



AMO Response to the Ministry of Health's Discussion Paper: Public Health Modernization

Submission to the Ministry of Health

February 10, 2020

Objective

AMO welcomes the opportunity to respond to this consultation to modernize public health in ways that will result in even more robust population health outcomes and best meet local needs. We trust that any changes will reflect this goal.

Currently the public health system delivers effective, co-ordinated and cost-efficient services to the people of Ontario. AMO acknowledges the challenges outlined in the Public Health [discussion paper](#) and the need to seek continuous improvement. The public health sector can work with the Ministry of Health to continue to find efficiencies and enact helpful changes that will increase effectiveness to all the people of Ontario regardless of who they are or where they live.

AMO's goal is to work with the Province to strengthen public health, help end hallway health care, and reduce overall health costs through finding efficiencies to reinvest into services, not by increasing the municipal cost-share contribution. Underlying our advice is that local situations vary, so a 'one size fits all' approach across the province will not work.

Municipal governments have grave concerns regarding the comprehensive restructuring of public health that was suggested in the 2019 Budget. However, AMO understands that the government is open to hearing other ideas through this consultation. This response to the Ministry of Health's (MOH) [discussion paper](#) provides structural and programmatic alternatives for the Province to consider. Any structural changes should be carefully designed, based on sound evidence and not rushed. Or else they have the potential to weaken, not strengthen public health, with the result that hallway health care may increase. Upstream interventions reduce hospitalizations and incidents of chronic disease.

Context

According to Budget 2019, the Province is looking to restructure public health into ten regional entities, which would make coverage areas larger and make it harder to integrate with local municipal services. It is further understood from Budget 2019 that proposed restructuring is to produce provincial savings (e.g. \$200 million) and change identified issues including improved capacity and reducing duplication.

To date, the Province has made some changes to its Budget 2019 intents – such as, effective January 1, 2020, public health funding will move to a 70% provincial and 30% municipal cost-sharing arrangement including the majority of those previously 100% funded provincial programs (e.g. does not include the new senior dental program).

The Province has promised a 10% cap on municipal levies for 2020. Still, municipal and public health officials are concerned about the 2020 Budget impacts. For 2021, when the full impact of the 70:30 changes occur, officials are very anxious. For 2020, local public health agencies are not filling vacant positions, laying off small numbers of staff, and some are using their municipally funded reserves to manage fully the operating budget gap.

Municipal governments paid on average about 38% of public health costs in 2018, well above the 25% mandatory contribution. There is tension in the system as the funding has never been sufficient enough for public health units to meet all the required provincial standards. Municipal governments in most areas have increased their contribution to cover the shortfall.

The \$200 million provincial savings has not been removed from the table and its timing may now have been delayed. This gives rise to the thought that the Province is continuing to be focused on producing public health savings for the Province, not to incur more costs through modernization.

General Comments

The bottom line is that savings will not be achieved under the proposed Budget 2019 system restructuring in the short-term and are very unlikely in the longer-term. This is the collective lesson of previous municipal amalgamations and downloading experiences over the last 25 years.

Restructuring a few local public health agencies where it has been demonstrated that restructuring is the only viable way to fix long-standing capacity and response issues, will be less expensive and disruptive than a full system transformation that goes from 35 local public health agencies to 10 regional entities—with all staff in flux. It would be costly, complex, and disruptive to the public, public health staff, and the public health system. According to estimates, there are 7,000 public health staff covered by 73 separate collective bargaining agreements across the province. To change their employers with all the labour relations costs that go with such an exercise (e.g. severances, successor rights, going to single collective agreements from several).

Many of the system challenges can be overcome by addressing the Auditor General's (AG) 2017 [recommendations](#) for chronic disease prevention. AMO's response to the consultation questions in this submission provides solutions that address the AG's recommendations.

Fundamentally, there is a need to preserve what is working well and fix what needs fixing. The system is not broken per se. Changing the system wholesale will cause disruption without clear demonstrated evidence of the benefits. People-centred programs and service delivery systems must continue to be accessible to clients and the public and be accountable to funders of the system.

The health care system's role is to treat illness, while Public Health works to reduce and prevent illness from happening in the first place. It does this in many ways to address the social determinants of health (SDOH). If local public health does not do this with respect to SDOH, then no other player from a system perspective will. Others such as Community Health Centres can play a role as well where they exist, but public health brings a comprehensive provincial-wide systems approach.

Investments in public health make sense to keep people healthy through a focus on the social determinants of health. It contributes to ending hallway health care and saves provincial health costs in the long-term. Research in other jurisdictions has shown that public health has a high rate of return on investment. For example, In California, \$1 invested in public health resulted in \$67 to \$88 of benefits to society (Academy Health, 2018). Prevention approaches reduce 50% to 75% of cardiovascular disease deaths in high-income countries, and 78% globally (World Health Organization). \$10 invested in public health can decrease 7.4% of infectious disease deaths (Academy Health, 2018).

It is also important to maintain investments in public health in order to control health care costs. In Canada, it is estimated that 80% of total provincial program spending will be used to cover health care costs by 2030. Escalating costs are driven mostly by preventable conditions.

A separate discussion on funding is urgently needed prior to any consideration of restructuring. Municipal governments cannot be expected to make up for reductions in provincial funding. Nor

can they bear the costs of provincial restructuring. It is not sustainable. An immediate discussion regarding impact in 2020 and beyond is needed. A reset or provision of on-going mitigation funding to cap increases in municipal contributions in future years is required in the short-term. Municipal governments need an adequate runway with time to plan for upcoming fiscal impacts. A freeze or moratorium on funding changes in 2020 is required until after the Health Advisor concludes the review and produces a report.

Alternatively, or concurrently, the level and scope of provincially mandated public health activities (through the 2018 Ontario Public Health Standards and the formerly 100% provincially funded programs) could be reduced so that the work required by the Province aligns with the funding available to local public health agencies from the Province and obligated municipalities. Changes need to be "fiscally neutral" so available funding fits the required mandatory work.

Health is a provincial responsibility, not a municipal one, and this must be reflected in funding arrangements. A longer-term discussion about who pays for what is in order. Public health should however continue to be community driven at the local level. As long as municipal governments are paying for public health, we appropriately need "say for pay." This includes local programmatic and budgeting decisions as well as input into provincial policy decisions, legislative and regulatory changes.

One size does not fit all. Consistency in service delivery and reducing inefficiencies do not depend on a single governance or leadership type. In terms of public health structure, building capacity and better system coordination, there could be:

- incentives for voluntary mergers and sharing services between health units
- exploration of functions that could be done centrally by the Province, Public Health Ontario, or other entities
- more back office integration (e.g. corporate services like IT, legal, HR) **and** sharing of medical expertise through regional hubs (e.g. AMOHs, epidemiologists) between PHUs

This will result in greater effectiveness and cost efficiency.

Populations also matters. Specific provincial strategies, resources and funding are needed to guide and equip local public health agencies to appropriately serve Indigenous and Francophone populations.

The answers provided to the specific consultation questions in response to the identified challenges are guided by the considerations listed above.

Key Challenges

Insufficient Capacity:

What is currently working well in the public health sector?

- Overall, the public health sector plays a critical role providing upstream health promotion and prevention interventions that change people's trajectory across their life span. It eases strain on the rest of the health care system, including contributing to reducing hallway health care by addressing health conditions before they become an acute care situation.

- The public health sector plays a role to raising awareness and promoting broader societal solutions at the local level to address the social determinants of health – which are not dealt with by the health care system.
- Some local public health agencies have amalgamated willingly to increase capacity. (Note: AMO understands that some are currently considering such voluntary mergers, which could be encouraged if the right provincial incentives are provided.)
- It is well known that the public health units embedded within regional and single tier municipalities are the strongest with respect to overall capacity, critical mass, and surge capacity for Public Health emergencies. The full back office costs for supporting the local public health agencies are often absorbed or partially offset by the municipality. If moved from the host municipality, the full back office costs will be revealed and will add costs to the system.
- The right legislative and regulatory framework is in place to realize the vision of modernized public health. The *Health Protection and Promotion Act*, related legislation (e.g. *Immunization of School Pupils Act*), and the [Ontario Public Health Standards](#) are strong foundations to guide public health in Ontario.
- Public Health Ontario ([PHO](#)) provides valuable services to support local public health agencies.
- [alPHa](#) also contributes to consistency in the sector and knowledge transfer to support communities of practice.
- Local agency leadership, professional, and administrative staff support the work of public health for the people of Ontario.
- Relationships with community partners, including other health and human/social service providers, make the system stronger from a 'social determinants of health' perspective and approach.
- A 24/7, 365 days-a-year response capability serves community residents well especially in emergencies.
- Provincial cost-sharing contributions are necessary to ensure financial sustainability and a high quality of service.

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

- It is the Ontario Public Health Standards Foundational Standards (including population health assessment, health equity, program planning and evaluation, and emergency management) that are challenging for some health units to make sure they have the needed capacity to achieve the Ministry's requirements.
- The Ministry of Health can develop a funding model that reflects changes made to improve capacity and coordination as well as more equitable provincial funding for public health units. The Auditor General (AG) in her follow-up 2019 [report](#) found that the Ministry was in the process of doing so by January 2020 (see page 156 of the AG's report, recommendation #11).

There is tension in the system as it is widely held that the provincial funding available is not enough to meet the requirements of all the standards. Municipal governments are expected to make up for reductions in provincial funding.

- However, and to date, there is no public written information on the details of the future funding model beyond the announcement of the 70:30 cost-sharing split and one-time funding in 2020 so that municipalities would not experience an increase of more than 10% over their current public health costs due to the 70:30 cost-sharing change.
- The ministry, working with the sector, should use a risk management approach and focus on those local public health agencies that have the greater capacity and response challenges first.
- Service and/or mutual aid agreements between PHUs can be used to increase capacity when a public health emergency response is needed.
- Improved health equity focus and Indigenous engagement can increase capacity for all populations.
- Complimentary provincial campaigns on key/emerging issues (e.g. cannabis, opioids, vaping) would increase capacity to support local achievement of public health outcomes.

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

- The Province should think of capacity building as more than just service delivery, but also the other things that Public Health does particularly by addressing the social determinants of health which should be at the foundation of Ontario's health system. The sector needs to be able to influence decision-makers in health care and beyond health care. Public health can help to foster changes and relationships with others if it has influence. One example is that public health could help inform a 'health in all policies' lens, as recommended by both AMO and the Auditor General in the Chronic Disease audit to the Province.
- There is a risk to making the local public health agencies too distant from municipal governments. The link with community prevention services is vital. It will weaken connections that are needed in emergencies as well as ongoing work that municipal governments can contribute to public health promotions and protection. Examples of these include municipal alcohol policies, land-use planning to create healthy built environments, by-laws, and social services.
- Some local public health agencies that have identified capacity issues either have amalgamated or are in process of thinking about amalgamating.
- It is cheaper to maintain or build upon existing structures than creating something new. There are however, hidden costs to amalgamations. There are also complex questions to work out of who owns the assets. The Ministry of Health should assist by documenting and sharing the experiences and lessons learned with recent voluntary public health mergers to help guide decision making and execution of other mergers as warranted.
- Other local public health agencies could be *encouraged and supported* to merge if willing and with the right incentives; doing so would address noted capacity weaknesses. Some local

public health agencies' amalgamations may increase capacity in a targeted way through economies of scale. However, this is not the only option and may not work in all areas (e.g. northern Ontario, mixed urban-rural areas). For this reason, mergers should be locally driven. Forcing mergers will erode the public health system. Provincial guidance and advice would, however, be welcome.

- As an alternative or concurrently, the Ministry of Health could establish regional administrative back offices and a professional practice regional office(s) to both increase capacity and find cost savings through efficiencies.
- These could start with northeastern Ontario, and then northwestern Ontario. This could be rolled out to regional clusters of autonomous boards/local public health agencies so that information technology, human resources, funding, and performance management operations could be done and coordinated amongst the participating local public health agencies. This could increase administrative capacity and improve coordination/consistencies across Public Health.
- Regional and single-tier PHUs would need to follow the same administrative processes (where appropriate), again to increase provincial consistency where needed between PHU operations.
- Key skilled Public Health personnel could be part of a professional practice regional office(s) that would enable a critical mass of Community Medicine physicians, epidemiologists, data analysts, and any other needed and scarce public health professionals. This professional practice regional office could provide regional surveillance, program evaluation, and surge capacity for the fundamental standard.
- Again, this could start in northeastern Ontario, then northwestern Ontario. For southern Ontario, an assessment could be done of where such a professional practice regional office is needed between those local public health agencies under autonomous boards and the Ministry of Health.
- Physicians in these regional cluster(s) would be Associate Medical Officers of Health (AMOHs) cross appointed by all contributing local public health agencies to also provide vacation and weekend/night coverage to local single Medical Officers of Health (MOHs) as well as being available to provide surge capacity in an infectious disease outbreak or other public health emergency.
- The sector is looking for flexibility from the ministry so that potential creative solutions may resolve a local structural challenge, could be considered positively. This is consistent with the municipal one size does not fit all perspective.
- Any consideration of consolidating functions into back offices should be preceded by targeted consultation with local public health agencies following an assessment to determine exactly what is needed and in what form to make it work across the province.
- It should be noted that the Auditor General in the December 2019 follow up [report](#) to the 2017 report on Chronic Disease Prevention made no mention of any needed structural changes to the public health system.

- Size and geography matters. The ministry should resist the urge to automatically equate larger units with increased capacity. Making larger units may help in many cases, but there may be diminishing returns if made too large. Also, expanding the size of units will run up against the geographic challenge of serving very large catchment areas with dispersed populations including in remote areas.
- Note: More detail on the implementation steps of our restructuring vision is found in the final answers to the questions of this response. (See "Lessons Learned from Past Reports").

Misalignment of Health, Social, and Other Services:

What has been successful in the current system to foster collaboration among public health, the health sector, and social services?

- Public health plays an important role to address both the social determinants of health for the overall population and address individual social and health needs across their life span. The social determinants of health are not uniquely public health but work with other partners who could participate by providing perspective and guidance. For example, providing advice on housing or income security reform to reduce poverty. This must continue.
- Public health has been integrated over the years in varying degrees with other municipal service programs that make a difference to people's lives and align with the social determinants of health (e.g. housing, land use planning, transit, recreation). Local partnerships make this happen on the ground.
- Human services alignment is easier to facilitate in areas where local public health agencies are integrated into municipal structures rather than autonomous boards.
- Public health also connects well with other municipal services, especially in an integrated setting, including long-term care, housing, and Emergency Medical Services including community paramedicine that provides primary care. This needs to continue with strengthened local relationships.

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

- The health care system's role is to treat illness, while Public Health works to reduce and prevent illness from happening in the first place. It does this in many ways to address the social determinants of health. If public health does not do this, then no other player will from a systems perspective will. Others such as Community Health Centres play a role as well where they exist, but public health brings a comprehensive systems approach.
- Better connections and coordination to health care will result in improved client outcomes and have the potential to both reduce health costs overall and help end hallway health care.
- However, it is vital that public health remain a distinct system. Too close a connection will have the effect of subsuming public health into the broader health care system thereby diluting its mandate with diminished ability for upstream interventions that ultimately reduce demand on the health care system.

- There appears to be a disconnection in many areas of the province between the newly forming Ontario Health Teams (OHTs) and local public health agencies. Provincial guidance on how the two will interact is crucial in these early days. The Ministry of Health could require regional and community level coordination on those primary care activities through Ontario Health Teams that overlap with mandated Public Health population health activities (e.g. immunizations, sexually transmitted infections, healthy pregnancies and babies). This can be done by integrated policy and guidelines first and then by legislation and/or regulation if necessary.
- The two systems need to work together. For example, in the area of chronic disease prevention, support beyond public health is needed. Primary care needs to play a more active role, especially at the community and home care level.
- The Ministry of Health needs to coordinate and guide the two systems, starting with an overall vision of what the health system is intended to achieve.
- It is not recommended that public health be incorporated or integrated into OHTs in a mature, future state. Rather, they need to be connected to each other by breaking down silos and removing barriers.
- One such barrier is the lack of a central repository for patient information. Through Ontario's Digital Strategy, a single patient record should be developed. This could be shared between public health, health service providers, and Emergency Health Services. This needs to be a key modernization feature.
- Social and human services that address social determinants of health such as social assistance, housing, and child care are done by the municipal order of government. It would be helpful to require all autonomous boards of health to work with their local municipalities and District Social Service Administration Boards (DSSABs) to develop and then employ a plan to maximize program integration and collaboration opportunities. Alignment with social services is not an issue where public health units are integrated into municipal structures.
- Collaboration works best with good communication and information sharing between municipal governments and local public health agencies. This is not always the case in all instances with autonomous local public health agencies. There needs to be better alignment to effectively improve population health outcomes. Mandating collaboration between public health units and municipal governments could be added into a ministry directive. It could be similar to the structured relationship that was established between the LHINs and Public Health through legislation. The relationship should also be structured between Ontario Health Teams and local public health agencies. There is also similar precedent in the *Child Care and Early Years Act*, which mandates collaboration between school boards and municipal service system managers on service planning.
- The Province may also consider the establishment of health situation tables, similar to community safety tables that exists, which could bring together public health, Ontario Health Teams, emergency first responders and also municipal social services representatives to coordinate local services. This would require provincial funding to establish and maintain.

- Better coordination and complimentary support is needed from the mental health and addictions system working with public health and local municipal social services such as housing and social assistance. This needs provincial direction to collaborate.
- Coordination is also needed by both the corrections and child welfare/foster child systems to work with youth and adults coming out of facilities and systems of care and support. Better coordination to provide access to public health for health promotion and health protection activities would help. Links to the education system should also not be overlooked, as cited by the Auditor General in the 2017 Chronic Disease Audit. Some local public health agencies face challenges in accessing schools to provide health promotion programs. Partnerships between local public health agencies and school boards will help with acknowledgement that schools are a key component of public health.
- As reported in December 2019 by the Auditor General in [response](#) to the 2017 Chronic Disease Audit, progress has been made by the Ministry of Health (MOH) and Ministry of Education (EDU) to direct collaborative and sustainable relationships. The situation should be monitored on an ongoing basis to ensure the outcome of health promotion initiatives taking place within school settings, the identification of best practices, and the development of shared goals/objectives.
- AMO is available to further explore this topic and come up with solutions to achieve better connections of the health system with social services. This should involve participation from the Ontario Municipal Social Services Association ([OMSSA](#)) and the Northern Ontario Service Deliverers Association ([NOSDA](#)). A possible forum for this discussion is the Provincial-Municipal Social Assistance and Employment Committee (PMSAEC) under the AMO-Ontario Memorandum of Understanding, which is co-chaired by AMO, the City of Toronto and the Ministry of Children, Community and Social Services. Enhanced and consistent Ministry of Health participation with this committee would benefit both the provincial and municipal systems. The PMSAEC is a staff level confidential table with municipal social service representatives. Other ministries facilitate discussions with the committee. The Ministry of Health is not a regular participant.

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

- Local public health agencies delivering the Healthy Babies, Healthy Children program which fosters collaboration.
- The development of Community Safety and Well-Being Plans has been and is a good current opportunity to foster effective collaboration between public health, social services, health providers (e.g. mental health and addictions), and police services.
- [alPha](#) and social service organization organizations, such as the Ontario Municipal Social Services Association ([OMSSA](#)) and the Northern Ontario Service Deliverers Association ([NOSDA](#)) are well positioned to provide the ministry with further examples. The PMSAEC table under the AMO-Ontario MOU could be used as a forum to gather more examples.
- A collaboration between the mental health and addictions systems with Public Health is needed and should be facilitated by the government. Mental health and addictions is part of overall population health. For example, there is deep involvement of Public Health in

addressing the opioid overdose emergency. This ministry needs to link this work with the developing provincial strategy for mental health and addictions. It needs to be part of the conversation. AMO has provided [recommendations](#) to the Ministry of Health to inform a provincial response using a public health approach.

Duplication of Effort:

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

- Most functions should remain local given the nature of public health and the populations they serve.
- Research on matters with province-wide impact might be centralized. However, there will still be a role for local research projects particularly around the needs of target populations and their status indicators. However, the Province should enable independence to the organization providing any centralized research function as there may be conflicts with other government priorities (e.g. alcohol and cannabis revenues).
- Research needs to be evidence-based and objective. An arm's length agency, such as Ontario Public Health, is more appropriate to house a centralized research and dissemination function.

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

- Local public health agencies, within municipalities or as autonomous, are best positioned to provide local information and examples.

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

- There should be better coordination with Public Health Ontario (PHO), the Ministry and local public health agencies for priority system research products that local public health agencies can then use at the local level to reflect their community population(s).
 - A monthly e-newsletter or website posting could be developed and maintained to make sure those public health managers and staff, beyond Medical Officers of Health, who need to know, can get access to the information easily.
- The Ministry can also create virtual teams across local public health agencies and/or a Centre of Excellence (e.g. Lyme disease work) to develop priority policy materials that can then be used at local level. This would reduce duplication and increase consistent policy development. It could be directed and supported by the CMOH and PHO and/or a sponsoring local public health agency.
- The same approach could be used for virtual teams or a Centre of Excellence for administrative and performance indicators/analytics. It can be done like the above policy/research streamlining and efficiencies.
- The Ministry should create a provincial overarching strategy and approach to update, coordinate, and share research and best practices, including following through on the

commitment made in the 2018 Ontario Public Health Standards to develop a central repository. Note: According to the AG follow-up [report](#) (2019) this is on track for March 2020 (see page 151, recommendation #5).

- The Ministry should develop provincial performance indicators that measure local public health agency effectiveness in preventing both chronic diseases and health promotion activities. This can include development of program evaluation guidance materials for all local public health agencies to use to make sure that they are evaluating their programs in a consistent manner that includes provincial benchmark evaluation, return on investment analysis, continuous improvement, and public reporting on performance targets (to the Province and the public). The Auditor General reported out in December 2019 that the Ministry of Health is making progress on a strategy for chronic disease. The same should be done for health promotion.
- This would include direction to the local public health agencies to make sure that they are evaluating their programs in a consistent manner that include provincial benchmark evaluation, return on investment analysis, continuous improvement, and public reporting on performance targets. Note: The AG is finding progress being made – see AG follow-up [report](#) (2019) recommendations 7.8 on pages 153-154.
- This would require the Ministry to monitor the local public health agency performance and their evaluation of their performance across the Ontario Public Health Standards and related protocols.
- Note: The 2019 AG [report](#) has said now that the Ministry has addressed the epidemiological data issue.

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

- Epidemiology, disease surveillance, program evaluation, and population health assessments at the provincial and regional levels to inform the local work.
- If some functions are centralized and mandated to PHO, care should be taken to adequately fund PHO. In recent years, funding has been flat-lined, possibly with the effect of reducing PHO's capacity over time. To fulfil its mandate and play an effective role, PHO requires stable, predictable funding.
- PHO's health protection function needs strengthening before adding any new responsibilities.
- PHO should resume coordinating/funding the locally driven collaborative research program.
- PHO should continue to coordinate, in concert with ALPHA, OPHA, public health research, and knowledge transfer of successful population health interventions.
- PHO should support smaller local public health agencies with health analytics support.
- The provincial government could support public health and at the same time, the broader health care sector at large by developing and implementing a province-wide human resource strategy to address the shortage of health professionals in many areas of Ontario. There is

also a need for this in the Long-Term Care sector which should be co-ordinated with the Ministry of Long-Term Care.

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?

- An integrated data strategy that links provincial, municipal and public health data confidentially while allowing for enhanced data analysis and monitoring of population health outcomes.
- This will need to include the development of a single personal indicator for every resident of Ontario—to lead to better and improved health care/population health outcomes. A single, digital identifier is the only way an integrated “one window, any window” service portal for residents could begin. This might necessitate Ontario Cards being used on a single software system used across the health care, public health and emergency health services sectors. This should be considered as part of the government’s digital strategy.
- Significant service improvements and efficiencies could be made through greater automation.. The technology is available. Examples include surveillance data and follow-up on communicable diseases. This is still done by fax in many areas.
- Local public health agencies should be surveyed about the specific technology solutions they are implementing for sharing and knowledge exchange.

Inconsistent Priority Setting:

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

- Local public health agencies, within municipalities or as autonomous, are best positioned to provide local information and examples.
- Community of practices (e.g. French-language services) fostered by program/speciality networks (e.g. COMO, public health professional networks) are in place.
- Provincial-municipal planning tables (e.g. AMO and alPHa technical tables) also exist.

What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

- As the provider of provincial research/synthesis of other jurisdictions’ research and evidence, PHO can provide professional advice and expertise to local public health agencies.
- PHO could play a role to support the government to adopt a ‘health in all policies’ approach as recommended by the Auditor General. alPHa may provide further ideas about how this may work in practice.

What models of leadership and governance can promote consistent priority setting?

- AMO does not support a single governance or local leadership model as the only way to achieve consistent priority setting, if that is a desired approach.

- The Province directs all public health legislation, regulations, funding, policies, standards, accountability, and reporting requirements to all local public health agencies no matter their governance and leadership models. All local public health agencies are expected to deliver high quality public health programs and services within the provincial public health framework set out.
- Local public health agencies must deliver appropriate programs and services that follow provincial standards for their populations and communities. This may result in slightly different priorities for local public health agencies within provincially set parameters.
- Given the diversity of the province and its populations, we could ask why consistent priority setting within this provincial public health framework is being seen to be the pivot point for local models of leadership and governance.
- The Province should maintain municipally integrated local public health agencies within regions and single-tier municipalities.
 - Single-tier and regional municipal governments could consider having Boards of Health within their structures with some community representation, like Toronto and Ottawa, with municipal councils retaining final policy and fiscal approvals.
- The ministry should take a stronger leadership role in ensuring a focused, overarching and strategic approach to public health, including research, health promotion programs, and chronic disease prevention initiatives. This can be done through provincial working groups, policy and guidelines.
- The leadership at the local public health agency should be determined by each Board of Health based on their circumstances and needs. In many cases, this may have a Medical Officer of Health as the Chief Executive Officer (CEO) whereas others may opt for a non-Medical Officer of Health as CEO or Executive Director in a shared leadership model.
- Section 6.3.1 of the 2006 [Capacity Review Committee](#) provides a good overview on Health Unit Leadership that has informed our thoughts for the need for flexibility in an autonomous local public health agency. I.e. "We agreed that MOHs should be able to serve as CEOs of local health units. However, we were unable to reach consensus on whether the role of CEO should be assumed by non-MOHs. The complexity of this issue was evident in our extensive deliberations, which revealed a number of potential advantages and challenges to the model of non-MOHs serving as CEOs". [CRC report, page 39]

Indigenous and First Nation Communities

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

- Consultation and active participation in population health needs assessment.
- Indigenous community organizations such as the Ontario Federation of Indigenous Friendship Centres ([OFIFC](#)) should be asked about what has been successful in their view. We understand that their major concerns are from a social determinants of health perspective.

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

- Yes, local public health agencies can do this through local engagement and advisory processes. A high priority placed on this this will support reconciliation.
- More Boards of Health could use the ability to have First Nations participation though s. 50 of the [Health Protection and Promotion Act](#) (HPPA) or through Board of Health appointments.
- Guidance could be provided as one function of an Indigenous Advisory Committee to the Ministry and the public health sector.
- The Ministry of Health should consider funding Indigenous organizations to engage with local public health agencies like Ministry of Education has done previously with Child Care Journey Together funding.
- Additional provincial (and/or federal) funding to assist local public health agencies and health/social service agencies (e.g. mental health, supportive housing) with large vulnerable Indigenous populations could assist in improving their health outcomes in the community (upstream) rather than have them served primarily in the more expensive health care system. Focused local investment needed now to avoid larger future provincial health costs.
- It is important to recognize that as local situations vary, that there will be different solutions for various communities. Attention needs to be made to Indigenous people living in municipal settings as movement occurs from First Nation communities.
- The Province could incentivize and support the hiring of Indigenous public health workers and/or the purchase of Indigenous services to build and support local capacity. This could be done through working with and/or contracting with a local Indigenous Friendship Centre.
- Individuals and groups could be engaged in/on provincial-municipal planning tables.
- The work that local public health agencies do through their partnerships with local community organizations, including Indigenous associations, on the social determinants of health is critical to improving health outcomes and health equity for Indigenous people.

Francophone Communities

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?

- Local public health agencies, within municipalities or as autonomous, are best positioned to provide local information and examples.

What improvements could be made to public health service delivery in French to Francophone communities?

- The Province could provide specific funding to support local public health agencies to provide French language services in communities designated under the *French Language Services Act*.

- Further government consultation with francophone communities, the Association of Francophone Municipalities of Ontario ([AFMO](#)) and the Association of Local Public Health Agencies ([alPHa](#)) could generate further ideas. One idea is a provincial health human resources strategy to address issues such as training and recruitment of bilingual paramedics.

Learning from Past Reports

What improvements to the structure and organization of public health should be considered to address these challenges?

- The Province should maintain municipally integrated local public health agencies within regions and single-tier municipalities in recognition of the strengths and benefits afforded by them, including integration with social services and other municipal services/programs, back office supports from the municipality, and a strong understanding of community needs.
 - Single-tier and regional municipal governments could consider having Boards of Health within their structures with some community representation, like Toronto and Ottawa, with municipal councils retaining final policy and fiscal approvals.
- The Ministry should conduct an objective gap analysis and if merited, establish northwestern and northeastern public health regional offices to provide public health professional services (e.g. Associate MOHs, epidemiologists) and back office support.
- Leveraging existing collaborative work amongst existing northern local public health agencies will serve to avoid duplication. Identifying opportunities for shared services is a promising approach to consider before any units are restructured.
- The Ministry should conduct an objective gap analysis and only if/where merited, organize the southern local public health agencies (that are currently autonomous boards) under a Consolidated Municipal Service Manager (CMSM) model to increase capacity, critical mass and coordination. Identifying opportunities for shared services is a promising approach to consider before any units are restructured.
- The Minister of Health should create an Advisory Committee (including Ministry, municipal, board of health, and public health members) to oversee public health transformation if restructuring is identified as the best policy following an objective gap analysis of particular local public health agencies. This advisory committee should monitor issues and emerging concerns and propose corrective action if required.

What about the current public health system should be retained as the sector is modernized?

- Maintaining local flexibility rather than standardization. This is needed to be able to meet the local needs of communities include sub-population groups such as Indigenous People and Francophones.
- Local municipal representation on autonomous Boards of Health.
- The Province should maintain the current structure of municipally integrated local public health agencies within regions and single-tier municipalities given the capacity, strengths and benefits afforded by them, including integration with social services and other municipal

services/programs, back office supports from the municipality, and a strong understanding of community needs.

- The passion, professionalism and thoughtfulness of public health staff.

What else should be considered as the public health sector is modernized?

- The pace and scope of change in the municipal sector needs to be considered and managed. There is a cumulative impact from a number of provincial decisions from various ministries affecting municipal governments. Too much change at too fast a pace will not result in good public policy outcomes.
- The Ministry also needs to articulate an overall vision of health for the people of Ontario to guide how each system will work best on its own and connect better together. For example, the Ministry should set broad outcomes for all health systems and connect with other ministries with an 'all of government' effort.
- The Ministry should link their efforts and join in the Human Service Integration (HSI) initiative led by the Ministry of Children, Community and Social Services (MCCSS) on behalf of three human service ministries. It could help the transition to a CMSM model where applicable.
- Current funding direction and pressures are a key dis-enabler to positive change and modernization.
- The changes in cost-sharing issues need revisiting before any potential restructuring. It is not clear what the cost-share will be going forward. Clarity is needed on what exactly the municipal contribution is to cover. If 30% in a mature future state, then 30% of what? Of the status quo?
- With the new provincially mandated responsibility for previous 100% provincially funded mandatory programs, municipal contributions are significantly higher (estimated to be causing 30 -50% increases) on local public health agency budgets. The limited capacity to pay will likely result in reduced services and further strains on the property tax base.
- It is also problematic mixing existing funding into transition. Many local public health agencies are using their reserves for operational costs to manage the transition in an affordable manner. This has been necessary but is not the appropriate use of reserves for operational expenses. Such reserves are intended to cover capital costs and to be held until such a situation warrants a surge in capacity. This will result in a situation that in the lead-up to any transition many local public health agencies will have significantly depleted their reserves.
- Local public health agencies should be primarily funded by provincial revenues since this is the most appropriate revenue source. They should not be funded by the property tax base because there is no link to property and because they provide a human service, which is better funded through provincial tax dollars ([AMO Health Discussion Paper January 2019](#)).
- There should be no more changes to cost-sharing arrangements requiring municipal governments to pay more. Finding efficiency is a challenge when staffing is the majority of a public health budget.

- A few AMO member municipal governments may favour a full upload of provincial costs, however most members, especially those with local public health agencies integrated into municipal structures, may wish to retain some 'skin in the game' by continuing a municipal contribution.
- The Ministry can develop a funding model that reflects the restructuring changes made to improve capacity and coordination as well as more equitable funding for health units.
- This would include direction to the local public health agencies to make sure that they are evaluating their programs in a consistent manner that includes provincial benchmark evaluation, return on investment analysis, continuous improvement, and public reporting on performance targets.
- This would require the Ministry to monitor the local public health agency performance and the evaluation of their performance across the Ontario Public Health Standards and related protocols.
- Implementation should include providing local public health agencies and their funding municipalities with funding information as early in the provincial fiscal year as possible. This is a longstanding local public health agency and municipal request for more predictable and timing provincial funding.
- While they exist, municipal governments require provincial support to help control the rising costs of autonomous boards of health. It is sometimes noted that provincial appointees do not have due regard for municipal fiscal circumstances and the ability to pay for services exceeding the requirements of the standards. The most effective control to put into place would be to amend the *Health Protection and Promotion Act* (HPPA) to embed the municipal cost sharing arrangement in legislation with the provision that the municipal contribution is set at a maximum amount payable as determined by the percentage of the cost share. This would address the concern of autonomous boards levying municipal governments for amounts exceeding the cost shared contribution currently set by policy. AMO holds that a conversation about funding, however, is required before any legislative change to this effect. Municipal officials are also seeking clarity from the Province on the mandatory and discretionary aspects and scope of public health services and programs.
- A final word about funding, the Province should provide funding for service to residents in unincorporated areas. These areas are often remote with dispersed populations, thus adding to the cost. It is not fair nor appropriate that property taxpayers subsidize service to these residents.
- The proposal in the 2019 Budget to create 10 regional entities will only add another layer of government bureaucracy to the health system. If considering structural changes, the Province should be mindful of unintended consequences. Lessons have been learned from past experience. For example, the decentralization of paramedic services. Or, the creation of District Social Service Administration Boards (DSSABs) where disagreements between municipalities about governance representation and apportionment of costs exist to this day.
- If the Province moves to create new regional entities it will be complex, take time, and costly. It will take resources away from service provision. Examples of cost drivers and issues include pension, severance, and labour relations. The Consolidated Municipal Service Manager (CMSM)

model could achieve the goals without the unintended consequences. Ultimately to avoid unintended consequences, there is a need to separate out discussions of funding and restructuring.

- A prime consideration regarding governance is the need to ensure that provincial appointments happen in a timely manner. Delays resulting in vacancies on the boards is not good governance practice and may result in Boards of Health not being able to achieve quorum at some meetings.
- Previous reports on public health capacity that informed our considerations and responses were:
 - [Revitalizing Ontario's Public Health Capacity: Final Report of the Capacity Review Committee May 2006 \[CRC report\]](#)
 - [The Ontario Auditor General's 2017 Annual Report re: Value for Money Audits-Public Health: Chronic Disease Prevention](#)
 - [The Ontario Auditor General's 2019 Report-Public Health: Chronic Disease Prevention-Follow up on VFM Section 3.10, 2017 Annual Report.](#)