BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Briefing Note: Strategic Prioritization for the Middlesex-London Health Unit

September 2023

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The Problem

The Middlesex-London Health Unit is facing significant budget pressures in 2024 and will no longer be able to sustain its current or historic levels of service.

These pressures are the result of the following:

- *Enduring structural deficit*
    - The expenses of the agency, despite significant efforts to find efficiencies, continue to rise. This is the result of population growth which has increased the demand for health unit services, and inflation which has resulted in increased salaries and corporate expenses.
    - Despite the rise of expenses, funding has not kept pace.
        - In 2011, the population of the Middlesex-London region was 436,947 people, and the cost-shared budget was $25,313,964. This represents a per-capita funding rate of $57.93 per Middlesex-London resident.
        - By 2021, if funding had increased to account for inflation and population growth, per-capita funding would have increased to $68.37 per Middlesex-London resident. Given the increase in population to 500,434 people, the 2021 cost-shared budget would have been $34,214,673.
        - Instead, the budget had risen only to $27,824,702, representing a significant decline in per-capita funding to $55.60 per Middlesex-London resident.
    - This represents a structural deficit of $6,389,971 in 2021. This deficit will have worsened by 2023, given the ongoing rise in both inflation and population, with minimal increases to the base budget.
    - For 2024, given negotiated contracts with unionized employees, health unit policy of wage parity for non-union staff, and continued corporate inflation, the specific inflationary pressures account for ~$800,000.
- *Discontinuation of COVID-19 associated funding despite the continuation of COVID-19 associated work*
    - The COVID-19 virus is here to stay, and although the magnitude of the response is not nearly as substantial as it was from 2020 to 2023, the agency must continue to provide enhanced outbreak management, infection prevention and control support, and immunization support. Except for IPAC Hub funding, the extraordinary funding that had been temporarily provided to fund these services will cease at the end of 2023, requiring the agency to fund this work from the pre-existing cost-shared base budget.

    - Investments are specifically required for the Infectious Disease Control, Vaccine Preventable Disease and Healthy Organization teams in order to ensure a robust and sustained response to COVID-19.
    - For 2024, this accounts for a pressure of ~$1,160,00.
- *Reduction in the budgeted gap*
    - The budget gap is a mechanism that anticipates vacancies and underspending of program funds throughout the year and allows for the redistribution of funds across the agency. Through the pandemic, the gap was higher to account for an increased number of staff and significant challenges in the recruitment and retention of temporary staff.
    - Moving forward to 2024, the gap must be reduced to account for both a reduction in staff and a reduced vacancy rate, accounting for a pressure of ~$540,000.
- *Budget adjustments*
    - Through a zero-based budgeting exercise and examination of the budget, staff have identified the need to adjust the budget. Specifically, funding for the IPAC Hub had to be correctly accounted for, and staffing costs were realigned to the correct MLHU company, accounting for a pressure of ~$800,000.

In total, these pressures account for an approximately $3,240,000 shortfall if additional revenue or funding is not identified.

The following assumptions have been considered regarding funding for 2024:

- Increase in municipal contributions by 3%
- Increase in provincial contribution by 1%

Given these assumptions, the anticipated shortfall shifts to approximately $2,600,000 to $2,800,000.

This remains a substantial shortfall, representing approximately 10% of the cost-shared base budget. Historically, the agency has engaged in Program Budget Marginal Analysis (PBMA), a process by which teams identified efficiencies and opportunities for marginal disinvestments. Additionally, a zero-based review of General Expenses yielded significant savings in 2023. The PBMA approach will no longer be impactful, and there is unlikely any further efficiencies to be found via zero-based budgeting. Therefore, the agency must identify strategic areas for disinvestments, as opposed to marginal disinvestments, in order to balance the budget. This will notably impact service delivery, with labour relations consequences and potential changes to the structure of the agency.

Goals and Objectives

The goals of this project are to:

- Assess and define the current work of the agency;
- Utilizing well-articulated principles, prioritize the work of the agency to determine areas for strategic disinvestment;

- Ensure that the remaining interventions are sufficiently resourced;
- And restructure the organization as appropriate.

Principles for Prioritization

As we make thoughtful decisions about prioritization, we commit to the following:

- We will focus on the core work of local public health.
- The work that we do must be definable and clearly articulated.
- The work must have an impact on our community.
- We will consolidate our resources to that core work to ensure that we 'do what we do well.'
- Insomuch as the work fits within the core work of local public health, we will adjust our work to meet the gaps, needs, and expectations of our funders and community.

Understanding core work of a local public health agency

Public health has nearly an infinite scope. Given the impact of our social, economic, and physical environments on health (i.e. the social and structural determinants of health), everything can rightly be considered a 'public health issue'.

However, the role of a local public health agency in addressing a 'public health issue' is highly differential. The work of local public health agencies, like the Middlesex-London Health Unit, is scoped by their expertise, their mandate, and their resources. For some issues, the local public health agency is well positioned to take the lead (ex. outbreak management); for others, the agency may be a key contributor (ex. early childhood development) , and for others, perhaps only a resource (ex. housing and homelessness, climate change).

At the local level, public health action:

- Protects and promotes the health of the community;
- Is grounded in a population health approach with a population-level impact on health;
- Is unified by its focus on prevention, upstream interventions, and societal factors that influence health. In other words, public health aims to prevent people from getting sick in the first place and is focused on primordial and primary prevention; and
- Is equity oriented.

The work of public health is different and distinct from the work of primary care and the health care system. As public health, we generally want our work to be focused at the community and population-level. However, public health interventions can still occur at the individual level, and public health work and primary care work can overlap.

Public health's one-to-one, individual-oriented interventions must be a component of a population-wide or priority-population focused program. They must be scalable (within resources) to have a population-level impact. They should have an impact beyond the individual receiving the intervention, meaning that in addition to 'treating a client or patient' for their own

health, the goal of our intervention is to also improve the health of those around the client, and therefore, the broader community and population.

Defining our work

Public health work is active and must be clearly articulated with explicitly defined goals and objectives. If we are not able to clearly explain aspects of our work, even if it is complicated, then we can no longer afford to prioritize resources for that intervention.

Public health interventions focus on the work that we do for the community. They are intentional, action-oriented, outward facing, and for the community. For the Middlesex-London Health Unit, our common intervention types are:

- Communication and Social Marketing
- Education and Skill Building
- Healthy Public Policy Development
- Community and Partner Mobilization
- Surveillance
- Inspections
- Investigations
- Case, Contact, and Outbreak Management
- Clinical Services Delivery
- Health Resource Inventory Management
- Vector Control

Making an impact - consolidating our resources and doing our work well

There is little point in doing the work of local public health if we do not do it well. Stretching our limited resources too thinly compromises public trust in our work, minimizes our collective impact, and pushes staff to burnout and frustration. To do our work well, our interventions must have sufficient resources allocated to them to enable the appropriate dose and intensity to generate reasonable impact; in other words, we're either in the game or we're out of the game. As much as we can, we must avoid having one leg on the bench and one leg on the ice. Given the limited resources we have, we must consolidate our resources in prioritized areas, which means displacing resources in other areas. And this means that we must stop doing things we've been doing previously, even if some of those things could make a difference in our community.

Building on our understanding of the core work of local public health, we have previously stratified the work of the health unit into broad categories of legacy work, aspirational work, essential work, and critical work.

- **Critical work** is our truly mandatory work. It is work that is clearly defined within the *Health Protection and Promotion Act* and the Ontario Public Health Standards and aligns with our core understanding of local public health agency work. It is also work that is part of our critical business infrastructure. This is our 'keep the lights on' work that continues through the winter closure or redeployments.

- **Essential work** is the work that fundamentally aligns with our core understanding of the work of a local public health agency and is largely defined or referred to within the *Health Protection and Promotion Act* and the Ontario Public Health Standards. This work fits within our organizational strategy.
- **Aspirational work** is the work that may fit a community need but doesn't necessarily align with our core understanding of 'public health work'; it might be novel or new work that we would explore if we had additional resources.
- **Legacy work** is the work that we've been doing for a long-time that no longer fits within the mandate of a health unit, nor does the community need for us to do the work.

As of 2023, the MLHU is no longer doing work that fits in the aspirational or legacy categories; all that remains can be captured in the critical and essential categories.

The need to prioritize work within the critical and essential categories highlights the tight fiscal reality currently faced by the MLHU. To balance the budget, we will no longer be able to fulsomely fulfill the spirit of the Ontario Public Health Standards.

As we attempt to prioritize this critical and essential work, we recognize that local public health agencies build our credibility and political capital by responding effectively to acute and emerging risks. This credibility positions us to work further 'upstream' and advance solutions that can address more distant and long-term health outcomes.

Meeting the gaps, needs, and expectations of our funders and community
Sometimes, local public health agencies need to provide interventions or programs that fill a gap in the community. This can be an important role that we play. However, when we fill these gaps, the interventions still must generally fit within the core understanding of our work; filling gaps in the community do not, in isolation, justify an intervention.

The Provincial government has generally indicated that the priorities of local public health agencies should include immunization, emergency preparedness (for both communicable diseases and health hazards), health system integration, substance use, and child development.

Methodology for Prioritization

To balance the budget and realize the necessary budget savings for 2024, significant strategic prioritization is necessary.

Historically, the MLHU has utilized the Program-Based Marginal Analysis (PBMA) process to find efficiencies in the organization. This process relies on staff and manager-driven solutions and proposals, which are fed up to senior leaders for decision making. It is relatively inclusive and democratic and can, as the name suggests, redistribute marginal resources throughout the organization to maximize impact. However, it has proven relatively ineffectual in the face of significant budget shortfalls as it does not empower large strategic decisions. It can result in spreading resources too thin across the organization, rather than making the hard decisions to stop doing something in order to do something else well.

For the strategic prioritization that is necessary at this time, staff and middle management are poorly positioned to provide significant proposals for disinvestments, given the inherent and understandable passion most have for their work, and the inherent conflicts of interest associated with their own positions within the organization. A PBMA-style process would be fundamentally unable to deliver solutions, and furthermore, would compromise the morale of the organization.

Instead, strategic recommendations will be developed by the Medical Officer of Health and Chief Executive Officer for consideration by the Board of Health. The strategic prioritization and, if necessary, restructuring process will consist of **Assessment and Planning**, **Implementation**, and **Evaluation and Optimization**.

Assessment and Planning

1. *Assessment of the work of the Middlesex-London Health Unit and local public health in Ontario*

Since the beginning of 2022, substantial efforts have been taken to review and assess the work of the agency, including:

- The development of a 2023-2024 Provisional Plan.
- The documentation of all the interventions of the agency, and preliminary descriptions of the work that is performed.
- The development of common ways to describe the work of the agency.
- Meetings of the MOH and the CEO with every manager to review the compositions of each team and the daily and weekly activities of the team.

Work is also underway to review how other public health agencies in Ontario and beyond deliver public health services, including:

- Comprehensive environmental scan of Ontario public health units and their priorities and organizational structures.
- Literature review of the effectiveness of health promotion interventions.
- Consultation with provincial partners regarding priorities.

Lastly, prioritization principles have been developed, as described previously, that will inform the determination of priorities of the agency. These principles align with the goals and direction of the 2023-2024 Provisional Plan.

2. *Prioritization of the work of the Agency*

Using the principles for prioritization and knowledge of the work of the agency, the Medical Officer of Health will develop a draft proposal for prioritized and de-prioritized programs/topics, settings, and/or interventions. This proposal will be presented to the CEO and the Senior Leadership Team for feedback.

The MOH and CEO will make the final decision regarding the recommendations of prioritized programs and interventions to the Board of Health. The priorities will be presented to the Board for approval.

3. Redistribution of resources and development of a new organizational structure

Form should follow function, and therefore the prioritized work will inform the organizational structure of the agency. Upon approval of the priorities by the Board, the MOH and CEO will develop a draft organizational structure, including the distribution of staff and leadership to specific teams and interventions. For areas of the organization in which work has been deprioritized, this process will include a comprehensive assessment of the model of service delivery, and the specific allocation of resources to align with assigned activities. This will be specifically supported by the AMOH, the Director, Public Health Foundations, and other members of the Senior Leadership Team, as appropriate.

Utilizing a zero-based budgeting process, the cost of the draft organizational structure will be determined with the support of the Associate Director, Finance. The anticipated budget will be compared to the estimated funding of the agency, and necessary modifications and additional prioritization will be made.

The draft organizational structure and model will then be confidentially reviewed with select external consultants and experts, before confidential feedback is solicited from the Senior Leadership Team.

Labour relations impacts will be assessed by the CEO and the Manager, Human Resources, with legal consultation. Impacted staff and the costs of severance fees will be determined. Every effort will be made to minimize impact to staff, including exploring the feasibility of retirement incentives with each union group.

The final draft, including labour relations impacts, will then be presented to the Board of Health for review and approval.

4. Development of the implementation and evaluation plan

Following Board of Health approval, an implementation and evaluation plan will be developed. External consultation will be considered for support. This will include a comprehensive communications and employee support strategy.

Implementation

The new organizational structure will be implemented in early 2024, following the implementation plan. Management will be informed shortly before the broad roll-out to staff; this will ensure that leadership is in place to support staff at the time of the announcement. There will be minimal time between the announcement of the new organizational structure and the date of time in which the new structure comes into effect.

Evaluation and Optimization

The effectiveness of the new structure will be evaluated through the organizational performance management system throughout 2024 and early 2025. The intersection of this evaluation with the strategic planning process of the organization will need to be considered.

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Conclusion

The 2024 budget pressures provide an opportunity for the Middlesex-London Health Unit to evaluate its work and prioritize its resources. The principles and process outlined in this report will ensure that the agency continues to meet its mission to protect and promote the health of the residents of Middlesex-London.