Public Health Modernization in Ontario

Recommendations from the Middlesex-London Board of Health

February 28th, 2020

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Table of Contents

Executive Summary and Recommendations

Public health protects and promotes the health of our communities and provides a high return on investment for keeping Ontarians safe and healthy. The 2019 Ontario Budget Protecting What Matters Most threatened to roll back previous investment and place an increased burden on our already stretched health care sector.

The Middlesex-London Health Unit (MLHU) welcomed the decision to reassess and reconsider these proposed amalgamations and budgetary changes. The challenges identified in the discussion paper released November 2019 are consistent with other local and provincial reviews of public health over the last twenty years.

The 2019 budget announcement rightly highlighted the importance of independent Boards of Health. Autonomy allows such organizations to be hotbeds of innovation in programming and cost control. As the largest autonomous public health agency in Canada, the MLHU has countless concrete examples of how public health can work to serve the needs of our communities in creative and efficient ways. Developed through consultation with the board of health and staff, our recommendations for how to modernize public health are below, followed by a more in-depth elucidation of the related issues.

Public Health Mandate

• The province should retain and strengthen our unique legislative mandate of upstream population health and disease prevention.

• The province should continue to support and enhance the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability as the basis for public health programming.

Public Health Governance and Jurisdictional Size

• The province should support opportunistic and voluntary mergers for health units where there is a need to achieve critical mass in public health human resources and enable surge capacity.

• Where possible, boards should remain autonomous and locally-responsive.

• Boards should include both appointees that are skills-based and municipally elected members, and be representative of the local community.

• The province should ensure representation of urban, rural, and Indigenous communities.

• The province should consider improving or replacing the Public Appointments Secretariat and Order in Council process for provincial representatives.

• Provincial appointments should be offset from municipal elections to avoid wholesale turnover of a Board.

• Provincial support regarding governance bylaw and policy development, as well as board training and capacity building, would be highly beneficial.

Health Unit Leadership Model

• The board of health should be given the authority to determine the most appropriate leadership model.

• Regardless of the leadership model, the Medical Officer of Health must report directly to the board of health.

• The Medical Officer of Health must maintain their autonomy and legislated authority.

• Any attempt to curb independence of the Medical Officer of Health by imposing constraints centrally would be risky for the Ministry, and may require Medical Officers of Health to violate medical and public health ethics.

Local Relationships and Partnerships

• There should be a recognition that relationships require time and energy to be successful.

• Defined and purposeful partnerships are very effective and should be encouraged and supported by the province.

• Reciprocity in the mandate for relationships and partnerships should also be considered.

• Integration and collaboration with the health care system should not come at the expense of relationships with other social services and community agencies.

• The structure and boundaries of public health units can positively or negatively affect relationships with municipalities and other local organizations.

• Supports should be provided by the province to enable effective partnership and collaboration between public health units.

Public Health Programs and Services

All Programs

• For all public health programs, delivery should continue to be at the local level, and the province should support opportunities for better coordination across health units.

• The province should provide clear and actionable strategy, coordinate regional public health unit collaboration, and support local delivery wherever possible.

• Innovation happens at the local level and should be funded, supported, and championed by the province.

• The province should support the robust sharing of information across health units regarding program delivery through appropriate technology and facilitators.

• Policy development should continue to be conducted at the provincial level, and at the local level by health units in order to ensure a fit with local values and environments, and a wide variety of opportunities for innovation.

• Where there is strong consensus across communities on a public health issue, but provincial legislation or policy does not exist, the province should provide leadership.

Foundational Standards

• Communication capacity should be maintained or enhanced at the local level to ensure issues are addressed with consideration of the local culture and media landscape.

• The province should initiate broad communication strategies with topics identified and prioritized in partnership with local health units.

• Population health assessment and surveillance should be maintained or enhanced at the local level to ensure there is adequate and relevant data to inform public health program delivery.

• Local public health units require sufficient population health assessment and surveillance capacity to provide data interpretation beyond analysis.

• The province should actively engage in the development of additional population health assessment data and protocols, with topics identified and prioritized in partnership with local public health units.

• Program planning and evaluation capacity should be maintained or enhanced at the local level to ensure there is sufficient support to plan, monitor, and public health program delivery.

• Research and knowledge exchange capacity should be enhanced at the local level to ensure that research evidence can be translated and applied to public health programs.

Corporate Services

• The province should analyze and provide information related to public health expenditures to assist health units with resource allocation decisions.

• There are considerable opportunities for the province to standardize budgeting processes, practices, and systems across public health units.

• There should be an alignment of strategy between provincial, regional, and local work, with variability for local priorities.

• The province should guide the development of project management standards and support information sharing amongst health units for large scale and strategic projects.

• The province should provide an overarching information technology strategy for local public health units and support regional collaboration.

• The province should provide an overarching human resources strategy for local public health units and support regional collaboration.

• The province should provide partial delivery and coordination of human resources centrally with most service delivery at the local level.

• The province should provide support regarding records retention standards and practices.

Public Health Human Resources

• The province should ensure that health promotion, as well as health protection programs, are adequately funded to meet day-to-day needs as well as incidents that require surge capacity.

• When extraordinary capacity is required, the province should provide readily available funding for staffing, supplies, or other needs.

Role of the Ministry and Public Health Ontario

• The province, through legislation and policy, should ensure that funding for public health is stable, predictable, equitable and adequate for the full delivery of all public health programs to meet local population health needs.

• The province should ensure that boards of health have the autonomy to allocate and manage funds to meet local population health needs.

• When mandating new public health programs, the province should ensure new resources are available.

• The province should develop robust and meaningful performance indicators for all standards that public health units report on annually.

• The Ministry of Health should support a health-in-all policies approach across ministries.

• The Chief Medical Officer of Health must be independent and unconstrained to provide public health advice and guidance to the government and the public.

• Public Health Ontario should continue its strong focus on infectious diseases, while expanding its work in health promotion and chronic disease prevention, which represent a far greater burden of illness and death in Ontario.

• Public Health Ontario should guide the development of planning and evaluation standards and support information sharing amongst health units for planning and evaluation.

• Public Health Ontario, in partnership with the Ministry of Health, should conduct evaluations where programs are being implemented by all public health units with little variability across the province.

• The Ministry should allocate research and knowledge exchange capacity to local priorities.

We submit these recommendations to the Ministry for careful consideration and reflection. We share the goal of modernizing our public health system to better serve the people of Ontario and are committed to any change that will accomplish this. There are considerable opportunities at both the provincial and local level. This submission focuses on the recommendations that we feel can be best addressed by the province.

Full Report

Introduction

Public health protects and promotes the health of our communities. It is most effective when it is locally-provided, regionally-coordinated, and aligned with a clear and evidence-informed provincial strategy. Research has shown that investments in public health reduce demand on health care services. For example, Community-Based HIV Prevention helped prevent 16,672 HIV infections in Ontario between 1987 and 2011 and saved the health care system $6.5 billion (Choi et al., 2016).

In April 2019, the 2019 Ontario Budget Protecting What Matters Most proposed to significantly restructure Ontario's public health system, including the dissolution of its 35 health units and the creation of 10 new regional public health entities. This would have resulted in new boards of health, substantial adjustments to provincial-municipal cost-sharing, as well as a reduction of the overall budget envelope for local public health. These proposed changes threatened Ontario's long history of local public health leadership and may have increased the burden on our already stretched health care sector. While there some health units that could benefit from opportunistic mergers, forced amalgamations were more likely to increase costs and bureaucracy while decreasing responsiveness to local needs.

The Middlesex-London Health Unit (MLHU) welcomed the November 2019 decision to reassess and reconsider these proposed amalgamations and budgetary changes. We applaud the Ministry of Health for identifying the challenges articulated in the Discussion Paper regarding insufficient capacity, misalignment of health, social, and other services, duplication of effort, and inconsistent priority setting. These challenges are consistent with other local and provincial reviews of public health over the last twenty years. The province will find solutions through the careful contemplation of evidence and the hard-earned experience of public health professionals and boards of health. We are grateful to the Ministry for the opportunity to provide feedback during this exciting time of transformation.

As the largest autonomous public health agency in Canada, the MLHU has rich and concrete examples of how public health can work to serve the needs of our communities. We can also demonstrate our track record of accountability to the public, and the delivery of innovative and responsive solutions to ever-evolving population health challenges. These hard-earned insights come from decades of front-line service to our community. In preparation for the written and in-person responses to the Discussion Paper, we sought input and advice from staff, management, and the board of health. Extensive consultations through January 2020 identified key areas for consideration during the modernization process. These key areas are:

- Public Health Mandate
- Board of Health Governance
- Jurisdictional Size
- Health Unit Leadership Structure
- The Role of Public Health Ontario and the Ministry
- Local Relationships and Partnership
- Public Health Human Resources
- Program and Service Delivery

MLHU recognizes the Indigenous peoples that have cared for this land since the beginning, and applauds the Ministry of Health for ensuring that the modernization process includes specific consultation with Indigenous nations and organizations.

In the following pages, we provide specific recommendations from each of these critical areas that we believe will address the challenges. The evidence and experience presented by MLHU in this submission are not uniquely insightful; the parallels with previous reports on public health reform are evident. The value of a high-performing public health system and the importance of keeping Ontarians safe and healthy may be most evident during a crisis such as the threat of the novel coronavirus 2019. However, infectious disease emergencies such as Walkerton or SARS should not be the only triggers for a collective realization of the importance of a sufficiently supported public health system. Beyond disease prevention and control, public health has proven and cost-effective programs and interventions to help reduce demand on the primary, acute, and long-term care in Ontario and alleviate the challenge of *Hallway Medicine*.

Choi, S. K., Holtgrave, D. R., Bacon, J., Kennedy, R., Lush, J., McGee, F., Tomlinson, G. A., & Rourke, S. B. (2016). Economic Evaluation of Community-Based HIV Prevention Programs in Ontario: Evidence of Effectiveness in Reducing HIV Infections and Health Care Costs. AIDS and behavior, 20(6), 1143–1156. https://doi.org/10.1007/s10461-015-1109-8

Public Health Mandate

The priorities of public health are continuously shifting and evolving. Infectious and communicable diseases, chronic diseases, mental health, substance use, and demographic trends all present challenges to which we must be ready to respond.

The Health Protection and Promotion Act (HPPA) is the principal enabling and operating statute for boards of health. Boards of health must provide or ensure the provision of a minimum level of public health programs and services in the areas identified by the Ontario Public Health Standards.

The province should retain and strengthen our unique legislative mandate of upstream population health and disease prevention. We keep people healthy, prevent disease, and reduce health inequities long before people end up in primary, acute, and long-term care. We collaborate with and complement social services and other health care services by understanding our community health needs and priorities and understanding with gaps in service and inequities in health exist. This focus stands in contrast to those of health care, which focuses downstream on the need of individual patients and not entire populations.

The province should continue to support and enhance the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability as the basis for public health programming. The Standards are a critical document that guides the work of public health units and provides direction on how to deliver on our mandate. Significant changes to the standards and its population health focus required and benefit from fulsome consultation with local and front-line public health.

Board of Health Governance and Jurisdictional Size

The Middlesex-London Health Unit (MLHU) is the largest autonomous health unit in Canada, serving a population of over 450,000 people in a mixed rural-urban geography of 3300 square kilometres. This structure and geography is a unique position from which to provide feedback to the province during this modernization process. MLHU is in the sweet spot for jurisdictional size. Research has found that a larger jurisdiction size, up to a maximum of 500,000 people, was a positive predictor of performance (Mays et al., 2006).

T**he province should support opportunistic and voluntary mergers for health units where there is a need to achieve critical mass in public health human resources and enable surge capacity.** Merging health units to serve larger populations and geographies will make it difficult to understand the communities that are served and to adjust programs and interventions to meet local needs. The geographic size and people served by any future health unit should seek to optimize the competing demands of efficiencies of scale with the need to remain responsive to the specific needs of communities.

Transformative Innovation: Expanding Regional Cooperation

Effective regional partnering processes must be replicated in new areas. Currently, Tobacco Control Area Networks (TCANs) ensure that all public health units provide consistent, high-quality tobacco programming. Key ingredients are a modest amount of human resources, and an oversight process that includes input from all health units in a given region. This approach would have great benefits if expanded to other areas, such as falls prevention, school health, and promotion of healthy eating and physical activity.

Where possible, boards should remain autonomous and locally-responsive as there are risks to being integrated within local governments. Research in Ontario has shown that independent health units behave more in alignment with provincial expectations than those integrated within municipalities (Lyons, 2016). Additionally, autonomous governance ensures that a trusted, accountable, and independent public health voice is present in a community.

Boards should include appointees that are both skills-based and municipally elected members, and be representative of the local community. Representatives should be from the local community and appointed by the province and municipalities with consideration of skills and the diversity of the population the board serves.

The province should ensure representation of urban, rural, and Indigenous communities on Boards. The Middlesex-London Board of Health feels that the current

Mays, G. P., McHugh, M. C., Shim, K., Perry, N., Lenaway, D., Halverson, P. K., & Moonesinghe, R. (2006). Institutional and economic determinants of public health system performance. American journal of public health, 96(3), 523–531. https://doi.org/10.2105/AJPH.2005.064253

mix of five provincial appointees, three City of London appointees, and three Middlesex County appointees has adequately balanced the voices of the residents that the board serves. Any future state must consider the representation of Indigenous communities on the board.

The province should consider improving or replacing the Public Appointments Secretariat and Order in Council process for provincial representatives. There have been considerable challenges in the past with the prompt recruitment of appointees. Steps should also be taken to enhance the transparency, independence of appointments, and the promotion of vacancies to attract suitable candidates.

Provincial appointments should not be offset from municipal elections to avoid wholesale turnover of a Board. There can be substantial board turnover because of municipal elections. Having provincially appointed members provide continuity of board functioning is highly beneficial.

Provincial support regarding governance bylaw and policy development, as well as board training and capacity building, would be highly beneficial. There is considerable opportunity to reduce duplication of effort that occurs with boards of health when they individually develop bylaws and policies. Additionally, standardized training would enhance board governance and reduce the burden of that training on public health unit staff.

Health Unit Leadership Model

There is considerable variability across Ontario in how public health units establish their leadership model and report to the board of health. Some have Medical Officers of Health as the Chief Administrator while others do not. MLHU has always had a harmonized MOH/CEO position, and the Middlesex-London Board of Health values this unified leadership model for this agency. The Health Unit also values the role of the Chief Nursing Officer as a senior leader in the organization.

The board of health should be given the authority to determine the most appropriate leadership model. This model should be considerate of the size and complexity of the organization.

Regardless of the leadership model, the Medical Officer of Health must report directly to the board of health. This reporting relationship ensures that the board has direct access to public health expertise and holds the Medical Officer of Health accountable as an employee of the board.

The Medical Officer of Health must maintain their autonomy and legislated authority. This autonomy and legislative authority are critical for Medical Officer of Health to best advocate for the community health needs and priorities and to have a platform and public voice when communicating issues of public health importance.

Lyons J. (2016). The Independence of Ontario's Public Health Units: Does Governing Structure Matter?. Healthcare policy, 12(1), 71–83.

Any attempt to curb independence of the Medical Officer of Health by imposing constraints centrally would be risky for the Ministry, and may require Medical Officers of Health to violate medical and public health ethics.

Local Relationships and Partnerships

The Discussion Paper focuses on strengthening relationships with primary care and the health care system. In addition to this admirable goal, it is critically important for public health to maintain and strengthen its relationships with the other services that influence the social determinants of health, such as housing, education, and regional planning. Furthermore, to effectively address health equity, public health must be empowered to build relationships with communities that are not necessarily represented in formal structures or organizations. These relationships are paramount and essential to achieve public health's unique upstream population health and disease prevention mandate.

There should be a recognition that relationships require time and energy to be successful. It has taken years of deliberate action by health units to establish strong local relationships and partnerships. Amalgamations have the potential to negatively disrupt these relationships and partnerships, and they will not be easily rebuilt.

Defined and purposeful partnerships are very effective and should be encouraged and supported by the province. Examples of these defined partnerships in Middlesex-London include the HIV Leadership Table that includes representation across the health and social services sector working in collaboration to address HIV, as well as a partnership like the dental clinic being offered in health unit space by the Southwest Aboriginal Health Access Centre.

Reciprocity in the mandate for relationships and partnerships should also be considered. For example, in the Ontario Public Health Standards, public health units are mandated to collaborate with school boards. However, there is no reciprocal mandate that requires school boards to work with public health units. This gap can present challenges in delivering public health programs and interventions that rely on schools for successful implementation. Other scenarios include the lack of mandated data sharing between local emergency medical services, police, and hospitals.

Transformative Innovation: Partnering with Primary Care

MLHU uses an academic detailing approach to partner with primary care providers. A public health nurse visits each clinic to speak directly with clinicians in their environment on their terms about how we can work together on prevention and health promotion. Uptake is excellent, and strong relationships are leveraged in times of crisis such as the current Coronavirus outbreak.

Integration and collaboration with the health care system should not come at the expense of relationships with other social services and community agencies. Public health acts as a nexus between the health care system and broader community, focusing attention on needs that have been identified through population health assessments and community engagement.

The structure and boundaries of public health units can positively or negatively affect relationships with municipalities and other local organizations. These boundaries should be considerate of the range of stakeholders and partners with the understanding that larger health units (in both size and population) will have more difficulty cultivating these relationships.

Supports should be provided by the province to enable effective partnership and collaboration between public health units. One example that has been praised is the Tobacco Control Area Network (TCAN) structure. This initiative has a provincial strategy, regional coordination, and local public health service delivery, which is very useful in reducing duplication of effort.

Other examples of exceptional partnerships include:

- Active and Safe Routes to School
- Nurse-Family Partnership Advisory Committee
- Health Care Provider Outreach
- Child and Youth Network
- HIV Outreach
- Community Drug and Alcohol Strategy
- Temporary Overdose Prevention Site
- Hospital Screening and the Healthy Babies Healthy Children Program
- Municipalities
    - o Mayors Poverty Panel
    - o Newcomer Settlement
    - o Road Safety

Public Health Program and Service Delivery

At MLHU, we continuously strive for program and service delivery excellence by optimizing evidence-informed planning and evaluation, fostering strategic integration and collaboration, and addressing the social determinants of health. We do this to maximize the value and impact of our resources and to ensure our residents receive the programs and services that best meet community health needs.

All Programs

For all public health programs, delivery should continue to be at the local level, and the province should support opportunities for better coordination across health units. There are no local public health programs that could be delivered more effectively at the provincial level. However, these programs could be enhanced through provincial coordination and support.

The province should provide clear and actionable strategy, coordinate regional public health unit collaboration, and support local delivery wherever possible. A helpful model of coordinated programming and integration is the Smoke-Free Ontario Strategy wherein regional tobacco control area networks support local service delivery. This allows for local variability and innovation with information sharing enabled through a formal network and coordination. Another example is the Shared Library Services Partnership, which provides research and knowledge exchange capacity to health units that do not have those resources in-house.

Innovation happens at the local level and should be funded, supported, and championed by the province. There are thousands of variations in programs being delivered across the province that act as natural experiments. The province should have a fulsome understanding of this variability in program delivery, promote the sharing of information, and assist with scaling up effective interventions across health units.

The province should support the robust sharing of information across health units regarding program delivery through appropriate technology and facilitators. An profound amount of time is spent by Ontario public health units trying to learn and apply best practices to their local jurisdiction. Current information sharing is done in an ad hoc way. It is often dependent on professional associations and other workgroups who should be focusing on professional development rather than gathering provincial data.

Policy development should continue to be conducted at the provincial level, and at the local level by health units in order to ensure a fit with local values and environments, and a wide variety of opportunities for innovation. Often, local priorities and policies drive more substantive and expansive policy efforts – indoor smoking bans being one such example. Municipalities should continue to provide leadership on healthy public policy that can then be scaled up to the provincial policy arena.

Where there is strong consensus across communities on a public health issue, but provincial legislation or policy does not exist, the province should provide leadership. For issues such as water fluoridation or vaccine hesitancy, it is inefficient for each health unit to engage in policy discussions. In these cases, the province could provide leadership through enacting province-wide legislation.

Foundational Standards

Communications

Communication capacity should be maintained or enhanced at the local level to ensure issues are addressed with consideration of the local culture and media landscape. Often, the provincial standardization of communications can come at the expense of local appropriateness. The more locally relevant public health communications are, the more effective those messages will be.

The province should initiate broad communication strategies with topics identified and prioritized in partnership with local health units. There are cost-saving opportunities that are available through bulk media buys and the development of communications material. These initiatives should intersect with and complement local communication strategies.

Population Health Assessment and Surveillance

Population health assessment and surveillance should be maintained or enhanced at the local level to ensure there is adequate and relevant data to inform public health program delivery. Localized and real-time data

most effectively guides local public health action. This data requires relationships and data sharing agreements with organizations such as local police, emergency medical services, and hospitals.

Local public health units require sufficient population health assessment and surveillance capacity to provide data interpretation beyond analysis. Due to capacity constraints and the lack of appropriate local data from the province, most population health assessment, and surveillance capacity is taken up with analysis and reporting. Additional capacity for data interpretation will ensure that public health action is reflective of population health outcomes.

The province should actively engage in the development of additional population health assessment data and protocols, with topics identified and prioritized in partnership with local public health units. For example, there is a shortage of information on public attitudes, perceptions, and behaviours, particularly relating to opioids, vaping, and vaccine hesitancy. These gaps in data limit public health effectiveness.

Program Planning and Evaluation

Program planning and evaluation capacity should be maintained or enhanced at the local level to ensure there is sufficient support to plan, monitor, and public health program delivery. There are considerable capacity constraints that limit robust program planning, implementation, and evaluation. This capacity should be enhanced at the local level to improve programs that are being delivered with variability from health unit to health unit.

Research and Knowledge Exchange

Research and knowledge exchange capacity should be enhanced at the local level to ensure that research evidence can be translated and applied to public health programs. This translation to practice requires access to research literature, library professionals, and capacity beyond front-line service delivery to support this work.

Corporate Services
Finance

The province should analyze and provide information related to public health expenditures to assist health units with resource allocation decisions. There are considerable reporting requirements for public health units such as the Annual Service Plan and Standards Activity Reports that are submitted to the province with little or no further follow-up. This data is invaluable to enhance the management of public health units that should be analyzed, followed-up on, and shared.

There are considerable opportunities for the province to standardize budgeting processes, practices, and systems across public health units. Examples that are ripe for standardization include procurement, payroll system, variance reporting and analysis, Program Budgeting and Marginal Analysis, and the establishment of a uniform chart of accounts. Standardization would improve health unit interoperability and reduce the duplication in identifying needs, selecting and implementing processes, practices, and systems.

Transformative Innovation:
Budgeting for Maximum Impact

Since 2013, MLHU has used a budget reallocation process to shift resources out of lower impact areas into high impact areas. Using criteria linked to the Ontario Public Health Standards, disinvestment and investment proposals are scored, with the best ones moving forward. This has freed up over $7 million of resources for re-investment into high priority work.

Strategic Planning and Projects

There should be an alignment of strategy between, provincial, regional, and local work, with variability for local priorities. The province should articulate a clear public health system strategy on a regular basis to drive improvements across all public health programs. This approach for public health priority setting should not be top-down or bottom-up; instead, it should be reflective of the diverse needs at each level. This alignment requires strategic planning capacity at all levels.

The province should guide the development of project management standards and support information sharing amongst health units for large scale and strategic projects. Examples of this would include the provisions of standards, guides, tools, and templates to establish consistent practices across the province or through the development of an online repository where project plans and status updates could be shared.

Information Technology

The province should provide an overarching information technology strategy for local public health units and support regional collaboration. Regional collaboration could include joint strategy and management of services as well as the procurement of infrastructure, hardware, and software. End-user support will always be required at the local level.

Human Resources

The province should provide an overarching human resources strategy for local public health units and support regional collaboration. The provincial strategy should ensure that there is a pipeline of trained and competent staff that is being developed in post-secondary education, preceptorships, residencies, and fellowships, as well as local and regional strategies to address specific local needs. This strategy should be done in collaboration with public health professional associations.

The province should provide partial delivery and coordination of human resources centrally with most service delivery at the local level. Some of the aspects of human resources that could benefit from province leadership include collective bargaining, job descriptions, core competencies, job advertising, administrative policy development, provincially-legislated training, vulnerable sector screening, and employee performance management systems. Aspects that require local delivery include employee relations, recruitment, and occupational health and safety.

Privacy and Records

The province should provide support regarding records retention standards and practices. Currently, each health unit develops and implements a records management strategy to meet the same legislative requirements. Duplication of work could be avoided through the development of standardized policies and practices.

Technology

The province should conduct regular audits and inventories, and support information sharing for technologies that are employed for public health program delivery. This information could help to establish consistent technology usage and practice across the province.

The province should provide standardized information technology solutions to public health units were similar needs are identified. This standardization would enhance health unit collaboration, interoperability, and create significant efficiencies from a procurement, training, and implementation perspective. Examples that could benefit from this approach include electronic client records, inspection reporting (like hedgehog), iPHIS, emergency messaging services, human resource and financial information systems, website platforms, and online community of practice portals.

The province should support pilot testing of solutions at the local level to scale up systems into common province-wide platforms whenever possible. This pilot testing would allow for innovation and the development of new practices that complement existing provincial infrastructure.

Processes

The province should provide leadership and coordination of public health medical directives to ensure consistency and interoperability across public health units. Medical directives that enable the work of public health staff under the direction of the Medical Officer of Health are specific to the jurisdiction in which they are employed. There is considerable variability in medical directives across health units, and this results in duplication of effort as well as challenges in responding to cross-jurisdictional public health issues. The province could provide support by standardizing common medical directives, providing practice guidelines or protocols, or by enabling public health units to more readily share their practices.

Public Health Human Resources

The staffing of public health professionals accounts for approximately 80 percent of public health expenditures in Ontario. Any reduction in funding would have a considerable negative impact on addressing the challenges that were identified in the Discussion Paper relating to lack of critical mass and surge capacity. Given the breadth of the Ontario Public Health Standards and the unquenchable need for public health programs, there will always be capacity constraints.

The province should ensure that health promotion, as well as health protection programs, are adequately funded to meet day-to-day needs as well as incidents that require surge capacity. The work of health protection and health promotion are highly complementary within health units. Staff who work in upstream health promotion programs can provide surge capacity in the event of a public health emergency. While necessary for the long-term health of the population, health promotion activities can be suspended for a short period of time during public health emergencies to provide much-needed surge capacity.

When extraordinary capacity is required, the province should provide readily available funding for staffing, supplies, or other needs. With the emergence of several acute and ongoing public health challenges, health units have had to rapidly deploy resources from other programs with more upstream focus to address these crises. However, given the sustaining nature of these crises, over time this has led to a shift from programs focused on chronic public health issues to those that are more acute. Additional provincial resources are necessary to sustain ongoing upstream work that will, in time, decrease these acute population health challenges.

Role of the Ministry and Public Health Ontario

The Ministry of Health and Public Health Ontario will play critical roles in addressing the challenges identified in the Discussion Paper. Local public health units have attempted, individually and collectively, to address insufficient capacity, misalignment of health and social services, duplication of efforts, and inconsistency. The work of the COMOH ISPA Working Group to standardize the interpretation of grace periods is an example of this type of collaboration. However, local public health units are often not ideally positioned to coordinate or address issues of provincial standardization; this is the role of provincial authorities. Provincial leadership is critical in supporting local public health in being more efficient, effective, and innovative.

The province, through legislation and policy, should ensure that funding for public health is stable, predictable, equitable and adequate for the full delivery of all public health programs to meet local population health needs. Public health funding provides an excellent return on investment compared to dollars and reduces demand on primary and acute care in Ontario.

The province should ensure that boards of health have the autonomy to allocate and manage funds to meet local population health needs. Recent funding announcements have often been earmarked for specific public health programming or needs with little increase to the cost-shared component of the budget. It is important to ensure that boards of health retain their autonomy to set and manage their resources as they are most attuned to local need. This autonomy includes the ability to establish and hold reserves, as well as carry-over budget surplus from year-to-year with appropriate financial controls.

When mandating new public health programs, the province should ensure new resources are available. The need for existing programming does not diminish when new public health issues arise, but public health units are often asked to do more with the same or less funding. New mandates without new resources position local public health for failure in achieving the desired objectives.

The province should develop robust and meaningful performance indicators for all standards that public health units report on annually. There is considerable variation and duplication of effort in developing performance indicators for each standard. This reporting process should facilitate improvements at the program level through the provision of feedback from the province, and information sharing across health units about what is working well.

The Ministry of Health should support a health-in-all policies approach across ministries. Given the importance of the social determinants of health, the Ministry of Health should not be the only Ministry that affects change in population health. There should be mechanisms for shared priority setting and policy across all levels of government.

The Chief Medical Officer of Health must be independent and unconstrained to provide public health advice and guidance to the government and the public. The primary objective of the CMOH is to protect and promote the health of Ontarians. This advice and guidance will often, but may not always, align with the agenda of the government of the day. Previous provincial reports have provided guidance on mechanisms and structures that would ensure the autonomy of the CMOH. These recommendations should be implemented. Additionally, to support the work of the CMOH, additional deputy CMOH positions should be filled.

Public health units should help to set the priorities of Public Health Ontario to ensure that the expertise and support being provided is meeting local public health needs and overarching provincial priorities. Public Health Ontario is a critical and essential resource. Their expertise is essential for Ontario's public health system to achieve its world-class, high-quality aspirations. There should be a willingness for the province to engage and hear from public health units to inform government action and ensure that Public Health Ontario is meeting the needs of public health units.

When appropriate, Public Health Ontario should be enabled and empowered to provide definitive guidance on the evidence for healthy public policy and public health practice. Public Health Ontario's mandate clearly limits its role in setting policy; this is the job of the Ministry. However, where the evidence exists, Public Health Ontario should provide fulsome and conclusive health public policy analyses. This is a gap in the current services provided by Public Health Ontario that has been filled by local public health units with relatively limited capacity. It is also an explanation for some of the observed duplication across the province.

Each standard in the Ontario Public Health Standards should have a provincial strategy that is supported by technical expertise at the Ministry of Health and Public Health Ontario. Examples of this include the Scientific Advisory Committee Reports (led by PHO), which compiled interventions and provided evidence from white and grey literature for Tobacco Control. This information is invaluable for helping to guide local action.

Public Health Ontario should continue its strong focus on infectious diseases, while expanding its work in health promotion and chronic disease prevention, which represent a far greater burden of illness and death in Ontario.

Public Health Ontario should guide the development of planning and evaluation standards and support information sharing amongst health units for planning and evaluation. Examples of this would include the provisions of standards, guides, tools, and templates to establish consistent practices across the province or through the development of an online repository where program plans, monitoring plans, or evaluations could be shared.

Public Health Ontario, in partnership with the Ministry of Health, should conduct evaluations where programs are being implemented by all public health units with little variability across the province. An example of this would be the Low-Income Seniors Dental Program. Where there is local variability in program delivery, evaluations should be conducted locally and shared provincially.

Ministry should allocate research and knowledge exchange capacity to local priorities. Amongst health units, there is periodically duplication of work like literature and evidence reviews or jurisdictional scans. Some of this duplication is necessary and reflects variation in local needs and realities. Some could be avoided through provincial leadership and investment in answering questions that are relevant to local public health practices. Additionally, the coordination and support of local research activities could be much more effective with provincial leadership. The establishment of the Public Health Ontario Ethics Review Board is one such example that has been highly beneficial.

Conclusion

The Middlesex-London Health Unit shares the goal of creating a modernized and resilient public health system that supports the health and well-being of all people in Ontario. The recommendations detailed in this submission reflect the lessons learned across MLHU's long history and the shared experience and expertise of our board and public health professionals.

There is an opportunity to address challenges that have continued to be present in public health since the early 2000's at both the provincial and the local level. This submission focuses on the recommendations that we feel the province is best situated to provide leadership on, but the feedback we collected will also be used to inform local action.

We eagerly await the findings of Mr. Pine, Ms. Blair, and Dr. Williams in the spring of 2020 and look forward to actively engaging with the implementation efforts of the Ministry.

BUREAU DE SANTÉ DE
MIDDLESEX-LONDON
HEALTH UNIT

www.healthunit.com