MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 117-12

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2012 October 18

2013 BUDGET – "PROTECTING THE GAINS"

Recommendation

It is recommended that the Board of Health determine the approach it wishes to take in regards to the development of the 2013 Cost-shared Programs budget.

This report provides information to assist the Board in considering the impact of the budget shortfall created when applying a 2% increase in provincial grants with a 0% increase in municipal revenue for the Cost-shared Programs budget. It also highlights several concerns and challenges going forward in an environment where the Health Unit can no longer rely on adequate provincial increases to maintain programs and services.

What Is Known

Over the past six months, the Board of Health has received a number of reports regarding the Health Unit's budget. A review of past Board of Health consideration regarding the 2013 budget can be found in Report No. 129-12 of this agenda. In addition, the following facts add context to the Board's budget deliberations:

1. In May 2004, the Province made a commitment to increase public health funding to enhance public health programs and services.

2. Middlesex-London Health Unit was not keeping up with other health units. In 2003, this Health Unit was one of the "poorest" in terms of per-capita funding, and one of the worst performers in terms of compliance with Mandatory Programs.

3. Since the Board adopted the "2005 Business Plan", approximately 8.0 million provincial dollars have been invested in the cost-shared Mandatory Programs / Ontario Public Health Standards to enhance and maintain programs and services in Middlesex-London in keeping with provincial requirements.

4. Since 2004, no additional funding has come from either the City of London or Middlesex County.

5. Boards of Health are responsible and accountable (under the Public Health Accountability Agreement) for delivering public health programs and services as defined by the Health Protection and Promotion Act, and the Ontario Public Health Standards.

6. The Province may make grants to health units, but municipalities must pay for public health programs (as per Section 72 of the Health Protection and Promotion Act).

7. The majority of health units in the province are not funded 75% by the province. In fact, 12 (or 33%) are funded 70% or less by the province.

8. The Province is trying to balance its budget by controlling costs and reducing grants, which is expected to results in health units receiving smaller increases in provincial grants than in the past.

9. Municipalities are also trying to control costs. In the City of London, the political promise of four straight years of 0% tax increase is placing pressure on programs and services.

10. Even a 2% increase from the province combined with a 0% municipal increase will create a shortfall of $477,682 and will require savings to be found in order to maintain public health programs and services.

The Gains Made

Since 2004, the increase in the Health Unit's budget has been made possible entirely through additional funding from the Province of Ontario. This has allowed the Health Unit to meet many of its obligations under the Mandatory Programs / Ontario Public Health Standards, several of which were not being met prior to 2005. Through this increased provincial funding, the Health Unit has been able to fulfill much more of its inspection requirements, including those at restaurants, grocery stores and other food premises; small drinking water systems; personal service settings like tattoo shops, nail salons, and barber shops; as well as daycare centres and long-term care facilities. There has also been expanded dental care programs for low-income families and increased services that help ensure healthy pregnancies, healthy babies, healthy schools and healthy families. These are only a handful of the many enhancements in public health since the province committed to increased funding to health units.

2013 Budget Shortfall

Table 1 in Appendix A provides a summary of the Health Unit cost-shared funding from all partners as a result of a 2% provincial increase combined with a 0% municipal increase. It can be seen that an additional $301,984 from provincial grants is the anticipated increase in cost-shared funding for the 2013 operating year.

Table 2 in Appendix A provides a list of anticipated increased costs that will need to be covered in 2013. They total $779,666 and include negotiated salary and related benefit increases, an increase in OMERS rates, the need to cover the 2012 shortfall from lower than expected provincial grants, and some minor revenue changes. As in the past, in 2013 there will again be no request for increased funding to cover general inflationary costs associated with health promotion activities, program travel, and office supplies related expenditures.

In 2013, the anticipated increases in costs ($779,666) are greater than the anticipated increase in provincial grants ($301,984), leaving a shortfall of $477,682.

Meeting the Shortfall

Table 3 of Appendix A identifies potential areas in the cost-shared budget that can be reduced, while minimizing the direct impact on programs or services. A significant source of funds for this shortfall ($206,785) comes from managing position vacancies (i.e. managed gapping). Finding this amount of savings through managed gapping will be challenging and will require close monitoring of vacant positions throughout all programs and services. Other considerations outlined in Table 3 include reductions in corporate training/ professional development and purchased services which will result in indirect impact on program and services as staff have less capacity to develop new initiatives, contract outside expertise or participate in educational opportunities. Reductions in building maintenance and repairs can also be considered to address the shortfall and will reduce the overall appearance of office locations.

Areas of Concern

Meeting the anticipated shortfall of $477,682 highlights several concerns and challenges going forward in an environment where the Health Unit can no longer rely on adequate provincial increases to maintain programs and services. These are as follows:

1. Reduced training and fewer professional development opportunities limits the capacity of the Health Unit to keep its workforce up-to-date regarding public health content, professional knowledge and skills, health and safety related topics and management skills for its Management staff. Reduced emphasis on training does not support the Health Unit's commitment to continuous quality improvement and ongoing learning, and does not support succession planning.

2. A reduction in funds to purchase specialized services or conduct focused projects will reduce the organizations ability to respond to emerging issues and special investigations. In the past, this budget has been utilized to address strategic initiatives or projects such as development of the recently launched Community Health Status Resource, website redesign, the development of the Discovery Report to inform our recent 10 year Strategic Plan, implementation of the City's and County's smoking by-laws and the hiring of external expertise in specialized content areas.

3. The organization's ability to manage corporate assets such as the maintenance and replacement of information technology may be impacted. Utilizing technology is a strategic priority for the organization. Over the past 3-5 years, the Health Unit, along with many other organizations, has placed a greater emphasis on the use of current technology to enhance program delivery and gain efficiencies such as reducing duplication of data entry. Some examples include: electronic documentation for food safety inspections; influenza clinic and sexual health clinic management software; implementation of field documentation in the Health Babies, Healthy Children program; and digital imaging and records in our dental treatment clinic. The budget for software and hardware is currently not adequate to replace this technology at required intervals. In the past, a portion of the savings from position vacancies had been re-invested into purchasing hardware and software. Under the potential sources of savings outlined in Table 3, these savings would no longer be available as they would be needed to meet 2013 and future budget shortfalls.

Implementation of Operating Reserves

A partial solution to mitigate the areas of concern outlined above is for the Board of Health to establish a reserve fund. Annual municipal surpluses, if any, could be placed in the reserve fund to be used by the Board to fund future strategic initiatives, technology enhancements, etc. Mr. John Millson, Director, Finance & Operations, will provide a report at a future Board of Health meeting in regards to parameters for developing reserve funds for this purpose. The report will include an environmental scan of what other health units do in regards to reserve funds, potential drawbacks and a draft policy for the Board to consider.

This report was prepared by Mr. John Millson, Director, Finance and Operations.

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Acting Medical Officer of Health

This report addresses Policy No. 4-10 (Budget Preparation and Approval) as outlined in the Middlesex-London Health Unit Administration Policy Manual.