding changes that were planned to be completed for cost shared programs by April 1st 2021. Historically, the municipal levy share for Region of Waterloo Public Health has been very close to 25%. In 2018, the municipal portion of cost shared mandatory programs was 25.3% municipal and 74.7% on cost shared programs. For programs that have been traditionally funded 100% by the province, all Health Units will begin paying the new cost sharing arrangements i.e. 30% initially and 40% once fully implemented.

Ministry funding letters for 2019 have not been received at this time. The 2019 Regional Base Budget for Public Health was prepared with the assumption that provincial funding would be maintained at 2018 levels (no increase or decrease). Based on the change in the cost sharing ratio that was to take effect on April 1st, 2019 (and which has since been deferred) and preliminary information shared by ministry staff, it is anticipated that the impact of the first change (to 70%/ 30%) is a loss of annual provincial funding of \$2.3 million. As seen in Table 1 below, when the final revised cost shared ratio is in

place by April 1st, 2021, the total projected loss of annualized provincial funding related to public health programs in Waterloo Region is \$5.4 Million. This equates to a reduction in approved provincial funding of 22.5% compared to 2018 levels.

Table 1: Loss in Provincial Annual Funding Related to Change in Cost Share Ratio

	Cost Sharing Ratio (Provincial/Municipal)	Loss In Provincial Funding (Million \$'s)
	75%/25% and 100%	-
1 st change in cost sharing ratio	70%/30%	2.3
2 nd change in cost sharing ratio	60%/40%	3.1
Annualized Funding Reduction following full implementation (currently planned for April 1 st , 2021)		5.4

Availability of One-Time Funding

When the original cost sharing changes were planned for implementation on April 1st, 2019, Ministry staff indicated that one-time transition funding would be made available to health units for the period April 1st, 2019 to March 31st, 2020; the funds were intended to enable health units to maintain public health services and mitigate some of the impact of the reduced provincial funding on municipalities in 2019/20. Although written 2019 funding approvals have not been received at this time, it is now assumed that one-time money will no longer be made available since the province has deferred cost sharing changes until after this calendar year.

Provincial Expectation of Reductions in Addition to Cost Sharing Changes

The April 2019 provincial budget indicated total provincial funding for public health would be reduced by \$200 million by the provincial fiscal year 2021-22. Ministry staff has clarified that the \$200 million reduction will be achieved by a change in the cost sharing ratio (with municipalities picking up an increased share), as well as a reduction in the overall public health unit budgets in the province. The latter is expected to be achieved by the consolidation of executive leadership, back-office services and general administrative savings resulting from efficiencies gained by regionalization to 10 new public health entities currently planned to take effect April 1st, 2020.

Proposed Boundaries for Public Health Units

In early May, Ministry of Health staff provided individual health units with preliminary information regarding the proposed boundaries for the regional public health entities within which each current health unit would be placed.

Based on discussions with ministry staff, it is our understanding that the proposed

boundaries were based on a few considerations including: size, geography, similarity, trying to keep existing units together wherever possible, etc., but also how to better align with the rest of the health system to enable a greater population/people centered focus, knowing the challenges that came with the differing LHIN boundaries. The new Ontario Health Agency is considering how it will organize itself across the province and that was also a key consideration.

Region of Waterloo is in a proposed grouping that includes the existing health units of Wellington-Dufferin-Guelph, and the Regions of Peel and Halton. It is noteworthy that this proposed entity, with a population of approximately 2.9 million would be the largest Public Health Entity in the province, exceeding the proposed entity of the City of Toronto.

Attachment #1 is a map (unofficial) which illustrates the boundaries of the 10 regional public health entities as they are currently proposed by the province; Attachment #2 shows the estimated populations (2017) and the geographic area (km²) of the proposed regional entities.

Consultation Processes

The ministry has committed to consultation processes with a variety of stakeholders, including the Association of Municipalities of Ontario (AMO), the City of Toronto and the Public Health field. The consultations are expected to focus on geographic boundaries, governance, and leadership models, and are intended to inform the proposed legislation. The new legislation is expected to be tabled in the fall when the provincial legislature resumes sitting following the federal election on October 21st; the legislative process will include another consultation phase in addition to any consultations that are completed prior to the tabling of the legislation.

Impact and Implications of Changes for Region of Waterloo

In the new model, Public Health programs and services within Waterloo Region would be delivered by a regional public health entity covering the geographic boundaries of the 4 current Health Units including Wellington-Dufferin-Guelph, Region of Peel, Halton Region, and Region of Waterloo. As one of 10 autonomous regional boards of health, the new Public Health Entity would be governed by a single autonomous board. Currently, there are no details available regarding the composition of the board.

Currently, Region of Waterloo Public Health is 1 of 10 Public Health Units that operate under the administration of a regional or other municipal government structure. It operates in a fully integrated manner with other regional departments in areas such as social services, child care, housing, water supply, transportation, planning and community safety. Public Health occupies space at 99 Regina Street, Waterloo and at 150 Main in Cambridge and benefits significantly from shared corporate services

including Finance, Facilities Management, Information Technology, Human Resources and Citizen Services, Legal Services and Council and Administrative Services. Regional Council serves as the Board of Health.

The current integrated system in Waterloo Region has significant benefits from both a Public Health and Regional perspective; innovative approaches and effective collaborations in areas such as water protection and water quality, the Regional Official Plan, active transportation and by-law implementation (e.g. tobacco and pesticides) are examples where the municipally integrated model of public health governance has worked to the overall benefit of the community.

Under the current arrangement, the Public Health base budget includes a rent allocation for the space occupied at 99 Regina Street, Waterloo and 150 Main, Cambridge. In addition, there is an allocation for shareable administration costs related to corporate services such as finance, human resources, information technology, legal and the service first call centre; the current allocation of \$1,049,705 in shareable administration has not been adjusted since 2015. The true value of all services and benefits received by Public Health as a result of being fully integrated with the Region exceeds the current allocation for shareable administration.

If the planned provincial changes are implemented, Public Health would no longer be a part of the Region of Waterloo, and the integration and coordination with other Regional programs would be compromised. The significant value and in kind services received by Public Health from the Region would be lost and Regional Council's role as the Board of Health would cease.

The proposed cost sharing changes would result in the Region's share of the current Public Health budget increasing by \$5.4 million. The final budget for the new entity and the proportion that will be allocated to Waterloo Region is unknown at this time; a cost sharing methodology will have to be determined in order to allocate the budget of the new entity among the participating municipalities and this will undoubtedly create additional cost shifts (both positive and negative) among the municipal participants. As a result, the full financial impact to Waterloo Region resulting from the transition to a regional public health entity is not known.

Region of Waterloo's Response Regarding the Planned Changes to Structure and Funding of Public Health in Ontario

The Province's planned changes to both the structure and funding of the Public Health system, will have broad implications provincially and locally. The following observations and feedback are presented with the goal of maintaining a strong system throughout Ontario and building on the strengths and success of the Public Health service delivery locally in Waterloo Region.

1) Changes should be evidence informed and the mandate of Public Health

should be maintained and preserved.

All changes to the structure, governance and funding of the province's public health system should be evidence informed to ensure best possible population health outcomes. The mandate of public health should be maintained and preserved; a strong public health system will contribute to the government's goals of ending hallway medicine and ensuring a broader health system that is sustainable.

Public Health's core function is the prevention of disease, and the protection and promotion of health; its impact in affecting the social determinants of health is key and the capacity of the system to advance the goal of a healthy population regardless of age, sex, language, socioeconomic status or geography needs to be maintained.

A strong public health sector keeps people out of overcrowded hospitals. The goal of public health is to keep people healthy, long before they become patients in the health care system. Public health programs focus on reducing risks to all residents. This ultimately drives down health care costs and makes the health care system more sustainable.

In an April 29th, 2019 Memo (Attachment #3), Ontario's Chief Medical Officer of Health, Dr. David Williams indicated; "The government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsible to the province's evolving health needs and priorities.

While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities. Modernizing and streamlining the role of public health units across the province will better coordinate access to health promotion and disease prevention programs at the local level, ensuring that Ontario's families stay safe and healthy.

As you know well, public health is a uniquely placed sector that must evolve to better meet ever-changing community needs. To that end, the Ministry of Health and Long-Term Care (the "ministry") has been working to define what a more resilient, modernized public health sector will look like, and also how it can contribute to the patient experience and better align to the new Ontario Health Agency, local Ontario Health teams, and the health system at large. The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local. The Ministry of Health and Long-Term Care will work with

boards of health and public health units to manage any potential reductions in budgets, including encouraging public health units to look for administrative efficiencies rather than reductions to direct service delivery.”

Despite the reassurances of the province, there is no evidence to suggest that the proposed changes and planned restructuring will maintain/improve public health delivery or population health either locally or across the province. There are significant unanswered questions about potential implications and real risks for the disruption of public health service delivery.

- 2) Current structure, organization, governance and accountability is working effectively in Waterloo Region. A new structure would need to be better or at least equivalent to what is currently offered by the Regional model in order to justify the disruption and risk to effective public health service delivery in the Region of Waterloo. Reconsideration should be given by the Province regarding its plan for implementation of a one size fits all approach to governance and structure for Public Health Units in Ontario; priorities should be established and changes should be implemented in Health Units/areas of the province where there are identified concerns; where issues do not exist, changes to structure and governance should not be implemented.**

Public Health in Waterloo Region (similar to other Regional and Single Tier PHUs) currently performs its provincially mandated programs but is fully integrated into the regional structure where it is engaged and collaborates in areas including housing, social services, child care, water supply, transportation and planning. In addition, Public Health receives cost effective support from the Region’s corporate areas including human resources, legal, finance and information technology. Our public health unit has benefited significantly from local political engagement, ownership and oversight, most notably during situations such as the implementation of the tobacco by-law locally. Separating public health units such as Waterloo Region Public Health which are currently part of the Regional government structure may have unintended negative consequences related to governance, processes and collaboration, and present risks to the close working relationship between Public Health and other municipal services.

Current structure, organization, governance and accountability is working effectively in Waterloo Region. Removing Public Health from the current integrated municipal structure locally has the potential to weaken the role of public health in our community, decrease municipal support, and weaken the ability of public health to be partners in local municipal services, planning and programming.

- 3) Bringing together the 4 existing health units of Wellington-Dufferin-Guelph**

and the Regions of Halton, Peel and Waterloo into a single Public Health Entity creates a regional entity that is too large. It will create unnecessary complexities and challenges as a result of the total population, large geography and diversity of local community need and composition. Consideration should be given to modifying the number and configuration of the proposed entities, with particular attention to reducing the size of the proposed entity that currently includes Waterloo Region.

Currently, the province's proposed geographic boundaries for the new Public Health Entities would result in Waterloo Region being part of the largest entity in Ontario based on population, larger than the proposed entity of the City of Toronto. The proposed entity would serve a growing population of more than 2.9 million, with both urban and rural geographic areas, extending over a relatively large and diverse territory. Peel Region would represent over half of the population within the proposed entity, with the potential to create significant imbalance. The proposed entity brings together an existing autonomous Health Unit and 3 Regional Health Units; this creates additional complexities in transitioning to one organization.

If the Province is open to alternative numbers and configurations for the proposed entities, there would be merit in representatives of the Region of Waterloo meeting with provincial representatives to discuss a number of alternatives regarding the specific placement/treatment of Waterloo Region within a reconfigured model. Priority should be given to including Waterloo Region in an entity that is more similar in size to the other entities (excluding Toronto and Northern Ontario) which have an average population of approximately 1.2 million.

At a recent Region of Peel Council meeting, a recommendation was passed to request the Minister of Health to establish Peel Public Health as one of the regional public health entities in Ontario, given its geographic size and population. As the second largest existing Health Unit by population (by a considerable margin) and given that Peel's population is larger than more than 50% of the other proposed regional entities, there is merit in making Peel a separate entity, similar to the City of Toronto.

When finalizing the configuration of the regional Public Health Entities, consideration should also be given to the outcome of the separate process of Regional Review that is currently underway by the government. Public Health Entity boundaries that would be inconsistent with evolving municipal boundaries and relationships would introduce additional unnecessary barriers and complexities. As a result, it is recommended that the Province's final configuration of Public Health Entities should take into consideration and be consistent with revised municipal boundaries resulting from the Regional Review.

- 4) **The proposed provincial changes will have significant impacts on funding and accountability for municipalities. The change in governance model to provincially established autonomous boards has the potential to create barriers and weaken collaborations with other municipal functions and local partnerships.**

The attached Briefing Notes/Recommendations from MARCO (Mayors and Regional Chairs of Ontario Single Tier Cities and Regions) to the Premier of Ontario and the Minister of Health and Long Term Care on May 1st (Attachment #4) and June 7th, 2019 (Attachment #5), raise significant concerns regarding impacts of the restructuring and funding changes in Ontario's Public Health Sector.

The \$220 million reduction in provincial funding and changes to cost sharing of public health programs will require significant increases in municipal contributions to public health programs and services. With the change to 10 regional public health entities with autonomous boards that have the ability to establish budgets and levy costs on municipalities, municipalities will be picking up a greater proportion of the costs for services that they will have less control of or input into decision making for.

If the move to regional public health entities proceeds, board composition must give priority to municipal representation from the local municipalities served by the new public health organization. It is recommended that the number of municipal representatives on the newly formed Boards, represent a majority. Consistent with the Province's statement that "The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local."

- 5) **Transition of governance to the new Boards is expected to be effective as of April 1st, 2020. This is an extremely ambitious timeline given that consultations have not been completed and legislation will unlikely be introduced until the government returns to the legislature following the October 21st federal election.**

Given the complexities involved in reducing the number of Health Units in Ontario from 35 to 10, and the resulting complexities of disentangling from municipal structures, merging different organizational cultures and labour environments, it is imperative that a reasonable time line be established for the transition process. Full transition and establishing of the 10 new entities by April 1st, 2020 is unrealistic.

To achieve the transformation work well, while ensuring the important work of public health continues uninterrupted, careful consideration must be given to sufficient transition time, funding and resources to support the required transition work; flexibility may be necessary in order to respond to potential regional variations.

The government should consider a phased approach; a longer transition period (such as 2 to 3 years) is more realistic, given the many complexities involved in achieving a successful implementation of the province's vision of a strong, effective, nimble and locally connected public health system in Ontario.

Corporate Strategic Plan:

Region of Waterloo Public Health works in collaboration with other regional departments and our community partners to build healthy and supportive communities. The strategic plan focus areas of particular relevance and significance are:

- Healthy, Safe and Inclusive Communities and
- Responsive and Engaging Government Services.

Financial Implications:

The majority of the Public Health programs and services have been historically funded within the Department's existing base budgets for Public Health Mandatory Programs; the budgets are established by Regional Council (as the Board of Health) and are funded up to 75% by the province's Ministry of Health & Long Term Care with the remainder funded by the local tax levy. To a lesser extent, some programs are funded 100% by the province.

Once the government's plans are fully implemented, all programs will be funded 60% by the province and 40% by local municipalities within the new entity. At this time, it is not known on what basis the total budget would be allocated to the municipalities in the new entity; currently the majority of autonomous boards of health allocate costs to municipalities on the basis of population.

It is unclear at this time what the final impact of the provinces plans for restructuring and funding changes in the Public Health sector will be on the Regional Tax Levy; this will only be known once the transition is complete.

Other Department Consultations/Concurrence:

The Human Resources and Citizen Service Department and the Corporate Services Department will be involved in preparing for and implementation of the transition of Public Health to a new regional entity.

Attachments

Attachment #1: Map – Proposed Boundaries of 10 Regional Health Entities

Attachment #2: Estimated population (2017) and geographic area (km²) of municipalities by proposed Public Health Entity, Ontario

Attachment #3: April 29th, 2019 Memo, Ontario's Chief Medical Officer of Health, Dr. David Williams

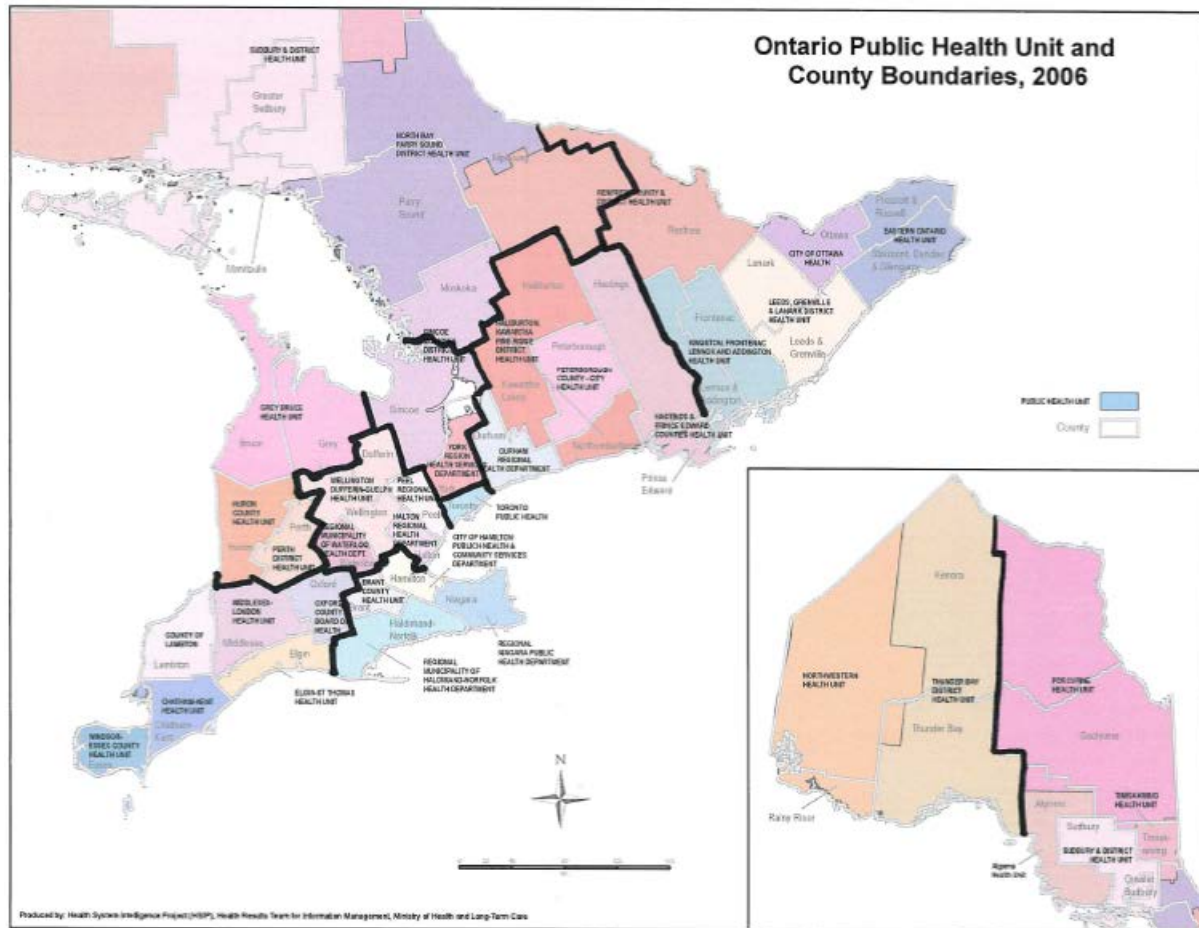
Attachment #4: MARCO Briefing Note – May 1st, 2019

Attachment #5: MARCO Briefing Note – June 7th, 2019

Prepared By: **Anne Schlorff**, Acting Commissioner
 Dr. Hsiu-Li Wang, Acting Medical Officer of Health

Approved By: **Mike Murray**, Chief Administrative Officer

Attachment #1: Proposed Boundaries & Health Unit Groupings (Unofficial)



Attachment #2: Estimated population (2017) and geographic area (km²) of municipalities by proposed Public Health Entity, Ontario

Region	Municipalities	Population (in 1,000's)	Area (km ²)	Region Total Population	Region Total Area
1	Essex Chatham-Kent Lambton Middlesex Elgin Oxford	412.3 105.9 130.4 484.5 92.4 114.3	1,850.9 2,470.5 3,002.3 3,317.3 1,881.0 2,039.6	1,339.8	14,561.6
2	Huron Perth Grey Bruce	59.3 79.0 97.2 69.4	3,399.3 2,218.5 4,513.5 4,090.2	304.9	14,221.5
3	Dufferin Wellington Halton Peel Waterloo	65.6 231.3 581.4 1,500.6 559.7	1,486.4 2,660.6 964.1 1,247.0 1,368.9	2,938.6	7,726.9
4	Niagara Haldimand-Norfolk Brant Hamilton	459.0 113.7 148.2 568.0	1,854.2 2,894.8 1,093.2 1,117.3	1,288.9	6,959.5
5	Toronto	2,929.9	630.2	2,929.9	630.2
6	Durham Haliburton Northumberland Kawartha Lakes Peterborough Hastings Prince Edward	682.4 18.5 87.9 77.7 143.8 140.5 25.5	2,523.8 4,076.1 1,905.2 3,084.4 3,848.2 6,103.9 1,050.5	1,176.3	22,592.0
7	Prescott & Russell Stormont, Dundas & Glengarry Ottawa Renfrew Lanark Leeds & Grenville Lennox & Addington Frontenac	90.4 115.2 994.8 105.4 69.3 101.8 44.0 161.9	2,004.5 3,309.9 2,790.3 7,448.6 3,035.6 3,382.9 2,839.7 3,787.8	1,682.8	28,599.2
8	Simcoe York	506.8 1,164.2	4,859.6 1,762.1	1,671.0	6,621.8
9	Kenora (East)* Cochrane Algoma Greater Sudbury Sudbury Timiskaming Manitoulin Parry Sound Nipissing Muskoka	7.1 79.9 116.0 165.0 19.8 32.5 13.4 43.3 87.7 64.0	122,180.6 141,268.5 48,814.9 3,239.0 40,204.8 13,303.3 3,107.2 9,326.5 17,103.8 3,940.5	628.7	402,489.0
10	Kenora (West)* Rainy River Thunder Bay	64.2 20.0 148.1	285,088.1 15,486.8 103,722.8	232.3	404,297.6

*Kenora East represents 30% of total population; Kenora West represents 70%.

Source: Statistics Canada (2017). Population Estimates by Census Division.

Attachment #3: Ontario's Chief Medical Officer of Health, Dr. David Williams


**Ministry of Health
and Long-Term Care**

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April 29, 2019

TO: Chairpersons, Boards of Health
Medical Officers of Health, Public Health Units
Chief Executive Officers, Public Health Units

RE: Public Health Modernization

As you are aware, the Ontario government released its Budget on April 11, 2019. The government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsible to the province's evolving health needs and priorities.

While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities. Modernizing and streamlining the role of public health units across the province will better coordinate access to health promotion and disease prevention programs at the local level, ensuring that Ontario's families stay safe and healthy.

As you know well, public health is a uniquely placed sector that must evolve to better meet ever-changing community needs. To that end, the Ministry of Health and Long-Term Care (the "ministry") has been working to define what a more resilient, modernized public health sector will look like, and also how it can contribute to the patient experience and better align to the new Ontario Health Agency, local Ontario Health teams, and the health system at large.

Notably, with respect to the public health sector, the ministry is proposing the following:

- Changing the cost-sharing arrangement with municipalities that would reflect an increased role for municipalities within a modernized public health system beginning 2019-20. The ministry will graduate the cost-sharing changes slowly over the next 3 years and will vary the final ratios by population size of the new Regional Public Health Entities. This is being done to recognize the variation across the province (i.e., geography, disbursement of populations, etc.). The cost-sharing changes, which will also apply to all 100% provincial programs funded by MOHLTC (except for the unorganized territories grant provided to northern public health units, and the new seniors dental program) are planned as follows:

-2-

- **2019-20 (April 1, 2019):** 60% (provincial) / 40% (municipal) for Toronto; and, 70% (provincial) / 30% (municipal) for all other public health units.
 - **2020-21 (April 1, 2020):** 60% (provincial) / 40% (municipal) for the Toronto Regional Public Health Entity; and, 70% (provincial) / 30% (municipal) for all other Regional Public Health Entities.
 - **End State 2021-22 (April 1, 2021):** 50% (provincial) / 50% (municipal) for the Toronto Regional Public Health Entity; 60% (provincial) / 40% (municipal) for 6 larger Regional Public Health Entities with populations over 1 million; and, 70% (provincial) / 30% (municipal) for 3 smaller Regional Public Health Entities with populations under 1 million.
- Creating 10 Regional Public Health Entities, governed by autonomous boards of health, with strong municipal and provincial representation. Realigning the public health sector at a regional level provides for enhanced system capacity, consistent service delivery and greater coordination to support health system planning. The role of municipalities are core aspects of public health that the ministry wants to preserve in this new model and will do so by maintaining a local public health presence in communities.
 - Modernizing Public Health Ontario to reflect changes in the health and public health landscape.
 - Introducing a comprehensive, publicly-funded dental care program for low-income seniors. The program aims to prevent chronic disease, reduce infections, and improve quality of life, while reducing burden on the health care system.

It is important to note that the \$200 million annual provincial savings target identified in the 2019 Ontario budget (by 2021-22) incorporates provincial savings related to the cost-sharing change, as well as savings from the proposed creation of 10 Regional Public Health Entities.

As mitigation, and to support boards of health experiencing challenges during transition, the Ministry of Health and Long-Term Care will consider providing one-time funding to help mitigate financial impacts on municipalities and consider exceptions or "waivers" for some aspects of the Ontario Public Health Standards on a board by board basis. Implementation of these exceptions will ensure that critical public health (health protection and health promotion) programs and services are maintained for the protection for the public's health.

The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local. The Ministry of Health and Long-Term Care will work with boards of health and public health units to manage any potential reductions in budgets, including encouraging public health units to look for administrative efficiencies rather than reductions to direct service delivery.

As a first step, we will be arranging calls with each of the Health Units over the next week to discuss the Annual Business Plan and Budget Submissions you have submitted, discuss the planned changes for this year and related mitigation opportunities, and ensure this next phase of planning supports your local needs and priorities.

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Further details on the 2019 Ontario Budget can be found on the government's website at:
<http://budget.ontario.ca/2019/contents.html>.

As previously noted, there is a significant role for public health to play within the larger health care system and it will continue to be a valued partner. I look forward to your input and collaboration as we work to modernize the public health sector.

Thank you for your ongoing support as the ministry continues to build a modern, sustainable and integrated health care system that meets the needs of Ontarians.

Sincerely,

Original signed by

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

c: Business Administrators, Public Health Units
Executive Director, Association of Municipalities of Ontario
City Manager, City of Toronto
Executive Director, Association of Local Public Health Agencies

Attachment #4: May 1st, 2019 Briefing Note/Recommendations from MARCO (Mayors and Regional Chairs of Ontario Single Tier Cities and Regions) to the Premier of Ontario

Briefing Note

Title:	Response to the Province's Proposed Restructuring of Public Health and Emergency Medical Services, and Public Health Funding Reductions
Submitted By:	Karen Redman, Chair, MARCO
Date:	May 1, 2019

Recommendation:

That MARCO takes the following actions in response to the Province's proposed restructuring of Public Health and Emergency Medical Services (EMS) and cost-sharing funding reductions for Public Health:

- a) Advise the Premier of Ontario and the Minister of Health and Long-Term Care (MOHLTC) that MARCO supports the current fully-integrated approach to Public Health delivery in most MARCO municipalities;
- b) Advise the Premier of Ontario and the Minister of MOHLTC that MARCO does NOT support the proposed restructuring of Public Health and Emergency Medical Services, and urge the Province of Ontario to re-consider these proposed changes;
- c) Endorse the position of the Association of Local Public Health Agencies (aLPHA) which also opposes the proposed restructuring of Public Health; and
- d) Advise the Premier of Ontario and the Minister of MOHLTC that any Provincial funding reductions to public health will have a significant negative impact on the health, safety and general well-being of the residents of Ontario. MARCO urges the Province to re-consider these proposed funding reductions;
- e) Urge the Province to consult fully with affected municipalities, and organizations such as MARCO, AMO, aLPHA and the Association of Paramedic Chiefs before proceeding with any changes to the structure and funding of Public Health and Emergency Medical Services.

Background:

On April 11, 2019, Finance Minister Vic Fedeli delivered the 2019/20 Ontario Budget. Of significant relevance and impact to municipalities was the unexpected announcement that the Province of Ontario is planning to reduce the total number of Public Health boards from 35 to 10 new regional boards with one common governance model by 2020/21.

Subsequent to the 2019 Provincial Budget announcements, the Association of Municipalities of Ontario (AMO) was informed on April 15, 2019 that the Province of Ontario intends to reduce the number of paramedic services in Ontario from the current 59 to 10; no further details were provided.

On April 18, 2019, Ontario Boards of Health received a communication from the Minister of MOHLTC advising that there would be adjustments to the provincial-municipal cost-sharing formula for Public Health programs. This has the effect of reducing Provincial funding for Public Health and increasing the expectation for municipal funding.

Public Health Units serving most of the MARCO municipalities operate under the administration of a Regional or other municipal government structure. These municipalities have been, and continue to be well-served by the current integrated approach to public health delivery in these communities. There is no evidence to suggest that the proposed restructuring would improve public health delivery or population health in our communities. There are significant unanswered questions about the implications of the proposals and there are real risks for the disruption of public health service delivery in our municipalities if the proposed restructuring plans for Public Health units and EMS services are implemented.

Removing public health from the current integrated municipal structure locally has the potential to weaken the role of public health in our communities; to undo the good work that has been done; decrease municipal public support; weaken the ability of public health to be partners in municipal services, planning and programming; and, lower the profile of our public health programs and services locally.

Concerns and feedback regarding the proposed restructurings and funding reductions include the following:

- **There is demonstrated success in delivering public health services in Regional and Single-Tier Public Health Units.**

In most MARCO municipalities, public health is fully integrated into the municipal government structure, where it collaborates with other programs including housing, social services, child care, crime prevention, water services, transportation and planning. In addition, Public Health receives cost effective support from the municipalities corporate areas including human resources, legal, finance, and information technology. Our Public Health units have benefited significantly from local political engagement, ownership and oversight.

- **Creating large arm's-length, unaccountable boards of health will weaken local engagement, create barriers between Public Health and other municipal functions, and weaken local accountability.**

It appears likely that the proposed large, municipally unaccountable boards of health will have the ability to establish budgets and levy costs on their constituent municipalities, with very limited municipal input. This is likely to re-create the disputes that have arisen in some areas with other arm's-length Boards such as Conservation Authorities. Debates about accountability, share of levy, size of levy, and board composition will consume time and energy, diverting the focus from pressing public health issues. Increasing the amount of property taxes levied by arm's-length, Provincially-controlled and less accountable bodies weakens local democracy and accountability. If this move toward large unaccountable arm's-length boards, with the power to levy costs on municipalities is repeated with EMS, it will further exacerbate the problems noted above.

- **Separating public health units, which are currently part of the Municipal government structures may have unintended negative consequences related to governance, processes and collaboration, and will likely result in the dis-integration of Public Health from other municipal services.**

In most of our municipalities, the municipal council is the Board of Health and is fully accountable and open with regular public meetings, rather than arm's-length boards which attract little public scrutiny and are not given the profile which comes with regular committee and council reporting. Municipalities are best positioned to address the social determinants of health (income, housing,

education, inclusion, etc.) – factors that weigh heavily on the overall health of a community and its members. For example, the contemporary challenges of obesity, inactivity (particularly in youth) and diabetes, for example, are well aligned with community planning, recreation and alternative transportation options – services delivered at the municipal level. Municipal support of sports venues and leagues, close alignment with local schools and surrounding neighborhoods, gives municipalities a major advantage in taking on the challenges of immunization. Provincial experience with large agencies has been fraught with challenge – witness recent examples of e-Health, ORANGE and, most recently, the shuffling of CCACs and LHINs. Municipal engagement is critical to the success of local public health. Loss of political ownership and activism will weaken the work of Public Health.

- **Public Health funding reductions will weaken public health services, and will put people's health at risk in our communities.** Public Health works diligently to prevent disease and illness and to promote health and well-being, often through upstream work to address social determinants of health. The services provided by Public Health help to keep our residents healthy and out of the far more expensive health care system. Money invested into public health is money well-spent, with an excellent return on investment – and is critical to the Province's stated goal of ending hallway medicine. In contrast, the planned cuts to public health are short-sighted and, over the long-term, are almost certain to result in higher overall health-care system costs.

Attachment #5: June 7th, 2019 Briefing Note/Recommendations from MARCO (Mayors and Regional Chairs of Ontario Single Tier Cities and Regions) to the Premier of Ontario

Briefing Note

Title:	Modernizing Ontario's Public Health Units: Public Health Restructuring
Submitted By:	Karen Redman, MARCO Chair
Date:	June 7, 2019

Recommendations:

That the members of MARCO, representing more than 70% of the population of Ontario, strongly urge the Government of Ontario to reconsider the preliminary boundaries for the ten (10) new boards of health in Ontario;

And that the Government of Ontario consult extensively and responsively with the affected municipalities and health-care stakeholders in advance of finalizing the new boundaries;

And that funding for health care services be reviewed through a lens of preventative patient care and an investment in the Province's goal of ending hallway medicine;

And that the Government of Ontario consider the following when reviewing the preliminary boundaries for boards of health:

- the fully-integrated health service model currently used by municipalities has proven to be cost-effective and efficient;
- the population, local demographics and geography of the affected municipalities, are vital elements of the review towards ensuring that the health of Ontarians are not negatively impacted by the boundaries changes;
- the distances between municipalities within a single board of health should be manageable and the newly-created public health units should not be overwhelmed in providing services to an increased population base; and,
- the formula for establishing board representation should allow for at least 80% municipal representation;

And further that these recommendations be forwarded to the Premier of Ontario and the Minister of Health and Long-Term Care by the Chair of MARCO.

Background:

In the 2019 Ontario Budget, tabled on April 11th, the Government of Ontario announced that it will replace 35 public health units and 35 local boards of health with 10 larger regional entities with boards of health of unknown composition and size, with the exception of City of Toronto, which will be one of the new entities.

The magnitude and speed of these changes is significant and will cause major disruptions in every facet of the system. This may result in substantial risk to frontline public health services such as vaccination programs and outbreak investigations.

The Association of Local Public Health Agencies (ALPHA) has prepared and distributed a Position Paper:

https://cdn.ymaws.com/www.alphaweb.org/resource/collection/822EC60D-0D03-413E-B590-AFE1AA8620A9/alpha_Position_Statement_PHR_240419.pdf and is calling upon the Ontario Government to re-consider the cuts and the timelines.

Building healthy communities through an efficient, proactive and locally managed public health system -- one that is mandated to lead on preventative measures to protect and promote the health of Ontarians -- can go a long way to reducing that demand. When combined with stable, designated funding, the public health system has the capacity to relieve pressure on doctors and hospitals.

Furthermore, accountability is firmly established by provincial legislation and policy ensuring that the money spent on public health is spent effectively and with purpose.

ALPHA will continue to communicate with Minister Christine Elliott and Dr. David Williams, Chief Medical Officer of Health, towards ensuring that ALPHA members, and its partners, including the Association of Municipalities of Ontario (AMO), are extensively consulted before final decisions are made with respect to the governance, management and administration of a regionalized public health system and the delivery of frontline public health programs and services.

During the week of May 6, 2019, the Ministry of Health and Long-Term Care held individual calls with Medical Officers of Health/PH CEOs to share the proposed boundaries for the larger entities within which their health units would be placed.

These proposed boundaries are subject to legislative change and further consultation with municipalities, Boards of Health, Medical Officers of Health, etc. over the next few months.

New legislation, expected in early fall, will specify the geographic boundaries of each new entity. There will be a consultation phase included in the legislative process as well.

Transition of governance to the new Boards is expected to occur April 1, 2020.

The Ministry of Health and Long-Term Care has said that they will work with their municipal partners to design governance and delivery models that will protect and preserve the voice of all municipalities. The Government intends to ensure that public health investments better meet the needs of local communities.

Overall Potential Impact for Municipalities:

- There will be less accountability, less responsiveness and less responsibility for local decisions and local priorities.
- The Government's significant reduction in the provincial contribution to the funding formula is of concern, as it will require significant increases in municipal contributions.
- Complicating matters is that further details are not known at this time and the proposed one-year timeframe for the reduction from 35 to 10 public health units is extremely ambitious given the complexities of delivering public health services.
- Municipalities may be forced to pay for services that they have little or reduced control over.
- Creating a centralized plan without consideration for local decision-making or how changes will affect people's health.