



**Creating a Sustainable
Public Health System
in Ontario**

A Renewal of
Health Protection,
Health Promotion,
Disease Prevention
and Surveillance

**A Position Paper of the
Association of Local Public Health Agencies**

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Executive Summary

The national, provincial and local structures that deliver public health programs and services in Canada have been under close scrutiny in the wake of last year's outbreak of Severe Acute Respiratory Syndrome (SARS). Most notable among several, the Naylor, Kirby and Walker reports present detailed recommendations for the renewal of the public health system at all levels. This paper complements that body of work with the perspective of Ontario's public health service providers, as represented by the Association of Local Public Health Agencies (alPHA). It is the result of broad input and discussion by alPHA's membership, which includes medical officers of health, board of health trustees and management representatives from public health administration, dentistry, epidemiology, inspection, nursing, nutrition, and promotion. Recommendations are presented for five topics: provincial health goals; public health funding levels; capacity of the Public Health Division and role of Ontario's Chief Medical Officer of Health; local public health agency (also known as "health units") capacity and role; and public health human resources.

Provincial Health Goals

Political, economic and social factors are just as significant to community and individual health status as disease control and healthy lifestyle choices. A renewed emphasis on prevention must therefore acknowledge the health impacts of policy decisions that do not fall under the purview of public health agencies. Broad health goals that bind *all* departments within government must be established to improve the public's health. Therefore, alPHA recommends:

1. That the Government of Ontario establish a process to develop a broad set of population health goals, with requirements and standards that bind all government ministries and government-funded agencies that are comprehensive, complementary and effective in promoting and protecting the health of Ontario's residents.

Public Health Funding

Governments at all levels must make a much stronger commitment to ensure the timely availability of sustained and adequate funding for the optimal delivery of public health programs and services in all communities. Every recent review of the public health system reiterates the significant inadequacy of funding from all levels of government for health promotion, health protection, disease prevention and surveillance programs and services. Careful thought must be given to devising a system that guarantees a sustainable source of funding that is protected from cuts due to economic and political pressures unrelated to the delivery of public health programs and services. Therefore, alPHA recommends:

2. That the province devise a strategy to increase overall funding to ensure:
 - a) optimal and sustainable delivery of all mandated and recommended health promotion, health protection, disease prevention and surveillance services in all health units;
 - b) the capacity for any optional public health programs and services to address local needs;
 - c) the ability to respond to public health contingencies; and,
 - d) coverage of all related administrative and support costs.

Personnel Recruitment and Retention

There are significant shortages of public health staff in Ontario, including medical officers of health, public health epidemiologists, public health dentists, health promoters, public health inspectors, public health nurses and public health nutritionists. Rapidly declining enrolment and graduation numbers in post-secondary public health programs, and the loss of skill sets acquired in these programs to more lucrative careers indicate that these shortages could become even more significant in the near future. Therefore, alPHa recommends:

3. That as part of its review of Ontario's public health system, the Ministry of Health and Long-Term Care, in consultation with local public health agencies and relevant associations, clearly itemize core competencies, appropriate remuneration and ideal numbers for public health staff to carry out mandatory and recommended public health services.
4. That the provincial public health agency, in consultation with alPHa and its Affiliate organizations devise a strategy to address the immediate shortages of medical officers of health and public health dentists, epidemiologists, promoters, inspectors, nurses and nutritionists.
5. That the provincial public health agency, in partnership with local public health agencies, devise a comprehensive, long-term recruitment strategy that includes promoting public health service as an attractive career choice. This strategy should include input from institutions with a public health curriculum, the Ministries of Education and Training, Colleges and Universities, and alPHa and its Affiliate organizations.
6. That the provincial public health agency and local boards of health devise strategies to provide or facilitate the provision of ongoing education for public health staff and training opportunities for students including, but not limited to, job placements, tuition-for-guaranteed service arrangements, and paid practicums.

Provincial Public Health Agency Capacity and Role of the Chief MOH

In Ontario, the central health promotion and protection functions of the Ministry of Health and Long-Term Care are overseen by its Public Health Division (PHD) and by the province's Chief Medical Officer of Health. This is where many of the funding and policy decisions for public health programs and services are made. The primary focus of these decisions must always be the health promotion, health protection, disease prevention and surveillance functions of health policy. Therefore, alPHa recommends:

7. That an extensive review of the province's centralized public health functions be undertaken, with a view to the establishment of an independent and effective provincial public health agency headed by the Chief Medical Officer of Health.
8. That the provincial government commit to ensuring that this agency has reliable sources of technological, human and financial resources to undertake its advisory, monitoring, analysis, coordinating, liaison, enforcement and response functions.

9. That the provincial government put in place the liaison, reporting and consultative mechanisms that will make the provincial health agency the focal point for monitoring and reporting on progress toward provincial health goals, as endorsed by all government agencies.

Local Public Health Agency Capacity and Role

A close examination of local public health agency capacities and community needs will be critical to the success of renewed strategies for funding, recruitment and retention, and central oversight. Local public health agencies are in the best position to assess the needs of their communities, and must retain the autonomy to make decisions about the locally appropriate planning and delivery of public health programs and services.

As demands on local public health agencies have increased, so have discussions of expanding local capacity for highly specialized public health expertise, such as epidemiologists, additional medical officers of health and legal counsel. As this may not be presently practicable for all health units, more detailed and creative capacity-enhancing strategies may need to be considered for some. These will require a detailed examination a wide range of local characteristics. Therefore, alPHa recommends:

10. That the province, in partnership with local public health agencies, undertake a comprehensive and detailed review of capacity and community needs to inform the development of long-term strategies to enhance local public health agency capacity to plan and implement optimal public health services.
11. That the goal of such strategies is to optimize human and financial resources, public health expertise and technical requirements for local delivery of public health services.
12. That the province fully consult with the Association of Local Public Health Agencies when evaluating strategies to optimize local public health agency service capacity, including but not limited to those under which realignments or amalgamation are considered.

Introduction

Until recently, most of the public discussion of health in Canada has focused on the treatment-oriented health care system. Public policy debates on hospital bed shortages, crowded emergency rooms and doctor/nurse shortages have taken precedence over addressing the needs of the public health system that is responsible for the health protection and promotion, disease prevention and surveillance programs and services whose goal is to keep people well. Examples of these include disease outbreak control, food safety inspections, smoking cessation programs, and healthy lifestyle education. These prevention-based activities, as part of a sustainable and strong public health system, ultimately relieve those very pressures on the acute care system.

It has been said that an efficient and successful public health system is invisible. It is impossible to itemize the number of cancer cases, obese individuals, adolescent pregnancies and disease outbreaks that were avoided because of effective prevention programs. When funding, personnel and policy deficiencies reduce the effectiveness of these programs, such adverse health outcomes invariably increase to expose those deficiencies. The *E. coli* gastroenteritis outbreak in Walkerton, Ontario in May of 2000 and the SARS outbreaks in the spring of 2003 are two notable examples of this, each exposing significant gaps in the public health system, precipitating a restored recognition of its importance, and demanding an unprecedented effort to review and reinvigorate it.

A substantial and detailed body of reviews of the public health system and recommendations for its renewal has been generated in the wake of these and other public health urgencies. The Walker, Naylor and Kirby reports¹ in particular contain in-depth discussions and detailed recommendations for comprehensive systemic improvements. The purpose of this paper is to build on and complement these with the perspective of the members of the Association of Local Public Health Agencies (ALPHA), which include medical officers of health, board of health trustees and representatives from public health administration, dentistry, epidemiology, inspection, nursing, nutrition and promotion within Ontario.

What follows is the result of broad input and discussion by ALPHA's membership on four topics: public health funding levels, public health human resources, capacity of the Public Health Division and role of Ontario's Chief Medical Officer of Health, and capacity of local public health agencies. Specific recommendations are offered for each that represent the consensus of the diverse public health professionals that make up the Association.

Background

Ontario's *Health Protection and Promotion Act* (HPPA) provides a strong legislative framework for the provision of programs and services to maximize community health. The *Mandatory Health Programs and Services Guidelines* (MHPSG) set out standards for the prevention of chronic diseases and injuries, the prevention and control of infectious diseases, and programs supporting family health. These are the minimum standards for programs that are to be delivered by all boards of health in Ontario. The intent of

¹ **The NAYLOR Report:** *Learning from SARS: Renewal of Public Health in Canada*, released by the National Advisory Committee on SARS and Public Health on October 7, 2003; **The KIRBY Report:** *Consultation Report*, presented by the Coalition for Public Health in the 21st Century to the Senate Standing Committee on Social Affairs, Science and Technology, on October 21, 2003; **The WALKER Report:** *For the Public's Health*, Interim Report by the Ontario Expert Panel on SARS and Infectious Disease Control, December 15, 2003

the legislation and the goal of these standards is to promote health and quickly identify the potential causes of adverse health outcomes and reduce or eliminate them.

This requires a broad range of activities – education, communication, investigation, inspection, enforcement, screening, and specific prevention measures such as immunization, to name just a few. These activities, alone or in combination, are effective tools in preventing food borne illness, infectious disease outbreaks, sexually transmitted diseases, low-birth weight babies, premature deaths from cancer, and many other preventable negative impacts on health.

In addition to regular programming, boards of health are faced each year with demands on already-scarce time and financial resources by unforeseen outbreaks of unusual diseases, new risks, and participation in environment and health-related local political debates (tobacco control, air pollution and pesticide regulation are pertinent examples). There may also be community-specific needs for additional public health programs that are not required of all health units by the province.

All local public health agencies in Ontario must have the financial and human capacity to meet minimum mandated standards, engage in the political process, address community needs and respond to public health emergencies, absorb unforeseen cost-increases and implement new mandatory programs. The success in carrying out these duties will come from the authority and expertise of public health professionals to make independent and informed decisions about the health of their communities, in combination with strong support and guidance from the province, and an adequate and sustainable source of funding.

A Guiding Principle: Provincial Health Goals

This paper will discuss topics as ways for optimizing the public health programs and services that contribute to the health and well being of all Ontarians. The MHPSPG set standards for “promoting improved health, preventing disease and injury, controlling threats to human life and function, and facilitating social conditions to ensure equal opportunity in attaining health for all²”. These standards bind only local boards of health, which alone cannot enable residents of the community to realize their fullest health potential. Such a broad purpose is an equally broad responsibility.

As such, alPHA believes that it is essential for the province to establish a set of health goals and to secure commitments from all government ministries and government-funded agencies to following standards that are binding, comprehensive, complementary and effective in achieving them. This would create a much stronger foundation for a healthy population by requiring health impact considerations and statements in all public policy decisions.

RECOMMENDATION:

- 1. That the Government of Ontario establish a process to develop a broad set of population health goals, with requirements and standards that bind all government ministries and government-funded agencies, that are comprehensive, complementary and effective in promoting and protecting the health of Ontario residents.*

² Mandatory Health Programs and Services Guidelines, December 1997, published by the Minister of Health, pursuant to Section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7

Public Health Funding

Overall Funding Levels

Health promotion, health protection, disease prevention and surveillance are effective and cost-beneficial strategies to keep people healthy. At a fraction of the cost of treating disease, they reduce morbidity and mortality by preventive means. Their value was clearly illustrated in the response to the Walkerton and SARS outbreaks, yet their funding levels remain inadequate. Most local boards of health are unable to deliver their minimum mandated programs, let alone contingency responses and additional, non-mandated services that would benefit their communities. Ontario will remain vulnerable to public health threats until governments at all levels commit to ensuring the timely availability of sustained and adequate funding for the optimal delivery of public health services in all communities.

In order to accomplish this, careful thought must be given to devising a system that guarantees a sustainable source of funding that is protected from cuts due to economic and political pressures unrelated to the delivery of public health programs and services. It must be reliable enough to allow for long-term planning and staffing. It must account for possible inequities that arise from disparities in population distribution and characteristics, and health unit size. Mechanisms must be built in to guarantee surge capacities to deal with contingencies such as outbreaks, unexpected cost increases and new mandatory programs. The goal of increasing funding for public health in Ontario must be to ensure that the health protection, health promotion, disease prevention and surveillance resources meet the health needs of all of Ontario's communities.

Funding Sources

The current practice for funding public health in Ontario is unique in Canada. In all other provinces, public health funding is entirely provincial. In Ontario, Section 72 of the HPPA clearly obliges municipalities within a health unit to pay the costs of public health programming, though the Minister is empowered by Section 76 to make grants as he or she sees fit. The current agreement, based on those sections, is a 50 percent grant for "approved costs" made by the province, to match the amount paid out locally. This grant is not guaranteed, is conditional and often untimely.

While this situation in practice is not ideal, it does reflect principles that our members believe should be maintained. As the province mandates and sets the standards for the core local services, it has a responsibility to ensure that the resources and guidance are available to carry them out. As the local authorities have the expertise and knowledge to tailor these services to the needs of their communities, they must retain a certain degree of decision-making autonomy. There may be several ways of achieving this, but it is clear that the administrative dysfunction in securing the necessary funds for public health needs to be addressed.

Funding Ratios

The major practical difficulty in the cost-shared system is that municipal funding must be in place before the provincial share is even requested. This means that boards of health must approve, present and justify their budgets to their obligated municipalities, leaving them to contend with a complicated, conditional and untimely reimbursement process. This is compounded by the fact that public health must compete for severely limited property tax revenues with more visible services such as solid waste disposal, transit,

and public works. This has created a climate where too much caution must be exercised when boards of health are setting budgets, especially where there is significant membership overlap with municipal councils.

There is a case to be made for total provincial funding as a solution to the above difficulties. It would ease the burden on municipalities, eliminate many of the administrative complications and allow medical officers of health to focus on the delivery of effective services rather than justifying their budgets in political and economic debate. The perceived drawbacks, however, are significant, including a loss of local health agency autonomy and the vulnerability of a single source of funding to political pressures.

An argument could also be made to have the province securely and consistently fund the basic mandatory public health functions, with a stronger mechanism for the local planning, funding and delivery of community-specific programming. This would give more weight to Section 9 of the HPPA, which provides the legal authority to do so, while transferring the largest financial burden for public health to the province's broader tax base.

The *Interim Report by the Ontario Expert Panel on SARS and Infectious Disease Control* (the Walker Report) has made a specific recommendation to "restructure the present municipal-provincial cost-sharing agreement so that the province pays 75 percent to 100 percent of public health expenditures within two to five years." The obvious reason for the range presented is that there was no consensus on a precise ratio, but a general feeling that an increase in the province's portion would eliminate many of the above-mentioned obstacles to adequate investment in public health services.

The existing administrative problems outlined above would not change with such a restructuring. Boards of health would arguably be faced with even greater difficulties if their municipalities were still required to front 100 percent of the costs for public health and await a 75 percent conditional reimbursement. The provincial share must therefore be guaranteed, timely, and well defined. It must also include equity strategies related to geography, population dispersion, and determinants of health, and be focussed on the standards that are expected in all regions.

The greatest perceived advantage of local responsibility for a portion of public health funding remains that of autonomy. It is a widely held assumption that financial support for programs is closely related to the amount of local influence and debate over decisions made on their provision. It is also seen as a built-in protection during times of fiscal restraint at the provincial level. The current 50/50 cost-share arrangement remains attractive to some of our members for those reasons, subject to significant modifications to the timing and conditions of the provincial portion.

Regardless of funding source and ratio, the funding of core capacities (delivery of mandated programs, health surveillance and monitoring, response to small-to-moderate contingencies) in every local public health agency must be reliable. The Government of Ontario must accept a larger role in guaranteeing timely and sufficient financial resources for the delivery of health promotion/protection and disease prevention activities that it mandates. This increased role must not interfere with local decision-making autonomy over the delivery of community-based public health services

RECOMMENDATION:

- 2. That the province devise a strategy to increase overall funding to ensure:*

- a) *optimal and sustainable delivery of all mandated and recommended health promotion, health protection, disease prevention and surveillance services in all health units;*
- b) *the capacity for any optional public health programs and services to address local needs;*
- c) *the ability to respond to public health contingencies; and,*
- d) *coverage of all related administrative and support costs.*

Personnel Recruitment and Retention

The professions related to health promotion, health protection, disease prevention and surveillance are currently enjoying unprecedented visibility due to the recent scrutiny and planned revitalization of the public health system. By extension, there is a greater understanding of their importance, which underscores the need to address significant shortages of qualified and willing individuals to fill these roles.

The shortage of doctors and nurses in the primary care sector is well known, and has often been called a crisis. A similar crisis exists in the public health sector, one that is compounded by the fact that it must compete with primary care for medically-trained individuals such as doctors and nurses. These shortages are just as significant for public health dentists, public health epidemiologists, health promoters, public health inspectors and public health nutritionists. Rapidly declining enrolment and graduation numbers in post-secondary public health programs, and the loss of skill sets acquired in these programs to more lucrative careers indicate that these shortages could become even more significant in the near future.

Attention must also be paid to support roles that are critical to the effectiveness of the public health system. These include (but are not limited to) program evaluation, curriculum development, social marketing, paralegal skills, environmental studies, database management, and communications. While shortages of these skill-sets may not be as significant, attracting them to the delivery of public health services must be part of the strategy to address human resources.

To achieve the renewal of the public health infrastructure that is being undertaken at this time, a full complement of qualified staff in each of the public health disciplines and the technical roles that support them is required. Careful consideration must be given to recruitment and retention strategies, to include specific attention to competitive pay, benefits, working conditions, educational incentives and professional esteem.

Core Competencies and Staff Levels

Before devising a recruitment and retention strategy for public health, a review of essential functions and core competencies must be undertaken. Beginning with an analysis of the essential public health services³, skill-sets required to carry them out must be itemized. Following this analysis, desired service levels must be considered in order to estimate the staffing requirements for them.

³ These are itemized in alPHA's August 2003 Board of Directors Discussion Paper, *The Future of Public Health in Ontario*. http://www.alphaweb.org/docs/ph_future_paper_final_version-17_12_2003-10_30_55.pdf

Public Health Definition and Profile

As with funding, there are clear immediate needs to address existing personnel shortages, but sustainability will depend on a reliable, renewable source of qualified and dedicated professionals. This will be an ongoing challenge if public health does not clearly define itself with a view to becoming more visible and attractive as a career choice.

At the foundation of this is reinforcing the importance of prevention for achieving broad health goals and identifying related professions. Where young children are introduced to police officers, firefighters, doctors and systems analysts in early education, it would be reasonable to include public health nurses and promoters, public health inspectors, nutritionists, and medical officers of health in this curriculum. Elements of health promotion and disease prevention theory must become a permanent part of education at all levels and taught in more detail in the health care disciplines.

If this fundamental understanding of the functions, roles and importance of the public health system becomes a part of societal common knowledge, there might be more interest in exploring this type of work with high school guidance counselors, at job fairs, and during school-hosted career days. This will, of course, require input from public health professionals and government agencies that are capable of clearly defining what the system is, and itemizing available careers and their necessary qualifications.

Once students begin to enter post-secondary training for careers in public health, opportunities must be created to foster a closer relationship between the learning institution and potential employers. Health units, with assistance from the central agency, must foster a learning environment and demonstrate increased involvement in educational programs both for staff and for students. Mentorships, job placements, bursaries, tuition-for-guaranteed service arrangements and paid practicums are mechanisms that work very well in other professions.

Retention is the other part of this equation, and job satisfaction is essential for ensuring that qualified public health professionals remain dedicated and effective. Much of this comes from a positive workplace environment, but the perception of the job itself is also significant. Following the SARS outbreak, there was little specific mention of the medical officers of health, communicable disease investigators, epidemiologists and data entry staff who went well beyond the daily demands of their jobs to manage the crisis. If public health is to become an attractive career option for those who wish to contribute to the well being of the population, it should certainly be promoted as something worthy of a better designation than “other health care workers” when they are being publicly recognized.

Training and Education

Financial issues are a significant part of any career choice – not just what the job pays, but what one must pay to get the job. The cost of post-secondary education has increased to prohibitive levels for many students, which makes financial incentives to follow a particular career path significant. Because public sector careers are not generally as lucrative as private sector jobs, other types of incentives must be considered.

Grants and bursaries from boards of health would be useful to help attract students to public health programs. Subsidized education in return for a period of service upon completion of studies is a

mechanism that works very well in other disciplines. Paid practical summer placements should also be encouraged as an important mechanism for hiring permanent staff.

Compensation, Benefits and Employment Conditions

While it is true that many people choose careers in public health to serve their communities and contribute to the greater good, it is not enough to rely on this type of goodwill to keep a competent staff in professions where pay is relatively low and expectations are extremely high. This is especially true if there are specialty education requirements in addition to the basic professional degrees, as is the case for medical officers of health and public health dentists.

There is a need for recognition of the value of public health work and a re-evaluation of appropriate compensation by governments for the public health professions. It may not be possible for the public sector to pay rates that are comparable to the acute health care sector or private industry, but higher baseline salaries are necessary to attract and keep good candidates. Attention should also be given to competitive wages for underserved areas.

Job perks such as medical benefits, affinity programs for insurance and investment, and no-cost opportunities for further education may also be effectively used to supplement comparative discrepancies between private and public sector incomes. Work-hour flexibility and subsidized services such as on-site day care are additional examples of considerations that attract workers to a place of employment. These and other creative strategies to benefit the employee should be evaluated for inclusion in the funding envelope that is dedicated to the delivery of public health services.

Recruitment and Retention of Medical Officers of Health

Section 62 of the HPPA requires that every board of health appoint a full-time medical officer of health. This position has become far more prominent, demanding and complex, and its importance was clearly underscored by the very first recommendation from the Walkerton Inquiry:

The Health Protection and Promotion Act should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant Medical Officer of Health position with a full-time Medical Officer of Health.

At present, there are nine vacancies within the defined terms of the legislation, with at least two retirements pending and very few new community medicine graduates entering the field. This represents an *increase* in vacancies since the above recommendation was made. Filling these vacancies is going to require finding not only qualified, but also willing candidates.

A subcommittee of ALPHA's Council of Ontario Medical Officer of Health (COMOH) is carefully addressing this issue, and more specific details are forthcoming, but an initial report has been submitted to the Walker Panel for inclusion in its final recommendations. The following considerations for MOH / AMOH recruitment and retention have been drawn from the work of that committee:

- Remuneration for MOH and Associate MOH positions is low relative to the other medical professions, especially considering the relative demands of the job. Salary improvements are an essential to attract and retain them.

- Enhanced support for the statutory powers under Section 67 of the HPPA that optimize the abilities of A/MOHs to fulfill their statutory duties, preserve their independence and protect them from political and administrative interference;
- The presence in each local public health agency of at least one AMOH to share duties, including after-hours coverage, and to provide medical advice, assistance and support;
- Opportunities and support for continuing medical education, maintenance of professional certifications and establishing linkages with local colleges and universities; and,
- Strengthening relations between A/MOHs and their local public health agencies with the Chief Medical Officer of Health and the Public Health Division (or central provincial health agency) such that constructive collegial relationships, collaboration, and cooperation are restored.

RECOMMENDATIONS:

3. *That as part of its review of Ontario's public health system, the Ministry of Health and Long-Term Care, in consultation with local public health agencies and relevant associations, clearly itemize core competencies, appropriate remuneration and ideal numbers for public health staff to carry out mandatory and recommended public health services.*
4. *That the provincial public health agency, in consultation with alPHa and its Affiliate Organizations devise a strategy to address the immediate shortages of medical officers of health, health promotion officers, and public health nurses, nutritionists, epidemiologists, inspectors and dentists.*
5. *That the provincial public health agency, in partnership with local public health agencies, devise a comprehensive, long-term recruitment strategy that includes promoting public health service as an attractive career choice. This strategy should include input from institutions with a public health curriculum, the Ministries of Education and Training, Colleges and Universities, and alPHa and its Affiliate Organizations.*
6. *That the provincial public health agency and local boards of health devise strategies to provide or facilitate the provision of ongoing education for public health staff and training opportunities for students including but not limited to job placements, tuition-for-guaranteed service arrangements and paid practicums.*

Provincial Public Health Agency Capacity and Role of the Chief MOH

Of equal importance to funding, human resources and local autonomy is a strong central system for the development of effective, evidence-based public health policy, the provision of leadership, advocacy and expert advice on public health issues. It is also necessary for the continuous and effective exchange of information between the local and central levels and across government sectors. Like the local public health authorities, this central agency must be sufficiently independent to act in the best interest of the public's health.

In Ontario, the central health promotion and protection functions of the Ministry of Health and Long-Term Care are overseen by its Public Health Division (PHD, formerly the Public Health Branch) and by the province's Chief Medical Officer of Health (CMOH). This is where many of the funding and policy

decisions for public health programs are made, and where the above functions ought to reside, as long as their health outcomes take precedence over political and economic pressures.

Characteristics

To ensure effective public health policy, the central public health body must receive its authority through legislation, but remain independent of political influence. This agency must be carried out by a well-resourced staff with appropriate specialist expertise to carry out the functions that are itemized in the next section of this paper. It must be responsive to the needs of the local public health agencies while being aware of the political and economic climate within which it must function. Its primary purpose must be to support the goals and objectives that are designed to promote and protect health.

The Ontario Expert Panel on SARS and Infectious Disease Control has recommended the creation of a new Ontario health protection and promotion agency, which would also include an Ontario public health laboratory and a new division of infection control. Many of our members support this idea, and believe that this agency should be an arm's length from government, or at the very least enjoy legally guaranteed independence to act in the interests of public health, similar to that of Ontario's local medical officers of health.

This central agency, with the Chief Medical Officer of Health (CMOH) at its head, should be adequately staffed by readily available experts familiar with current and emerging issues in environmental health, public health nursing, public health law, public health dentistry, nutrition and health promotion. A robust research and review function should keep the agency abreast of best practices and new developments in all of these areas, and must always provide well-informed, politically independent leadership in public health that will influence public health practice and policy at local, provincial and federal levels.

This leadership must also be a resource to the government as a whole, and should have effective linkages to the acute care sector, emergency planning agencies and to ministries that deal with other determinants of health (e.g. Education, Labour, Social Services and Children's Services). It should also be the authority on the proposed provincial health goals, empowered to evaluate and report on progress.

General Functions

First and foremost, a centralized health agency should set, monitor and revise provincial public health priorities and their minimum standards, in consultation with relevant agencies. It is our vision that these would include standards for the provision of public health services (i.e. the MHPSG) as well as those under the broader provincial health goals. Clearly established communication mechanisms and linkages would be utilized to ensure inclusive and iterative consultation.

In order to support this function, this central body must be well equipped to carry out and monitor public health-related research, have strong program planning and evaluation functions and an efficient strategy to ensure clear communication of results of these activities and meaningful response to them from key stakeholders. The net effect of all of this should be strong support, clear direction and good advice for the delivery of public health services.

The continuous and timely exchange of effective and consistent information is essential to the proper functioning of a strong public health system. Its absence was identified as a significant weakness in the provincial response to SARS, and has been a regular source of frustration for our members in the recent past. With the proper enhancements to staff, practical expertise, resident knowledge and clarity of purpose, effective communication could easily be strengthened.

Monitoring Functions

In order to maintain control over consistent and effective information, it is extremely important to ensure that the best possible supports are provided for its collection and analysis. The collection of data on reportable diseases and immunization records are existing examples of activities that are meant to identify trends and inform reports on health status. However, they would benefit from improvements in data management systems. An ongoing investment in appropriate, up-to-date information technology resources (infrastructure, support and training for users) for both the provincial and local levels will facilitate the monitoring and follow-up of infectious diseases and tracking of chronic diseases throughout the province, with links to national databases serving similar aims.

Consideration should also be given to centralizing and strengthening the collection, analysis and reporting data for the periodic *Report on the Health Status of the Residents of Ontario* as undertaken by the province's Public Health Research, Education and Development (PHRED) health units. This Report takes a broad approach to health status, accounting for the impacts of age, poverty, education, mental health, environment, violence as well as more direct health impacts such as disease and injury. This type of report should be based on solid and complete information as gathered by the central agency in consultation with local and other government agencies; its conclusions should be presented in context of progress toward the proposed comprehensive provincial health goals.

Response Functions

Disease outbreaks are the clearest illustration of the reality that political borders are not effective tools for the prevention of their spread. SARS, West Nile virus, and influenza are ready examples of situations where collective public health expertise and authority must be rapidly mobilized and efficiently coordinated.

Where local public health agencies should have the capacity to respond to local public health contingencies of small to moderate size in their areas, a similar, more centralized capacity must exist at the provincial level to respond to larger ones. A series of detailed contingency plans should be developed and communicated to the local agencies that will provide the ground level services, and should be regularly evaluated.

It should be stressed that an overemphasis on communicable disease control in renewing Ontario's public health system would be wasting a tremendous opportunity to reinforce the idea that public health is essentially about prevention. Better outcomes for the public's health can be predicted if the prevention activities are sufficiently upstream. Primary prevention (i.e. activities designed to identify and minimize risk factors) must remain the focus of public health system if it is to be successful. A strong communication function should also be built in to ensure that effective and consistent messages about health promotion, health protection and disease prevention are delivered to the public where appropriate.

Relationship with Local Public Health Agencies

It is important that the primary interest of this central entity remain the delivery of clearly defined health promotion, health protection and disease prevention services. As such, the stakeholders of primary interest must remain the boards of health that deliver them. It has already been made clear that those agencies must retain significant autonomy to make decisions that will serve the health of their communities, but the provincial body must still be a reliable source of information, expertise, guidance and other resources. A strong co-ordination role and central development of province-wide campaigns on public health issues that can be locally adapted should be expected.

Assuming that this central body remains responsible for setting the standards to which these local agencies are held, it should also be responsible for ensuring the proper resources to carry them out. Funding is certainly of primary importance, but so might be providing ongoing opportunities for consultation, providing services for training and professional development, and devising strategies to recruit and retain public health professionals in all of its disciplines. It must also be responsible for monitoring and enforcing mandated program delivery as an accountability function. These will be complementary functions, where the evaluating body also has some capacity and responsibility for addressing any identified service gaps or inefficiencies.

Finally, should this agency be responsible for the central administrative functions of public health in Ontario, it should retain oversight of the allocations of the provincial portion of health promotion, health protection disease prevention and surveillance expenditures.

Relationship with Government

Given the impending renewal of the public health system at both the provincial and federal levels, the advisory capacity of the renewed provincial agency cannot be limited to support for the local public health agencies. It must be very active at the policy-making and governance level, with input to the new national public health strategy (as overseen by the new Minister of State for Public Health), and serving as a focal point for a renewed and comprehensive provincial system.

In light of the proposed provincial health goals, we believe that a critical function of this central public health agency will be to oversee their development and progress on them. It must have the requisite capacity to evaluate a broad range of health protection, health promotion and disease prevention strategies including environmental and socio-economic ones, the political clout to secure commitment to them and the capacity to give expert advice on them.

Chief Medical Officer of Health

In order to achieve the objectives of these roles, we believe that the position of the chief executive officer for the agency must have the appropriate independence, credibility, expertise and political clout to be a leading voice for public health in Ontario. It would stand to reason that the province's Chief Medical Officer of Health position already possesses this combination of competencies, and should therefore be that voice.

The expertise of the person filling this position must be such that his or her recommendations are a respected source of strong, consistent and credible advice to the government, to the public health service

providers and to the public. He or she must be an effective liaison between the policy makers and public health professionals. He or she must also be an effective and respected voice for health perspectives on the business of all government ministries. He or she must also retain the legally guaranteed responsibility to make decisions that supersede political motivations when they are made in good faith and in the best interest of protecting the health of the province's residents. He or she will provide leadership for the many functions of the renewed central public health authority as itemized above.

RECOMMENDATIONS:

7. *That an extensive review of the province's centralized public health functions be undertaken, with a view to the establishment of an independent and effective provincial public health agency headed by the Chief Medical Officer of Health*
8. *That the provincial government commit to ensuring that this agency has reliable sources of technological, human and financial resources to undertake its advisory, monitoring, analysis, coordinating, liaison, enforcement and response functions.*
9. *That the provincial government put in place the liaison, reporting and consultative mechanisms that will make the provincial health agency the focal point for monitoring and reporting on progress toward provincial health goals, as endorsed by all government agencies.*

Local Public Health Agency Capacity and Role

The purpose of the above discussions of funding and personnel shortages is to examine immediate needs to improve public health service delivery. There has also been discussion about increasing requirements for highly specialized public health expertise (e.g. epidemiologists, legal counsel), which might not be presently practicable for all health units. The fact remains that the required financial and human resources may not be immediately available to accomplish both. This has led to discussions of more creative ways to improve public health unit capacity and performance.

Considerations

The evaluation of new strategies for optimum delivery of public health programs and services will require a careful and thorough examination of a wide range of local processes and outcomes. The ultimate goal of any strategy will be to increase overall public health capacity and solve existing program and service delivery difficulties for all of the province's communities. It cannot be implemented as a short-term measure to save money or achieve simple compliance with statutory requirements such as that of a full-time medical officer of health in each board of health. It must be a forward-thinking process aimed at the sustainable provision of optimum levels of health protection, disease prevention, and health promotion and surveillance activities in each of Ontario's health units.

As such, improving local capacity must be evaluated in the context of the funding, human resources and governance strategies already under review. It will also require an analysis of Ontario's diversity of communities and a detailed examination of existing and ideal characteristics of the health units that serve them. Only after this is achieved can service delivery improvement strategies be identified, with local public health agencies given full opportunity to participate in discussions to influence any process that leads to implementation.

Strategies to optimize the functions of public health units must be informed by the specific characteristics of the individual communities served by a given health unit, as well as those of the health unit itself. If different communities have different health needs, then it follows that their health units should have the appropriate expertise and resources to address them. The considerations listed below are meant only as examples, and should by no means be interpreted as complete:

Community Characteristics: total population; total land area; seasonal variation of population; population density pattern; economic and cultural factors; special needs areas; transportation systems; communication systems and media; educational opportunities; research facilities; administrative boundaries of other political agencies (provincial, federal, municipal); governance structures (e.g. relationship of board of health to city councils); health status broken down by statistical indicators; emerging health issues, etc.

Health Unit Characteristics: staff levels; program compliance; collective agreements; local partnerships and network participation; recruitment success rates; relative expenditures; number of satellite offices; supply contracts; number and types of regulated premises; existing agreements with neighboring health units and their success, etc.

Outcomes

Enhancements to local service delivery

First, assuming that public health costs continue to be shared, the local ability to plan, fund and implement community-specific public health programs should be strengthened. Second, all local public health agencies should have access to focused public health specialties (e.g. legal, toxicology, epidemiology, etc.). Third, consideration should be given to strategies to increase purchasing power based on deeper discounts for bulk orders of various goods and services.

Organizational improvements

New strategies should also be aimed at addressing communication, collaboration and administrative obstacles. If we continue to insist that public health services are closely linked with other activities that promote health and prevent disease, it would make sense that any strategy to enhance horizontal integration should be endorsed. Closer and more integrated communication and collaboration with other health services (e.g. hospitals, district health councils), as well as provincial administrative ones (e.g. school boards, ministry of environment areas), is certainly necessary. While realignments of health unit boundaries with those of other administrative and subjective jurisdictions could facilitate this type of lateral integration and collaboration, we do not see it as a prerequisite.

Elimination of inequities

There is ongoing concern about the difficulties faced by Ontario's northern health units because of their size and population characteristics. Issues of transportation, overhead for satellite offices, service accessibility and ability to recruit staff are significant ones. Forward motion on issues where several decision-making entities (e.g. municipal councils) exist is another. Of further concern is that larger jurisdictions alienate community members from the services that are supposed to be based on their

particular needs. This is also true of related agencies that need to be consulted on program and governance issues. Larger areas make it much more difficult to assemble them. Specific attention must be paid to solving these problems in Ontario's larger and more remote communities.

Health Unit Amalgamation

The idea of realigning the jurisdictional boundaries of boards of health to optimize services in the above context has been variously suggested as a possible strategy to which the above considerations might be applied. There have even been some concerted, though unsuccessful efforts by health units to enter into agreements and processes to merge in the past. This idea was recently brought back into the dialogue about improving public health capacity in the Walker Panel's interim report in the form of the following recommendation:

"The Ministry should review, in conjunction with the Medical Officers of Health, the Association of Local Public Health Units (sic) and the Association of Municipalities of Ontario, the existing number of public health agencies in the province. Within two years, the Ministry should act on the results of the review to consolidate the number of Public Health Units to between 20 and 25 units, retaining local presence through satellite offices" (Recommendation 6, page19).

In the absence of a clear rationale for this idea, alPHA members do not support the idea that the number of health units in Ontario is in and of itself the greatest obstacle to service improvements. alPHA's members strongly believe that merging health units should not be considered as a cost-saving or compliance measure. If a clear rationale for mergers as a means to enhance public health capacity does present itself, it must be undertaken with full consultation and close attention to the difficulties of such a process.

Amalgamations and realignments are complicated, politically contentious processes. Health units that have attempted it and boards of health in areas that were subjected to municipal amalgamations some years back have very negative views of the procedure, articulating that there are too many obstacles in the course of achieving its desired objectives. In the short term, mergers are energy intensive and would require large amounts of valuable human resource dollars for years to deal with merger issues. This is not an appetizing thought where resources to deliver the services themselves are already alarmingly scarce. Harmonizing collective agreements, restructuring goods and services contracts and maintaining pre-existing collaborative partnerships are all part of an enormous logistical exercise that may not be a wise use of resources at this time.

RECOMMENDATIONS:

10. *That the province, in partnership with local public health agencies, undertake a comprehensive and detailed review of capacity and community needs to inform the development of long-term strategies to enhance local public health agency capacity to plan and implement optimal public health services.*
11. *That the goal of such strategies is to optimize human and financial resources, public health expertise and technical requirements for local delivery of public health services.*

12. *That the province fully consult with the Association of Local Public Health Agencies when evaluating strategies to optimize local public health agency service capacity, including but not limited to those under which realignments or amalgamation are considered.*

Conclusion

This position paper represents a synthesis of our members' discussion of four topics that cover many, but far from all, of the required considerations in reviewing and improving the delivery of health protection and promotion and disease prevention services that are such a critical component of the overall health system. They are meant to add to the current and comprehensive set of reviews and recommendations contained in the various reports that were precipitated by public health crises such as the Walkerton *E. coli* and SARS outbreaks. Taken as a whole, this set of reports and their recommendations are consistent and complementary, and should form a strong foundation for strengthening the public health system to truly enable residents of Ontario to realize their fullest health potential.