AMO's Response to the *Final Report of the Capacity Review Committee: Revitalizing Ontario's Public Health Capacity*

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1. The Capacity Review Committee Final Report: *Revitalizing Ontario's Public Health Capacity*

With the release of the Final Report of the Capacity Review Committee: *Revitalizing Ontario's Public Health Capacity*, the Government of Ontario is in the position to consider addressing and correcting the fundamental issues that impede achieving what everyone recognizes is essential in Ontario: "a strong and integrated public health system that is effective and accountable for the work it does". [1] Timing is also right for the Government to move further towards achieving its commitments and health mandate outlined in *Operation Health Protection.*

The Capacity Review Committee (CRC) Report considers issues and makes recommendations in key areas related to the current function and delivery of public health in Ontario: health and human resources, accountability, governance and structure, funding and research and knowledge transfer. While all of the considerations and recommendations are important, the critical question remains: will the adoption of the recommendations better prepare us in our public health roles and responsibilities and ultimately achieve the functioning of the public health system we all agree upon?

2. The Public Health Context

Currently in Ontario, public health operates under a system of shared funding and varied governance models. Recently, the Government has made the much lauded move of recognizing that the municipal share of public health funding should be reduced and committed to achieving a cost-share of 75 percent provincial and 25 percent municipal by 2007-2008 through incremental adjustments beginning in 2005-2006. While the Association of Municipalities of Ontario (AMO) was pleased with the Government's recognition of the funding challenges and commitment to address the problem, the Association remains concerned that the real problem will remain unaddressed: no matter the cost share arrangement, public health in Ontario continues to be under funded by the province, and funding ultimately addresses the majority of issues related to capacity. In fact, the Government announced in March 2006 that board of health funding budgets would be limited to 5 percent growth in 2006. As a result, boards of health are again limited in their ability to meet their legislative obligations. Also important to recognize, as identified by the Association of

1 Tamblyn, Dr. Susan & Hyndman, Brian; *Revitalizing Ontario's Public Health Capacity*: *The Final Report of the Capacity Review Committee*, May, 2006.

Local Public Health Agencies (alPHa), is that as a result of the funding cap and based on Board approved budgets, rather than paying 35 percent of the mandatory programs budget as committed to by the Government, municipalities will be paying an average of 40.8 percent across the province. This represents an additional $35.5 million in municipal funding for 2006; this also means that the Ministry of Health and Long Term Care will not meet its commitment of a 65-35% cost share as they fall to funding only 59.2 percent of program costs for 2006.

So where does that leave public health in Ontario?

3. AMO's Position

In the 2004 *Interim Report: SARS and Public Health in Ontario* [2]*,* the issue of the municipal capacity to fund a provincial program from the property tax base was highlighted as a fundamental problem of public health funding and ultimately its functioning. AMO's concern with this arrangement was highlighted particularly in regard to the ability to respond to serious public health issues. This arrangement continues to be fiscally unsustainable and what AMO believes is an example of poor public policy. AMO's position remains that municipalities should not be funding programs that are a provincial responsibility from the local property tax base. This does not however preclude municipalities from delivering public health at the local level. Clearly, no matter how public health is restructured, it will be delivered at the local level.

Although, the Government has recognized that the municipal share of public health funding needs to be reduced by committing to cost sharing shifts, it is clear that concern with the efficient and effective functioning of public health, and the ability of boards of health to meet their mandates, still remains largely unaddressed within the current funding arrangement.

2 Campbell, The Honourable Justice Archie, *The SARS Commission Interim Report: SARS and Public Health in Ontario,* April 15, 2004

4. AMO's Response to the CRC Recommendations

Unfortunately, the CRC members were unable to achieve consensus on issues specific to the funding of public health in Ontario. As a result, the report ignores the important considerations of "who" should be funding public health and the principle of "say for pay".

AMO supports the recommendations related to *Revitalizing the Public Health Work Force, Demonstrating Accountability and Performance Measures*, *Research and Knowledge Exchange* and *Strategic Partnerships*-with one clear caveat: all new measures, functions and any additional administrative responsibilities should be 100% provincially funded, including all transition costs. AMO agrees that the public health system should have the most efficient, effective, simplified and accountable planning, management and delivery system for the taxpayer and the consumer of services. Fundamental to this is that this should be adequately funded by the provincial government.

4.1 Governance in Public Health

Despite a lack of a clear recommendation by the CRC on the funding of public health, the Report contains recommendations related to the governance of public health in Ontario. Recommendation 19 by the CRC " states "public health units should be governed by autonomous, locally based boards of health" and Recommendation 21 states "boards of health should consist of an equal balance between municipal appointees and local citizen representatives appointed by the board under the authority delegated from the province". Recommendations 19 and 21 are not reflective of nor responsive to the current public health arrangement in Ontario. In all other provinces across Canada, public health is neither funded nor governed by municipalities – instead, public health is located within regional health authorities and hospitals and under a single governance structure. Subsequently, any recommended governance models must reflect the current reality of public health funding in Ontario. Given the current framework of public health in Ontario and in the absence of a full provincial upload of public health funding, municipalities should retain governance over a program they are delivering and for which they are accountable and financially responsible.

It is important at this point to revisit the reason why the capacity of public health came under scrutiny in the first place. The unfortunate events of Walkerton and SARS revealed what has been referred to in numerous reports, as the "dysfunction" of certain

boards of health in the province. Justice Archie Campbell in his *First Interim Report*: *SARS and Public Health* (2004), recognized that the problems in public health in Ontario, what he appropriately referred to the as "The Public Health Ping-Pong Game", reflect the on-going lack of jurisdictional and funding commitment by many provincial governments to this very important service.

It is not entirely clear from the CRC Report what the benefits of a single model (autonomous boards of health) would be. Currently most boards of health are performing quite well. Justice Campbell in his *Second Interim Report: SARS and Public Health Legislation* [3] recognized that most boards of health are functioning well; although he did caution that disease does not respect boundaries. Importantly, in his *First Interim Report*, Justice Campbell stated "these problems will not be fixed by drawing boxes on paper around public health units and moving them into other boxes (pg. 189)". This begs the question, should well functioning boards of health be "penalized" for failures in others? Clearly the answer is that governance models that are working well should not be disrupted.

While recommending a single model of governance, the CRC report reveals inconsistencies across its recommendations. In principle, the CRC report recognizes and promotes the value of a governance system in public health beyond the proposed autonomous boards of health by reference to the Toronto model; which is an autonomous board within an integrated administration system. In addition, the Report provides for flexibility regarding governance as Recommendation 20 allows for boards of health and municipalities to "jointly agree on their degree of integration where they are already integrated". We believe that a more permissive approach will likely achieve better functioning boards that are able to respond to local needs than boards that are dictated. Furthermore, it is important that the opportunity to maintain the synergy of integration -- that is working well in many municipalities -- be maintained.

In response to the CRC recommendations on governance (Recommendations 19 and 21), AMO recommends: 1) that governance models that are working well to continue to exist; and 2) that where models have been measured and demonstrated to be under-functioning, a remedy be negotiated, either that of an autonomous or integrated board of health. This approach will avoid destroying the synergy of integrated boards of health that are functioning well, while respecting the "say for pay" principle.

3 Campbell, Honourable Justice Archie, *The SARS Commission Second Interim Report: SARS and Public Health Legislation;* April 5, 2005

It is important to note, that if public health does move to an autonomous governing model, a system that is already under funded may in fact find itself at greater financial risk. Leaving integrated boards of health in place will maintain funding relationships that are not subject to arms length arguments such as has been witnessed in some areas with autonomous boards. This dynamic has also been experienced regularly in the past with Children's Aid Societies, Conservation Authorities and Police Services Boards. The history of these relationships is clear and accounts for arguments previously put forth during municipal reforms which sought to reduce and eliminate, where possible, special purpose bodies.

Forcing a one-size fits all model will potentially result in reduced support for public health and diminish the importance of and accountability for public health in communities; a contradiction to what the CRC is attempting to achieve. Creating public health silos will likely result in a diminution of holistic community building and service delivery while creating new and unhealthy friction with funding municipalities.

In response to the composition of boards of health (Recommendation 21), AMO recommends that where autonomous boards of health continue to exist, municipalities be permitted to continue to appoint representatives to local boards of health. While it is widely recognized that public health is a function and reflection of local communities, and while municipalities continue to fund and remain locally accountable for public health, where desired, a mix of municipal representatives and skill-based representatives would provide a good local, accountable governing body.

If the Government moves to adopt the CRC recommendations on revitalizing the public health work force and accountability and performance measures, we are confident that appropriate and effective governance that is reflective of local needs, has the capacity to respond to local needs and that respects local decision making and community participation can be struck.

While AMO can sympathize with the desire to have a consistent governance model in place across the province, we do not support the suggestion of a "special purpose arms length body" design of governance. Proposing a single model of governance does not address the concerns that are the intent and purpose behind the CRC initiative. What should be of concern is what is needed locally to repair the problems of poorly functioning boards of health.

Autonomous boards of health and a “silo” approach to public health may in fact not help communities respond to public health needs but rather may exacerbate divisions and reduce support for public health. We reiterate our position for the need to develop a system that is flexible and reflective of local needs and capacities.

4.2 Funding Public Health in Ontario

It is difficult to dispute that ultimately capacity shall be achieved by appropriate and adequate funding.

AMO is pleased with a number of the recommendations in the report related to *Stable and Predictable Funding.* It is clear that the current funding and approval processes continue to impede the ability and efficacy of public health units achieving their mandates. Flexible, responsive and timely budget approvals will address some existing concerns. Additionally, the ability to maintain operating reserves is a productive recommendation. Clearly however, AMO opposes Recommendation 22 which suggests global funding based on Provincial budget approvals on a cost shared basis.

The inability of the CRC members to reach consensus on the funding of public health reflects the reality that opinions differ on the appropriate formula for funding of public health in Ontario. Nonetheless, recommending provincial approval for a service that municipalities contribute significant funding for at this time not only puts municipalities at risk of exposure, but again, is flawed in principle. Recommendation 22 is particularly troublesome in light of the current provincial funding cap for public health established for 2006.

Municipalities must maintain their authority and ability to negotiate on issues and programs for which they are accountable for and funding. AMO recommends that local boards of health determine local public health needs, pass budgets to meet them and forward them to the Province for approval within provincial guidelines and standards.

Without addressing the fundamental issue of public health capacity in Ontario – inadequate and unstable funding – the core issues remain.

4.3 Building Stronger Health Units

While AMO does not have a position on the proposed amalgamations of health units by the CRC, we express grave concern regarding the ability to negotiate and establish

governance and accountability that is reflective of local needs and capacity. The CRC, on the other hand, expresses concern regarding the need for effective governance; however, it is unclear whether this can be achieved in a multiple boundary scenario. How will cross-jurisdictional issues be negotiated, including establishing priorities and taxation? These are significant issues that cannot help but beg the question whether the recommendation is complementing or complicating public health capacity.

If at anytime the Ministry undertakes consideration of Recommendation 29, this should only occur in dialogue with municipalities. Forced amalgamations would not necessarily result in cost savings, better services, programs or improved relationships between provincial and municipal partners. Any considerations related to amalgamations or discussions of transition require a comprehensive researched review of the case for local amalgamations and in conversation with the affected municipalities.

5. What is Next for Public Health in Ontario?

We applaud the effort of the Capacity Review Committee members and the members of the five Sub-committees. An examination of public health capacity was timely and necessary. It is important to note however, that the recommendations put forth in the Report are a demonstration of the principles of public health practice and delivery rather than a researched demonstration of the outcomes and performance of public health units across the province. Decisions based on principles versus rigorous demonstrated findings of functioning should be carefully considered. Undoing what in fact may work well in many areas on a matter of principle may ultimately result in greater dysfunction than efficacy.

We know other threats, global and otherwise, remain in public health. Importantly, the CRC report recognizes the need for public health units to have surge capacity. This however, should not be at the expense of ongoing, well-funded and full functioning public health units. Specifically, surge should not come at the expense of service.

As demonstrated in this paper, AMO maintains its principled position, and it should be pointed out, that this position has been supported in numerous reports and by the government's commitment to shift cost-sharing in public health. It remains evident that capacity requires commitment and funding from all levels of government and service delivery as currently engaged. As we know however, the current arrangement is inadequate. AMO awaits provincial leadership on this important public service.

Appendix – Summary of AMO Recommendations

AMO Position and Principles:

- Full provincial funding for provincial programs
- "Say for Pay" - as long as municipalities are funding public health, municipalities maintain the authority to negotiate on public health issues.

Governance:

AMO recognizes the need to develop a response that reflects municipal size, flexibility and capacity. AMO also recognizes that a proposed governance model should be based on the consideration of who is funding public health.

In response to Recommendations, 19 – 21:

1) Allow for governance models to exist that are working well;
2) Where models have been measured and demonstrated to be under-functioning, a remedy be negotiated; and
3) Where autonomous boards of health continue to exist, AMO recommends that municipalities be permitted to appoint representatives to local boards of health.

This approach avoids destroying integrated boards of health that are functioning well.

Funding:

Maintain the "say-for-pay" principle.

In response to Recommendation 22:

4) AMO rejects provincial approval of budgets and recommends that local boards of health determine local public health needs, pass budgets to meet them and forward them to the Province for approval.

Municipalities must maintain their authority and ability to negotiate on issues and programs that they are funding and are accountable for.

Building Stronger Health Units:

In response to Recommendation 29:

5) If at anytime the Ministry undertakes consideration of Recommendation 29, this should only occur in dialogue with municipalities. Any discussion of transition needs to include a review of the case for local integration.