Revitalizing Ontario's Public Health Capacity:

A Discussion of Issues and Options

November 2005

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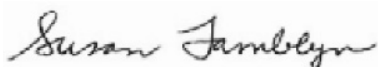Toronto, ON M7A 1R3

Dear Dr. Basrur:

On behalf of the Capacity Review Committee (CRC), we are pleased to present our interim report. It provides a high-level summary of the first phase of a two-phase process that the CRC is undertaking. The report provides insight into the work undertaken to date and provides some early information to the field regarding findings of the field surveys, which constituted a significant component of Phase I. The report also includes a brief description of the Capacity Review and the CRC, the approach we are taking, and some of the key issues and options that we will use to guide our consultations with stakeholders during Phase II.

The document reflects the early deliberations of the CRC. It is not a conclusive set of directions; it is, however, an opportunity to share information and provide to you and the wider public health community a sense of the thinking to date and the work that lies ahead.

To assist in providing focus to the field visits and interviews scheduled in the second phase of our work, we would ask that you make this interim report available to the health units and other stakeholders. We believe that this opportunity to share our deliberations will provide a contextual background for the next phase of our work.

The challenges and opportunities facing public health in the coming decade are complex and pressing and require a strong and well-structured public health system to be addressed effectively. The path to re-building our local public health system begins with a blueprint which we hope to provide. We trust that the observations provided here will provoke thought and input as we go forward.

Yours sincerely,

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Chair, Capacity Review Committee

Brian Hyndman
Vice-chair, Capacity Review Committee

cc: Honourable George Smitherman, Minister of Health and Long-Term Care
        Honourable Jim Watson, Minister of Health Promotion

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ACKNOWLEDGEMENTS

TABLE OF CONTENTS

Interim Report of the Public Health Capacity Review Committee

Revitalizing Ontario's Public Health Capacity:
A Discussion of Issues and Options

Preface

> *"Local public health units are the backbone of the public health system. … [T]hey are the front line of public health programs and services in our communities."[1]*
>
> **Operation Health Protection (2004)**

Rebuilding Public Health

Over the last decade, public health in Ontario, as in Canada as a whole, has gone from being somewhat in the shadows, its role rarely studied and frequently ignored, to being placed under the spotlight of numerous commissions of inquiry and expert panels.

In the recent past the role and importance of public health was first brought to prominence in the Walkerton tragedy, which underscored the value and need for public health to ensure the safety of the water we drink. Writing in late 2002, the Honourable Justice O'Connor who chaired the Walkerton inquiry acknowledged the importance for society of a well-staffed and functional public health system The Commission of Inquiry's first recommendation addressed the chronic vacancies of medical officers of health:

> *"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."[2]*
>
> **The Honourable Dennis R. O'Connor (2002)**

In the following years, mosquito-borne West Nile virus spread across North America with significant illness and death in Ontario. This reinforced the clear need to be able to respond to emerging health issues through public health protection and public education measures.

In 2003, SARS demonstrated the immense impact of another new disease on the life of a city and indeed a country. The SARS experience laid bare the pressing need for effective public health programs and services and the necessity for their strengthening locally, provincially and nationally.

The report of the Expert Panel on SARS and Infectious Disease Control chaired by Dr. David Walker[3], the report of the National Advisory Committee on SARS and Public Health chaired by Dr. David Naylor[4], and the two interim SARS Commission reports by the Honourable Mr. Justice Archie Campbell[5,6] highlighted the central importance of public health in protecting health and preventing the spread of disease. These reports collectively questioned how the current system was funded, managed and governed. They stated unequivocally, that while the public health system in Ontario is clearly strong in parts, overall, the status quo is not acceptable.

Although infectious diseases and the provincial experience with SARS have driven the call for change, it would be limited to see the work ahead as only focusing on health protection. In rebuilding, we must use the opportunity to strengthen our capacity to promote and enhance health and well-being as well.

The explosion in societal concern related to our modern epidemics of chronic diseases and their underlying individual, social, cultural, economic and environmental determinants were underscored by the Chief Medical Officer of Health's 2004 report on healthy weights.[7] This report cites the impending and significant health impacts of obesity on both life expectancy and healthcare

expenditures. It reinforces the breadth of the role of public health in promoting health and building healthy communities in the years ahead.

It is from the foundation laid in the many reports that have been tabled and from an increasing awareness of the risks to health ahead, that we are steering our work forward.

From Blueprint … to Provincial Plan

In June 2004, the Ontario government launched Operation Health Protection, a three-year plan to rebuild public health. The goal is a stronger revitalized public health system able to meet the population's public health needs. Although the impetus for Operation Health Protection came from concerns about our ability to control infectious diseases, the plan reinforces public health's role in *both* disease prevention and health promotion. It involves a series of related activities, including[8]:

- creating a new Health Protection and Promotion Agency which will provide scientific and technical expertise on communicable diseases, infection control and emergency preparedness, provide specialized laboratory and epidemiological services, and translate research and information into practical tools, advice and support to Ontario's healthcare providers and public health practitioners.

- strengthening health emergency management to ensure Ontario can respond effectively to health emergencies.

- enhancing the province's capacity for infection control by establishing a Provincial Infectious Diseases Advisory Committee and regional infection control networks.

- developing an information infrastructure for health system preparedness including a new provincial surveillance system, the integrated Public Health Information System (iPHIS), and Ontario's Public Health Alert System (PHAN).

- developing a health human resources strategy to ensure that Ontario has the public health professionals needed to protect and promote health.

- **renewing the public health system** by strengthening the independence and role of the Chief Medical Officer of Health, increasing the provincial share of funding for public health programs and services delivered through local health units, **reviewing the organization and capacity of local public health units,** reviewing and updating the *Mandatory Health Programs and Services Guidelines* (MHPSG), and preparing an annual public health performance report.

… to Changes on the Front Lines

The revitalization of public health focuses closely on the front lines. It is at the local health units where the day-to-day business of public health is conducted, where health emergencies are first detected, where programs are developed to prevent or control infectious diseases and prevent chronic diseases and injuries, and where public health staff work directly with their communities to protect and promote health. The work of the Capacity Review Committee, which will be described in detail in this report, will recommend the best ways to revitalize our local public health units as a key component of Operation Health Protection.

About the Capacity Review

> *"Ontario's 36 local health units are the front line of protection against infectious disease. That chain of protection is only as strong as its weakest link."[9]*
>
> **The Honourable Mr. Justice Archie Campbell (2005)**

> *"The Ministry should commission a review of existing local public health units. The review should incorporate expert input, and comparisons to appropriate jurisdictions to:*
> *– determine the required core capacities to be available at the health unit level, based upon core geographic, health status, health need, cultural mix, and core health determinants...;*
> *– identify key operational, systemic, and governance barriers that contribute to or may impede the successful functioning of local health units; and*
> *– recommend appropriate models of health unit consolidation where such consolidation is rational based upon the evidence generated above... and would contribute to strengthening local public health resources."[10]*
>
> **Ontario Expert Panel on SARS and Infectious Disease Control (2004)**

The Capacity Review

The Capacity Review is a comprehensive assessment of local health units' capacity to provide the public health services Ontarians need in the most effective way possible. It is informed by the work of Justice Campbell and Dr. David Walker. The Capacity Review is looking at public health as it could be in the future, as a *system* – as it could be better delivered, managed, governed and funded.

The Capacity Review is not an operational review or field assessment; it is not intended to grade health units as good or bad, nor will it examine the details of health unit programs.

The Capacity Review will look at how local public health can work more effectively as part of an integrated provincial public health *system.* The review will also articulate a vision of the place of public health within a health system that is rapidly changing.

Defining how public health could be governed, structured, organized and funded is no easy undertaking. Stating that change is required is the easy part. Because there are multiple and often competing perspectives, defining the exact manner, the approach and the timing for change is far more difficult.

If the Capacity Review is to have a lasting impact, it needs to identify strategies and operational processes required to implement the recommended changes and to monitor the impacts of these changes on service delivery.

The Capacity Review is also providing a way for local health units, municipalities, public health associations and others in Ontario who are interested in public health to share their ideas. These include identifying ways to strengthen the system from the ground up, enhance local leadership, create stronger partnerships among local health units, and build more effective collaborative partnerships with community and academic partners and other sectors that influence the public's health such as schools, housing authorities, recreation programs and workplaces.

Given the many changes that are occurring in other parts of the healthcare system, the Capacity Review also provides a timely opportunity for Ontario's public health system to define the potential future relationships of public health with other sectors (including new models for primary care delivery, Local Health Integration Networks, school boards and others) and the rest of the public health system in Canada.

Figure 1 illustrates how the Capacity Review fits within Operation Health Protection.

FIGURE 1

Operation Health Protection
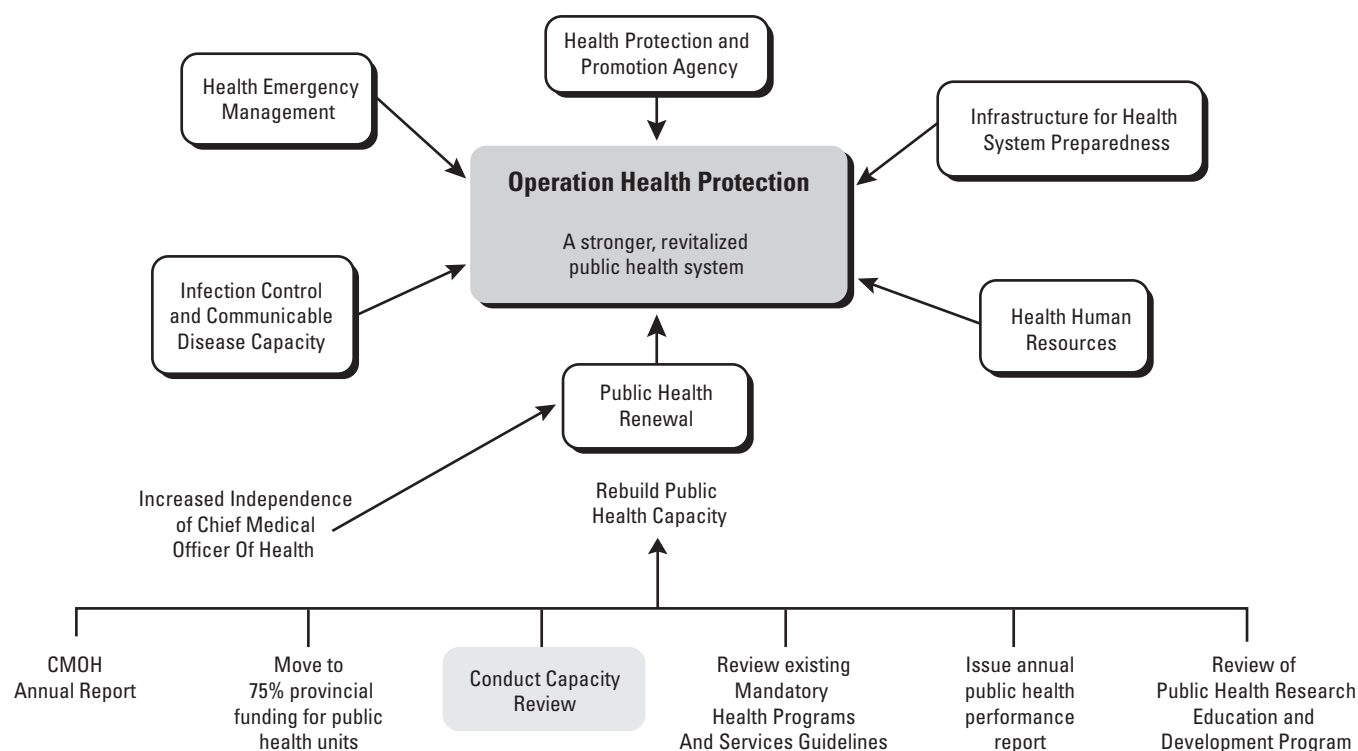
About the Capacity Review Committee

The Capacity Review is led by the Capacity Review Committee (CRC), established in January 2005 by the Chief Medical Officer of Health for Ontario. The CRC reports directly to the Chief Medical Officer of Health and, through her, to the Minister of Health and Long-Term Care.

Members of the CRC are listed at the start of this report. They have expertise in public health delivery and organization in Ontario, as well as in change management within the health system. They were chosen for their knowledge and experience in public health, and also reflect the need to hear voices from different geographic areas of the province and the experience of both large and small health units.

The responsibilities of the CRC are to provide advice on options to improve the configuration and function of the local public health unit system, including:

■ core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer)

■ issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.)

■ addressing operational, governance and systemic issues that may impede the delivery of public health programs and services

■ mechanisms to improve systems and programmatic and financial accountability

■ strengthening compliance with the *Health Protection and Promotion Act* (HPPA), associated regulations and the MHPSG

■ organizational models for health units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and

■ staffing requirements and associated operating and transitional costs.

For the CRC's full terms of reference, see Appendix 1.

Subcommittees

To help complete its work and answer the key questions listed above, the CRC established five subcommittees:

- Governance and Structure Subcommittee
- Public Health Funding Subcommittee
- Public Health Human Resources Subcommittee
- Public Health System Accountabilities Subcommittee
- Research and Knowledge Transfer Subcommittee

For the terms of reference of each subcommittee, see Appendix 2.

In addition, a working group was established to examine the issue of primary healthcare and public health particularly as this relates to Family Health Teams. Their working objectives are included in Appendix 2.

The Context for the Capacity Review

Public health has never faced more challenges and opportunities than it does today. Demographic pressures include the aging population and our increasingly diverse society. The epidemics of chronic diseases and injuries require comprehensive prevention strategies. Communicable diseases continue to cause significant illness and death as new infectious disease agents emerge or re-emerge. Environmental concerns such as air quality and safe water are increasingly recognized for their impact on health. Emergency preparedness and response to both natural and human-made disasters is an expectation and a reality that plays out somewhere in Ontario every year. Strong and consistent public health programs across the province are necessary to address these growing concerns and to ensure the health and safety of Ontario citizens.

The review is also being undertaken at a time of great change in healthcare at the federal, provincial and local levels.

At the federal level, the new Public Health Agency of Canada has been formed, and negotiations are underway among the provinces, territories and the federal government to strengthen working relations across and between jurisdictions. The Public Health Network (a federal/provincial/territorial body) has been established to promote collaborative planning and best practices. Six National Collaborating Centres for Public Health are currently under development to support the work of federal, provincial, territorial and local agencies delivering public health services; these include the Centre for Public Health Methodologies and Tools Development in Ontario.

At the provincial level, there have been a number of significant changes that have had or may have an impact on public health service delivery at the local level. The following examples illustrate the growing complexity of local public health service delivery relationships and multiple accountability requirements:

- In 2003, Ontario established a new Ministry of Children and Youth Services (MCYS), responsible for coordinating services for children and youth. Planning and funding for many of the children's services provided by health units, such as Healthy Babies Healthy Children and Preschool Speech and Language, have been transferred from the Ministry of Health and Long-Term Care (MOHLTC) to MCYS.

- In June 2005, a new Ministry of Health Promotion (MHP) was established. It is responsible for coordinating, improving and delivering health promotion programs such as Smoke-Free Ontario and Healthy Weights, Healthy Lives. The creation of a Ministry of Health Promotion brings increased focus to a range of activities currently central to the work of health units. While this represents a clear opportunity to strengthen the government priority and emphasis for health promotion programs, the full operational implications of these changes for health units are not yet fully known.

- The newly formed Local Health Integration Networks (LHINs) will be responsible for planning and funding a range of healthcare services in their communities, not including primary care and public health. The creation of LHINs themselves will provide both opportunities and challenges for public health in the years ahead. The planning boundaries for the 14 LHINs do not easily align in a number of health unit areas. Even where they do coincide, there is usually a one-to-many relationship between the LHIN and component health units. A challenge faced by the CRC is how to define a successful interface between public health and LHINs that will work in the best interests of all. Effective collaboration between LHINs and public health regarding population health assessment mandates is particularly important.

- The transformation of primary care and the development of family health teams (FHTs), family health groups (FHGs) and family health networks (FHNs), with increased emphasis on preventive care, provide opportunities for innovative collaborative work with public health. How best do we address the opportunities that lie ahead in this area?

- At the MOHLTC, change is underway with the re-shaping of the Public Health Division to rebuild capacity at the provincial level and address identified gaps and weaknesses.

- Finally, the government commitment to establish a Public Health Agency of Ontario provides an opportunity to examine the research and knowledge transfer supports that can be housed centrally to strengthen both local and provincial public health capacity.

Scope of the Review

The Capacity Review is focused on "how" Ontario's public health system should be structured and resourced, and how it should function. This is a somewhat different question than defining "what" the system does or does not do. The public health services delivered locally flow in large measure from the formal requirement for all public health units to meet the *Mandatory Health Programs and Services Guidelines* (MHPSG).[11]

It is well recognized that there is a clear need for these standards to be reviewed and modernized. Recent announcements from the Public Health Division suggest that this critical review will be undertaken in the near future. However, for purposes of the CRC review, it has been presumed that the core functions of public health are as set out in the current guidelines.

The task of the Capacity Review is to answer some key questions:

- How should health units be structured and governed in the future to strengthen the public health system?

- What is an appropriate, responsive approach to modernizing the way we fund public health units? How can we ensure that funding is allocated fairly and predictably in a way that will allow health units to meet public health needs and achieve more equitable health outcomes across the province?

- What mechanisms should be in place in the system to ensure that health units are demonstrably accountable to both funders and the communities they serve for the services they provide and their use of resources?

- How do we demonstrate progress and measure and report on goals and targets in a way that is understandable, consistent and transparent across the public health system?

- What people and skills do health units need to meet the needs of their communities and provide effective public health services?

- How do we attract and keep the number and mix of people we need in the public health system in the years to come? How do we raise the profile of public health and attract the best and brightest in the future?

- How can we strengthen the capacity of health units to participate in enhanced research and knowledge transfer activities and deliver services that are evidence-based?

At first glance, some of these questions might appear to have easy answers. However, while there is agreement that Ontario needs to continue its efforts to strengthen public health, there is often polarized debate about *how* best to strengthen the public health system.

The success of the Capacity Review will depend on the CRC's ability to address contentious issues, and to recommend a workable set of lasting solutions.

Principles Guiding the Capacity Review

The work of the CRC is guided by the following principles:

Meaningful participation. Public health units, municipalities, related associations and others interested in public health will have opportunities to participate in the review.

Diversity. The review process will recognize the diversity and unique nature of Ontario's health units and the communities they serve.

Best practices. The review will be informed by key experts, information on best practices, and local, provincial, federal and international public health initiatives and studies.

Alignment and coordination. The CRC will actively seek out and build on synergies with other processes, such as the development of the Public Health Agency of Ontario and other health transformation initiatives.

Transparency. The CRC will share the outcomes of its studies, consultations and deliberations with public health stakeholders in a timely way.

Sustainability. The CRC will focus on long-term and sustainable strategies and solutions.

Methods and Approach

The Capacity Review Committee is taking a phased approach to its work. Phase I, the subject of this interim report, has focused primarily on gathering information and developing options that can be discussed with the field in more depth during Phase II.

The following sections describe CRC Phase I activities.

Reviewing the Literature and Commissioning Research

As with any complex process, the CRC has drawn on work already undertaken, including written reports, studies, academic papers and consensus documents in a wide range of areas related to public health.

Each of the CRC's five subcommittees has developed extensive bibliographies pertinent to its theme areas. To assist with its work, the CRC has also commissioned its own research in key areas to inform CRC deliberations, including a:

- Detailed review of the organization and experience of public health across Canada, the UK, Australia and New Zealand

- Study paper on the career path and experiences of Ontario Medical Officers of Health from 1985 onwards

- Review of lessons learned from public health and primary care collaboration across selected jurisdictions

- Review of historical funding patterns and practices to determine lessons learned and strengths and weaknesses

- Development of options for possible funding allocation methodology.

Some preliminary findings from the research have been used to inform this report and are discussed in more detail in the relevant chapters; others are still in progress and will be used to inform the final report.

Conducting Preliminary Consultations

The CRC has conducted preliminary consultations with key stakeholders. To provide a forum for sharing information about the Capacity Review and obtaining feedback from stakeholders, the CRC has established a Reference Panel, made up of Ontario organizations representing public health and public health employees. The Reference Panel first met in April 2005 to discuss the review and provide advice used to design the CRC surveys, and in August 2005 to provide advice on health human resources and research and knowledge transfer and exchange. The Reference Panel will meet again during Phase II. The terms of reference and membership for the Reference Panel are found in Appendix 3.

Informal discussions have also been held with the Association of Municipalities of Ontario (AMO). Information sharing with AMO and the City of Toronto will continue through Phase II as appropriate.

Position Papers and Submissions

The CRC reviewed a number of formal submissions prepared by public health organizations, including:

- alPHa. Moving Ahead Together. A Position Paper of Local Public Health Agencies, August 2005

- alPHa Board of Health Section. Strengthening Public Health Governance, Funding and Accountability, July 2005

- Association of Nursing Directors and Supervisors of Official Health Agencies. Strengthening Public Health Nursing Capacity, August 2005

- Association of Ontario Public Health Business Administrators. Discussion Paper on Enhancing Local Public Health Capacity in Ontario, July 2005

- Community Medicine Residents of Ontario. Public Health Human Resources in Ontario: Recruitment and Retention of Community Medicine Specialists and Medical Officers of Health, August 2005

- Council of Ontario Medical Officers of Health. Enhancing Local Public Capacity in Ontario, June 2005

- Health Promotion Ontario. Health Promotion in Ontario: Fulfilling the Promise, February 2005

- Nursing Health Services Research Unit, McMaster University and University of Toronto. Nurses in Public Health in Ontario, March 2005

- Public Health Reearch Education and Development (PHRED) Operations Committee. Partnering with Education: An Investment in Tomorrow's Work Force: A Critical Strategy for Innovative and Competent Public Health Practice. Backgrounder Submitted to the Capacity Review Committee, September 2005.

Organizations and agencies also provided relevant background documents or reports prepared for other purposes that have served to inform the CRC. These submissions have been fully considered by the CRC and its subcommittees.

Making Presentations

Members of the CRC have been invited to a make a number of presentations to groups about the Capacity Review. In addition, the Chief Medical Officer of Health and Ministry staff have made numerous presentations on the work of the CRC to a range of organizations.

There have also been a number of presentations to Ontario municipal associations with fruitful dialogue.

Gathering Data

The absence of comprehensive and valid public health data has been well documented in the past, not only in Ontario but across Canada. In undertaking its tasks, the CRC has faced the same challenges around lack of data in a number of areas. Hence, during Phase I, the CRC has used a number of different strategies to obtain information and to involve stakeholders in dialogue.

Health Unit Survey

In June 2005, the CRC sent all health units in Ontario an extensive, online survey (130 questions) about issues such as governance, funding, accountability, human resources and their research and knowledge transfer capacity. Health units were asked to describe their management and reporting structures, as well as the strategies they use to recruit and support their boards, and to assess performance.

They were asked to identify the skills or services they maintain in-house as well as the services they outsource or share with other organizations (e.g., legal services, information technology, systems support). Health units were asked about the process they use to develop their budgets and the factors that should be considered in any province-wide approach to funding public health. They were asked about the accountability mechanisms they are using now, and how accountability can be improved in the field.

The survey asked health units to describe in detail their staff complement, turnover rates and staffing gaps. The survey also sought detailed information about research and knowledge transfer activities, and about any barriers to accessing information to develop evidence-based programs.

The health unit survey was designed to:

- provide data on how health units are currently structured, funded, and staffed, and about how they function

- help identify key issues that would guide the next phase of the CRC's work.

Staff and Board Survey

A separate online survey was also sent to health units to be completed by individual health unit staff and members of boards of health. It was designed to capture the opinions and insights of staff and board members.

Staff and board members were asked about changes they would like to see in the way health units are structured, governed and funded, and in their workplaces (e.g., If you could improve your workplace, what would you change?). They were asked about their research and knowledge transfer needs and the strategies they would use to attract more people to careers in public health.

Survey Results and Limitations

The surveys were designed to provide a snapshot of health units at a point in time. This is the first systematically attempt to obtain such comprehensive baseline data from public health units on issues related to governance, health human resources, funding, accountability, and research and knowledge transfer and exchange. All 36 health units responded to the health unit survey. For the board and staff survey, the CRC received 1,443 responses from health unit staff, and 67 responses from board members.

The information obtained will be valuable for the CRC and for the system as a whole as the analysis of the findings is further refined. Summary survey reports are currently being developed for each survey. We anticipate that they will be released in the near future.

Limitations of the surveys should be noted. Some health units experienced difficulties using the online tools. There is a possibility that interpretations to questions may have varied.

For the Staff and Board survey, the survey design could not rule out the possibility of multiple responses from one individual. The CRC was not able to send the survey directly to all staff and board members in all health units. Where the survey could not be transmitted directly, the CRC relied on the health unit to forward the survey link. Minor data coding challenges relating to the online entry limit the ability to undertake some analyses. Common to all surveys of this nature, there is the potential for a participation bias as the self-reported data reflects the perspectives only of staff and board members who took or were able to take the opportunity to respond. As a result, the staff and board survey results should be characterized as informative, but not necessarily generalizable to the entire province.

Capacity Mapping

The CRC has also collaborated with the Ontario Public Health Association (OPHA) to conduct a capacity mapping exercise to provide more information on the current public health workforce and human resource issues.

Eleven professional associations were involved in the mapping exercise. They completed a questionnaire and participated in a follow-up interview.

The purpose of this exercise was to gather information on members (e.g., age, education, best practices, experience) and on capacity gaps or issues. That information is summarized in a final report, *Capacity Mapping in Public Health: Results of a Survey and Key Informant Interview Process with OPHA Constituent Societies and Related Associations and Groups,*[12] and was used to inform this report. This report is available through the OPHA.

The CRC acknowledges that this work was done under a tight timeframe, and while not definitive, it provides some very useful insights into human resource and training issues across a range of public health professions. The CRC expresses its appreciation to the OPHA for undertaking this task.

Public Health in Ontario

Public health is the science and art of preventing disease, prolonging life, and promoting health through organized efforts of society.[13]

John M. Last (2001)

The Organization of Public Health Services

Ontario's public health system is different from systems elsewhere in Canada. It is the only jurisdiction in Canada to have organizationally distinct health units[A] that are not part of regional health planning bodies. It is also the only jurisdiction in Canada where the cost of public health services is shared between the provincial and municipal levels of government.

Ontario is also unique in having taken the highly progressive step (at the time) of defining and establishing mandatory programs and services to guide delivery of public health services.

In comparison with other provinces in Canada, public health is also comparatively well-resourced in Ontario. This is not to say that there are not ongoing needs and demands; however, on a cross-jurisdictional scale public health spending in Ontario compares favourably with that in other provinces.

These differences make it difficult to find neat, clean, comparators to assess how well or badly we are doing and make it nearly impossible to find ready-made solutions by looking across the border or to our neighbouring provinces and territories.

Ontario is divided into 36 public health unit areas of remarkable diversity. The size of the population within each health unit varies substantially, from 34,000 in Timiskaming to over 2.6 million in the City of Toronto. The area covered by health units also varies, from 630 square kilometres in the City of Toronto to over 250,000 square kilometres for the area served by the Thunder Bay District Health Unit. Several health units are larger than several Canadian provinces, American states and even many European countries. It is recognized that Ontario's geography may have a dual impact as it may be associated with increased health needs of the residents and also increased costs associated with the delivery of public health services.

The responsibility for providing public health services has been assigned to boards of health. Under the HPPA, the legislation governing public health services in Ontario, "every board of health shall superintend, provide or ensure the provision of the health programs and services" required by the Act and its regulations "to the persons who reside in the health unit served by the board."[14]

In Ontario, boards of health are supported in their efforts to protect and promote health by the Chief Medical Officer of Health (CMOH)/Assistant Deputy Minister (ADM) who oversees the Public Health Division. The CMOH/ADM has a dual reporting relationship within the MOHLTC and the MHP.

In the future, boards of health will also be supported by the Public Health Agency of Ontario, whose role is envisioned to be that of providing additional depth of capacity in provision of data, scientific and technical advice and some of the tools and supports that have been clearly identified as major priorities by individuals working in public health.

[A] Under the HPPA, the term health unit refers to the geographic area served by a board of health. However, the terms health unit and board of health are often used interchangeably to refer to the agency which delivers public health programs and services. In this report, the term health unit is generally used to refer to the agency, and the term board of health is used to refer to the governance body.

Programmatic Expectations of Health Units

The HPPA sets out expectations for boards of health, the legal term for the corporate entity providing public health services. Under the HPPA, the Minister of Health and Long-Term Care may publish guidelines for the provision of mandatory health programs and services, and every board of health is required to comply with the published guidelines.

The MHPSG set out the minimum requirements for fundamental public health programs and services targeted at prevention of disease, health promotion and health protection. They set out standards in the areas of:

- chronic disease and injuries
- family health
- infectious diseases
- and general standards that deal with:
  - equal access
  - health hazard investigation
  - program planning and evaluation.

The MHPSG are scheduled for review beginning 2005/06 and will be revised and updated accordingly.

Services to Meet Local Needs

The HPPA also contains a permissive clause to allow boards of health to provide optional local programs in order to meet local needs (i.e., boards of health "may provide any other health program or service in any area in the health unit served by the board of health if, the board of health is of the opinion that the health program or service is necessary or desirable" based on the needs of people in the area).

Expertise and Skills

The HPPA establishes minimum qualifications for a number of public health professions. The MHPSG identifies expectations for the technical expertise and skills that health units should have (e.g., epidemiology, health promotion, community needs assessment, risk assessment and communication, policy development, infection control).

Community Linkages

To fulfill these expectations, health units are expected to play a unique collaborative and coalition building function in their communities. Compared to other parts of the broader health system, they have more extensive links to other programs and sectors in the community which have an impact on health, such as education, social services, housing services, food services, water systems and environmental programs. They have specialized skills, for example in terms of risk assessment and population health, that are crucial to their communities.

Despite working from the same basic expectations, Ontario's 36 health units vary considerably in the type, level and depth of service they provide. While some variation is appropriate given the strong focus on local needs and different interpretations of the MHPSG, other differences may be due to distinct factors, such as geography, funding levels, staff skills, strategic decisions made by boards of health, and the capacity of individual boards of health or local municipalities to provide services.

Public Health Governance and Structure – Issues and Options

Governance is critically important to "ensure clear decision making authority and public accountability, that ensures a clarity of roles and responsibilities within a systems-wide perspective, and maximizes resources to achieve public health objectives."[15]

National Advisory Committee on SARS and Public Health (2003)

"Local boards of health must be strengthened to ensure that those who sit on them are committed to and interested in public health, that they clearly understand their primary focus is on the protection of the public's health, and that they broadly represent the communities they serve."[16]

The SARS Commission Second Interim Report (2005)

Overview

Ontarians have a right to expect a comparable mix and level of public health services available in their communities, regardless of where they live in the province. They also have a right to expect consistent, effective and focused governance of all health units whether they live in a large city, a small town or on a farm.

It falls to the boards of health to fulfill these expectations by exercising the appropriate legal stewardship of public health units that the law demands. The legal responsibilities and expectations placed on boards of health are significant. We must not forget that while much attention has been placed on the role of municipal council members on boards of health, individuals serving on boards of health generally do so as volunteers.

As volunteers their efforts are often unsung, and in many cases are in addition to a range of other responsibilities they hold with the community.

All boards of health play or are expected to play several roles: providing strategic guidance and stewardship to the health unit, linking and influencing other local and provincial services, and working effectively to anticipate and appropriately plan for the future.

It is a reasonable expectation that Ontarians should be served by a system where these board roles and responsibilities are well understood by board members and implemented fairly and consistently across the province.

Current Governance Structures

Under the HPPA, public health services must be governed by a board of health. There are three distinct board/governance structures in place across the province:

- 22 are autonomous boards of health, which operate separately from the administrative structure of their municipalities. Autonomous boards have their own policies and procedures, and are focused solely on their public health responsibilities. The MOH is usually the chief executive officer of the health unit and reports directly to the board of health.

- 4 are boards of health that have been integrated into municipal administrative structures. These boards are autonomous and focused solely on their public health responsibilities, but they operate under the policies and procedures of their municipality. The MOH may or may not be the chief executive officer of the health unit. The MOH reports directly to the board of health, and may or may not also report directly to the chief administrative officer of the municipality.

- In the 10 health units with a regional government, a single tier city or a restructured county (Oxford), the municipal council has the mandate and authority of a board of health. Public health services may be combined with other services or placed in other departments. The health unit reports to a separate or combined (e.g., health and social services) standing committee of regional council. As the regional council is responsible for a wide range of programs and services, public health is one of many competing priorities. The MOH may or may not be the chief executive officer of the health unit. The MOH may or may not report directly to the region's chief administrative officer. In some cases, the MOH reports to a department manager, who reports to a general manager who then reports to the council/board of health.

These variations in structure and leadership appear to be due in part to changes made to the HPPA in 1997, and in part to the differing proximity that boards of health have with their municipal infrastructure. As municipal structures have changed, so too has the structure of the board of health often changed.

The basic composition of the board of health is determined by the HPPA. It specifies that there shall be not fewer than three, and not more than thirteen municipal members on a board of health. The Lieutenant Governor in Council may appoint additional members (who are generally referred to as *provincial appointees*), but the total number must be one less than the number of municipal members. However, these provisions do not apply to regional municipalities or the restructured County of Oxford, or to any single tier municipality whose founding legislation has the rights, powers and duties of the board of health. The *City of Toronto Act* empowers city council to establish the size of the board, and to appoint all members to the board. Further, it provides for city council itself to undertake certain functions (e.g., the appointment, reappointment and dismissal of a MOH and associate MOHs; the appointment of the auditor).

Ontario Regulation 559, *Designation of Municipal Members of Boards of Health* defines the number of municipal appointees for each of the autonomous boards.[17] The regulation identifies the number of members to be appointed by each municipal council, or by a number of municipal councils together. Members appointed by municipal councils are generally, but not exclusively, elected officials.

The corporate/ administrative leader of health units also varies across the province:

- 25 health units are led by the MOH

- 4 are led by a non-MOH chief executive or administrative officers

- 3 are led by an executive director

- 2 are administered by general managers

- 1 is administered by a city manager

- 1 is led by a commissioner of health.

There are marked regional differences in how health units are led. Health units in the North and the East are all led by MOHs, while no units in the Central South are led by MOHs.

Are the Current Governance Structures Effective? Views from the Field

While the HPPA sets out some general requirements for board composition, appointments, and record keeping, it is silent on many of the core factors that contribute to what today would be seen as markers of good governance.

Early analysis of the survey data appears to indicate a pronounced level of variation regarding the formalized supports, training and orientation, tools and guidance available to board members. This variation appears to cut across both type and form of board structure and health unit. Regardless of how the form of board governance could or should change, this aspect appears to be clearly in need of significant effort. In other sectors and other parts of the healthcare system, the orientation tools and support provided to a board are increasingly seen as essential enablers for effective leadership.

In an attempt to determine how the current governance structures operate, the CRC survey of health units, board members and staff asked a series of questions about board activities and tools and approaches that are usually considered markers of good governance, for example board recruitment and training, reporting structures and strategic planning.

Board Recruitment and Support

According to the survey results, there is wide variation in how board members are recruited and supported. While it is recognized that recruitment of board members, particularly provincial appointees, does not apply to all board structures, only two health units report having developed additional recruitment criteria for board members beyond those required in HPPA.

Because municipal members make up most or all of the board of health, the board's composition is primarily dependent upon election results and/or the outcomes of municipal appointments across many committees. It is important to note, however, that direct citizen representation is clearly possible as seen in the City of Toronto which has successfully built citizen representation into a municipal model.

A number of health units with vast geographic area report that one of their greatest challenges is ensuring geographic representation among board members.

Board Vacancies

In the survey responses, 35 of 36 health units reported on the composition of their board of health. Across these health units, a total of 453 members are reported to serve on boards of health, ranging from 6 to 31 members. The majority of members are elected municipal officials; however 10 health units identified a total of 21 non-elected officials among municipal appointees.

Under the HPPA, the province has historically had the authority to appoint provincial appointees to a maximum of one less than the number of municipal representatives. A total of 65 positions for provincial appointees were identified for the 26 boards eligible for such appointments. However, only 43 of these (66%) were reported as being currently filled.

A total of 10 health units identified current vacancies on their boards of health with the number of vacant positions varying from 1 to 6. However, the CRC recognizes that the HPPA does not define the specific number of provincial appointees to boards of health, and vacancies are generally considered in light of historical appointment patterns or board bylaws.

According to the survey results, boards have the greatest difficulty filling positions for provincial appointees and non-elected municipal appointees. In addition, a number of health units expressed significant frustration with delays in provincial appointments while others noted a lack of interest among some municipal politicians in serving on the board as an ongoing challenge.

Most health units appear to have no organized process for recommending provincial appointments to the board. At minimum it seems that the knowledge of how this process does (or does not) work is limited and seen as somewhat opaque. Among those who do have a policy on provincial appointees, there is no common approach about how names are brought forward for approval.

Board Turnover and Instability

Uncertainty about the timeliness of provincial appointments is sometimes compounded by a "revolving chair" syndrome faced by some boards regarding municipal appointees (whose terms can be as short as one year) and the potential of wholesale board change associated with municipal elections.

All these factors are challenging for board stability and cohesion.

Board Orientation

Almost all health units report having an orientation process for board members and two-thirds have taken most or all of their board members through the process in the past three years. However, board orientation varies widely between units from minimal efforts to comprehensive day-long or multi-day sessions.

Those with municipal or regional structures report additional challenges due to the competing interests of the board members who require orientation to a wide range of municipal services. This may hinder delivery of a comprehensive orientation to their public health responsibilities, expectations and legal duties.

Board Self-Assessment

The approach to assessing performance of a board also appears to vary significantly among boards of health. In the health unit survey, 17 units report no process in place by which the board assesses its own performance, 5 report conducting a verbal debrief at the end of each meeting, and 10 report the accreditation process as being their performance assessment measure.

Strategic Planning

Although effective strategic planning is an increasingly recognized marker of a strong organization, the approach to strategic planning appears to vary considerably across health units. Early survey data indicates that 33 health units have a strategic plan, of which 14 were updated in 2005. However, 6 report not having approved a strategic plan since 1999 and in 3 health units, strategic plans appear to have lapsed.

Strategies to Strengthen Governance

When asked about ways to strengthen governance, health unit staff and board members survey responses recommended that board members be chosen based on their expertise or interest in public health. They also recommended that staff play a stronger role in decision making, and that there be better collaboration between the board and senior staff.

A number of staff in units where the municipal or regional council acts as the board of health recommended that boards of health be more autonomous from regional and municipal structures to allow for a greater focus on public health issues and concerns.

Staff and board views were echoed in the health unit surveys, which recommended improvements to board structure, more focus on health issues by board members, and greater visibility for board members within the health unit.

Structure, Composition, Expectations and Support

The deliberations and work to date, including the preliminary analysis of survey data and submissions from multiple parties, show that a number of different issues and challenges underlie the governance challenges in the Ontario public health system. In particular, the structural and operational issues associated with regional and municipal models are an area of considerable interest and study.

Reform of governance must be undertaken in a multi-pronged manner. Structural improvements in governance may be required, but these may be insufficient without the following:

- clearer expectations for boards of health and accountability systems for assessing performance

- more consistent and effective orientation, training and support

- improved functioning and timeliness of the appointment and selection process for provincial appointees as required.

Experience in Other Jurisdictions

In the past, most Canadian jurisdictions have had a mix of governance models for public health. Local boards of health often evolved as a local function funded by municipalities, while provincial governments were often involved in delivering public health services in less populated parts of the province.

With the creation of regional health authorities, other provinces have moved to greater consistency in their forms of governance. Similar trends have occurred in other jurisdictions, such as England and Australia – but not in the United States, which continues to have a mixture of city, county and multi-county local public health agencies often coexisting within individual states.

Based upon research reviewed by the CRC and consistent with observations made in the past by Dr. David Naylor, there are very mixed experiences across other jurisdictions in Canada where public health has been absorbed into the regional health authority structure.

The benefits of integration within regional health authorities include the development of better and more direct working relationships with other stakeholders within the health sector and the potential for enhanced surge capacity at the times of crisis.

Consistently referenced challenges include the competing fiscal and program pressures faced by regional health authorities – a frequent observation is that public health has (in some jurisdictions) faced significant challenges retaining profile and resources when co-housed within structures responsible for hospital funding. While some respondents have spoken of the benefits of collaborative planning, in reality it is not clear that the regional health authority model has been influenced or driven significantly by needs and issues specific to public health.

Would Ontario Benefit from Moving to a Single Model of Governance in Public Health?

The CRC review of existing public health governance revealed that there is wide and increasing range of variability. If governance were an abstract concept with no potential impacts on functionality or the services that people expect, then perhaps it would matter little.

However, the well documented experience of the Muskoka-Parry Sound Health Unit clearly illustrates that weak or divided governance can have impacts on a health unit's ability to fulfill its role in addressing health needs, its ability to respond quickly and effectively in a crisis, and its ability to recruit and retain medical leadership.[18]

At this stage in its deliberations, the CRC is exploring what would be required to move, in a staged manner, from the multiple models of public health governance currently in

place across Ontario now, to a single model of governance for public health with far more circumscribed opportunities for variation to reflect local needs.

Moving to a more focused or consistent model of governance for public health in Ontario seems to be a necessary step in building a more systems-based approach to public health.

Some of the advantages that may result from a single model include:

■ better system-wide functionality with enhanced capacity for shared resources and mutual aid

■ an enhanced capacity to leverage the entire system to accomplish public health goals

■ clear and consistent funding and operational timelines

■ governance structures and roles that can be clearly understood across the system by partners, stakeholders, the community and government

■ more opportunities to develop, implement and share governance best practices across the system

■ greater ability to develop and share basic supports, such as recruitment criteria, orientation packages and training materials

■ more opportunities for system-wide peer-based comparison and evaluation.

If the public health system decides to move to a single model of governance with some degree of local variation, the questions then become: *which model should be chosen and how much local variation is allowable or desirable?*

What is the Appropriate Role for Municipalities?

Ontario is unique among Canadian provinces for its involvement of municipalities in the funding, and in some cases, the delivery of public health programs. In other provinces public health is provincially funded and operates as part of regional health authorities.

The past ten years have been challenging ones for Ontario's municipalities as they have absorbed many new service responsibilities and financial obligations. In some communities, this has led to tensions between public health and local government as municipal councils

struggle to meet their requirement for a balanced budget while health units seek to meet their provincially mandated program obligations. There has been much debate about whether it is in the best interest of either party to tie this essential health service to the level of government that faces the greatest financial challenges.

Municipal involvement with public health has also brought strengths and opportunities, for example the ability to influence healthy public policy in other areas of municipal domain, and to share municipal support services in some instances.

What is less clear is whether the maintenance of close and productive ties with municipalities necessitates an ongoing role in funding and/or governance. If a 25% municipal funding contribution continues in the future (see Section 6), how can the interests of municipal property taxpayers best be protected? If we move to a single model of public health governance should this be a municipal model? If not, what continuing role should municipalities play in health unit governance? These questions are intertwined and not easy to resolve.

Principles of Effective Governance

In its work to date, the CRC has started to identify the principles of effective governance, which will be used to guide the recommendations regarding possible future governance models and identify the supports that boards of health will need to fulfill their role. Stepping back from the debates about forms of governance, the CRC has strongly agreed with the need for continuing local governance, whatever the level of provincial involvement or funding.

The CRC has drawn on literature and expert advice to develop some guiding principles for local governance which it is considering including in its recommendations. These principles include:

■ locally based (rather than provincially controlled)

■ clear purpose, role, responsibility and authority

■ ability to meet legislative and regulatory requirements

■ ability to reflect and represent the community

■ clear accountability for programs, services and budgets

■ strong linkages to key partners, particularly municipalities

■ sustainability and stability.

Markers of Good Governance

To help guide its recommendations on governance, the CRC is working to identify markers of good governance which could be used in self-assessment and for performance management review. These include:

- a strategic focus primarily on public health

- stable professional leadership

- board members with the appropriate mix of skills and competencies

- board composition that provides for continuity

- a set process for recruiting, orienting, training, supporting and assessing board members

- a set process for recruiting and assessing the MOH/CEO and engaging in appropriate succession planning

- a robust strategic planning process and capacity for risk assessment and planning

- mechanisms for internal and external communication, and clear rules of engagement.

How Do We Better Support Boards of Health In the Future?

As part of its efforts to enhance public health leadership, the CRC is looking at ways to strengthen and develop boards, including:

- developing criteria for recruiting board members

- recommending standardized orientation, training and development program and tools

- identifying the skills and supports required to manage health units effectively.

How Should Ontario's Public Health System be Structured?

Ontario is currently divided into 36 health unit areas. The Walker report recommended reconfiguring the public health system, and merging smaller health units. This recommendation was in part related to the issues of achieving critical mass and ensuring a sufficient surge capacity for public health crises.

What is Capacity? Defining Critical Mass

Recent federal and provincial reports on public health and multiple submissions from the field have all described the importance of having sufficient breadth and depth of capacity within both the system and individual public health units to allow for a strong response system.

The phrase "critical mass" is cited repeatedly as a marker of a desirable end-state for all health units. Critical mass for public health services, that is, the minimum amount of resources, expertise and capacity boards of health require to fulfill expectations, is not an easy thing to define.

Defining critical mass is not simply about counting the positions in a health unit. To guide its thinking, the CRC is taking into account, among other factors:

- the expectations of boards of health in the MHPSG

- the requirements set out in the HPPA and government policy that help describe what a health unit needs to be able to do and how it is expected to be organized and led to promote and protect health

- core public health functions including:
  - population health assessment
  - health surveillance
  - health promotion
  - disease and injury prevention
  - health protection.

- comparative studies of the organization, structure and role of public health in other Canadian jurisdictions.

Expectations

Partly, though not exclusively linked to critical mass, is the issue of spelling out the minimum expectations we should have of all health units. In the past, Ontario had been a leader through the development of mandatory program guidelines to define programmatic requirements. These are now out of date, however, and on their own, guidelines cannot provide us with insight into the depth or level of activity or response that should be in place.

For example, public health units are responsible for investigating and managing communicable disease outbreaks. What size of outbreak should we expect each Ontario public health unit to be able to manage without aid from other public health units? This is not necessarily the same as critical mass.

This is not an abstract question. Being clear about what each health unit is expected to be able to handle is a first step in defining an assessment of capacity and defining

expectations. This also speaks to the concept put forward by Justice Campbell, that the system is only as strong as its weakest link.[19]

The CRC continues to explore these issues around the following sorts of questions:

- What are the implications of critical mass for system infrastructure, including public health workforce development or system configuration?

- What arrangements are necessary for effective deployment of resources when situations requiring surge capacity are faced?

- What additional mechanisms need to be in place in advance to allow additional capacity to be quickly and effectively deployed?

This type of analysis may, over time, help more clearly define performance expectations and the critical mass of skills and resources that all Ontario public health units must have.

Benefits and Risks of Reconfiguration or Amalgamation

A reconfigured system could:

- strengthen and enhance service delivery

- improve overall management of the public health system

- improve the province's capacity to support and coordinate the public health system

- improve operational depth and the ability to recruit and retain staff, because each health unit would have greater access to a broader range of specialized skills and services

- improve the system's capacity to respond to critical needs

- provide greater critical mass to respond to emergencies

- align the public health system more closely with other partners.

The risks associated with reconfiguration of health units also have to be considered. Reconfiguration could include the following impacts:

- the loss of key relationships with municipalities

- reduced proximity of service provision to the community

- perceptions of providing less service

- it might take a significant amount of time to implement

- substantial direct and opportunity cost

- substantial disruption to the public health workforce.

What Factors Should Ontario Consider in Reconfiguring Public Health Units?

The "right" size and configuration of health units depends on a number of factors. In its deliberations on public health system configuration, the CRC is considering:

Critical Mass. What capacity or critical mass of people, skills, funding and other resources do health units need to fulfill their role? Some of the factors that may be used to determine appropriate critical mass are the size of the public health unit area and the size of the population served.

Mutual Aid. Health units are part of a larger public health system and should be able to call on assistance from other health units, the province and the federal government. The CRC will look at the types of services that can be shared between health units, and identify the capacity that must exist within the system regionally and provincially to support an effective public health system.

Functionality. Some health units are highly effective while others have difficulty meeting expectations within existing resources. In making recommendations about configuration, the CRC will consider factors such as functionality and capacity to deliver programs and services. It will also look at the cost of service delivery, capacity to recruit and retain a mix of staff, local partnerships, participation in networks, existing agreements and number of satellite offices.

Geography. Health units serving large, remote, sparsely populated areas of the province may require a different mix of skills and supports. In these cases, the CRC will take into account the total land area to be served and population density and distribution.

Other Factors. The CRC will also consider the impact of other service boundaries (e.g., LHINs, Regional Infection Control Network, municipalities, school boards, other health programs), transportation routes, history, economics, political realities and culture.

Public Health Funding – Issues and Options

The Current Approach to Health Unit Funding

The HPPA defines the mechanisms by which public health units are funded. Budgets are set by local boards of health, and the Act defines the requirement for obligated municipalities to pay the expenses of the boards of health and local medical officers of health. The Minister of Health and Long-Term Care has the ability to provide grants directly to boards of health. Prior to 1998, the provincial share of public health funding was 75% for most health units, and 40% for Toronto health units. In addition, the province paid 100% of selected programs including tobacco and sexual health. In 1999, the responsibility for funding public health programs was transferred entirely to municipalities, with the province making 100% grants for the newly established Healthy Babies Healthy Children program. In 2000, the province committed to fund 50% of public health programs. As committed to in Operation Health Protection, the proportion of provincial funding is being increased. The MOHLTC currently pays 55% of health unit budgets, rising to 75% by January 2007. It also provides:

■ 100% of funding for unorganized areas (areas of the province that are not municipally organized)

■ 100% of the cost of 180 infection control Full Time Equivalents (FTEs)

■ 100% of Heart Health Programs

■ $5 per dose for the Universal Influenza Immunization Program

■ Enhanced funding for tobacco use prevention and enforcement

■ 100% of the costs of certain specific initiatives (e.g., asthma, FOCUS alcohol and drug abuse program, e-Health strategy) that are only offered by some health units.

Other programs that had been funded 100% by MOHLTC, such as Healthy Babies Healthy Children, Infant Development and Preschool Speech and Language, and Infant Hearing were transferred to the Ministry of Children and Youth Services (MCYS) in October 2004. These programs are now funded 100% by MCYS. Respondents in the health unit survey continue to observe that the funding provided in these MCYS programs does not necessarily cover the associated overhead and administrative costs.

Some health units have also been successful in accessing competitive grant and project based funds from a variety of other sources.

Budget Setting

The process for establishing annual budgets in health units varies significantly depending on type of health unit and number of obligated municipalities involved in the process. However, across all units regardless of type, the basic rule is that the budget set by the board of health is the de-facto trigger for the provincial allocation or "grant" which typically follows many months after the budget is approved. The fiscal year for health units and for municipalities runs from January to December, while the provincial fiscal year is April to March.

The board of health approved budget may be interpreted locally as the "conditionally approved" budget (until provincial funding allocations are received) or, in some units as the approved budget, against which the provincial allocation is simply assumed. The variability of survey responses reflects the lack of certainty or predictability that appears the hallmark of public health funding. Figure 2 illustrates the challenges for health units working within the nonaligned fiscal years and the processes of two levels of government.

FIGURE 2

Steps for Budget Approval: Municipal/Provincial Involvement

MUNICIPAL LEVEL			
Generally, PHUs start budget preparation for next calendar year (e.g. 2006) Medical Officer of Health/CEO approves PHU's proposed budget PHU's proposed budget forwarded to Board of Health (BOH)	The BOH approves the budget (e.g. for 2006) and municipality(ies) provide the funding for their share	Grant Requests due at the Ministry by April 30	Annual Settlement Report (approved by BOH) due at Ministry by June 30, including Audited Financial Report
FALL 2005	**WINTER 2005/06**	**SPRING 2006**	**SUMMER 2006**
Approve	*Derive Budget Request*	*Review*	*Set Budgets*

PROVINCIAL LEVEL			
Ministry communicates details of grant approval for current year to BOH (e.g. 2005) Provincial fiscal planning process begins for upcoming fiscal year (e.g. MOHLTC develops its multi–year budget request for Mandatory Programs for forthcoming year	Ministry sends out guidelines for Grant Requests (e.g. 2006) Government reviews Ministry budgets	Ministry starts Grant analysis Reconciliation of actual expenditures against Ministry funding Provincial Budget Printed Estimates	Ministry sets program budgets

Two key points to note are that:

- the MOHLTC is required to estimate the public health budget for its internal planning purposes before it receives health unit budget requests

- final Ministry allocations to health units are confirmed towards the end of the period in which the money was spent or for which it was allocated.

The View from the Field

According to survey respondents, the current approach to budget planning and approval does not provide adequate funding to fulfill health units' legal and program expectations. Health units are currently not 100% compliant with the requirements of the MHPSG.

The budget setting process is difficult because municipal councils, like any large organization dealing with multiple issues, are not solely focused on one set of needs. Municipal councils, faced with relatively small budgets and competing demands for services and resources, may, in some cases, be forced to allocate funding intended for public health programs to meet other urgent municipal needs.

While some survey respondents suggested that the shift to 75% funding from the province may alleviate some of the fiscal pressure on municipalities, they suggest it will not resolve the basic structural problems such as: budget timing (i.e., the different provincial and municipal fiscal years); lack of multi-year funding to enable better long term planning; lack of clear expectations about mandatory services; annual budget allocations that result in unpredictable funding; and the lack of an allocation methodology that adequately reflects the costs associated with providing services in rural or remote areas, unorganized areas, or to populations with complex needs, such as off-reserve Aboriginal people. The shift in the source of funding will not, on its own, guarantee that health units receive enough funding to deliver the mandatory programs.

Recent Reports

The challenges of the current funding approach and possible solutions have been enumerated in recent years: in 1996 in a report titled, *Towards Equitable Funding for Public Health*[21]; in 2001, in a proposed methodology for allocating provincial funding for public health developed by a working group established by the Public Health Branch[22]; and in the 1997 and the 2003 Annual Report of the Office of the Provincial Auditor of Ontario.[23,24] As the Provincial Auditor noted:

> *"[T]he Ministry had not analyzed the extent to which individuals received differing levels of public health services or were exposed to greater levels of risk depending on where in Ontario they lived [or] whether funding for mandatory health programs and services was based on assessed need or on a jurisdiction's commitment or capacity to pay for the programs and services … 2002 per capita funding for mandatory health programs and services, while averaging $37 for the province, ranged from approximately $23 per capita to $64 per capita."[25]*

Guiding Assumptions for Appropriate, Responsive Public Health Funding

The Subcommittee on Public Health Funding has identified the following principles to guide development of a funding allocation model:

- To improve the capacity of public health

- To provide equitable access to programs and services in order to reduce inequities in health behaviours and health outcomes

- To comply with and support the HPPA, other relevant legislation and the revised MHPSG (being developed)

- To ensure the funding envelope is adequate to meet legal and program requirements, and factors in contingencies for local episodic and unanticipated health needs (e.g., health hazards, emergencies, outbreaks)

- To develop an allocation methodology that is evidence/needs-based

- To establish a funding process that is more predictable, explainable and accountable

- To ensure appropriate funding/support for any reorganization or restructuring transition costs

- To ensure that any new funding model reflects system needs including administrative and other supports (e.g., legal, IT, HR), episodic funding (e.g., surge capacity, outbreak control) and capital costs (e.g., equipment, space).

Possible Solutions

Would Multi-Year Funding Resolve the Problems?

Would more stable, multi-year funding help address the funding issues? The MOHLTC has recently moved to multi-year funding for hospitals to address some of the same funding concerns that occur in public health, such as funding instability and the inability to do long-term planning.

The CRC is in the process of discussing strategies that could result in a more rational budgeting and funding process. The issues under consideration and some of the resulting questions include:

- multi-year planning and funding (e.g., a three-year rolling budget approved annually with some planning and performance management reports)

- the development of clearer Ministry expectations and a clear link between expectations and funding.

- accountability measures that are feasible, realistic and don't impose an unreasonable burden

- the use of Ministry incentives to ensure deadlines are met — what would incentives look like?

- more communication between health units and the Ministry during the budget process

- the establishment of an operating reserve to cover unanticipated in-year episodic surge requirements — what is a reasonable amount for an operating reserve? What guidelines would be required for use of an operating reserve?

- appropriate allocations for administrative costs and other supports (e.g., legal services, human resources, IT) as part of the budget

- a structured program for capital and working capital — what would health units like to see in a capital funding program?

- more timely submission of settlement forms

- options for a funding model — what are the advantages and disadvantages of 75% and 100% provincial funding respectively?

What are the Characteristics of an Equitable Funding Allocation Model?

The issue is not just the total amount of funding for public health, but how that funding is allocated within and across health units. Per capita funding on its own is not an appropriate model. The CRC is in the process of identifying the characteristics of an appropriate funding allocation system and potential indicators that would be:

- valid and equitable proxies for health needs and service costs
- stable over time
- simple to operate in the context of a funding model.

The CRC is also considering whether funding allocations should be used to address targeted longstanding recruitment and retention problems. For example, should the Ministry provide 100% funding for MOH positions?

The CRC is also taking into account the impact of any change in funding model and the need to monitor the impact over time. Although the goal is to build capacity, transition to a new funding model should not result in budget cuts to health units that are adequately resourced now. Implementation may have to be phased in over time, using new funding.

Public Health System Accountabilities – Issues and Options

"The Ministry did not have adequate procedures to ensure that its expectations for public health were being met in a cost-effective manner."

"The Ministry had conducted virtually no regular assessments of local health units in the last five years to determine whether the health units were complying with the guidelines for mandatory programs and services."[26]

The Provincial Auditor of Ontario (2003)

Public health duties, roles, and responsibilities are primarily set out in legislation (HPPA) and in Ministry guidelines (MHPSG). In order to build an accountability system around such foundations, they must be current, evidence-based, valid and credible. The CRC has reiterated the need to review and update the MHPSG as outlined in Operation Health Protection.

The Current Accountability Mechanisms

According to survey responses, health units currently use a number of different processes to ensure accountability for their programs and services, and for their use of resources, including:

- internal planning processes

- budgeting processes

- reporting on the MHPSG, including the Mandatory Program Indicator Questionnaire (MPIQ)

- annual reports, health status reports and open board meetings (i.e., to report to the public/their communities).

However, such processes are not applied in a consistent fashion across individual health units or the public health system. Other tools, particularly those available to the Public Health Division and related to assessment, are not integrated into an overall system that monitors quality or performance of stakeholders.

View from the Field

While existing accountability mechanisms provide some information on what health units do, the primary tool historically used by the MOHLTC, the MPIQ was considered the least useful. As the province's MOHs noted in their submission to the CRC:

"There is currently no formal accountability process in place for Ontario's public health system. The current mix of accountability related strategies and tools for local public health units … [is] inadequate."[27]

This view was echoed in the alPHa report, which stated,

"Universally supported are the principles that accountability should be built on standards that are applied at provincial and local levels of the public health system, and that standard data collection tools that are part of the everyday work of the health unit need to be developed."[28]

These views were reinforced by the health unit survey. According to the responses, existing accountability mechanisms are inadequate and do not provide the tools health units need to monitor and improve the quality of public health services. The provincial compliance monitoring tools, particularly the MPIQ, were considered the least useful in this survey.

Health units currently use a variety of approaches to collect, monitor and report information on the 17 MHPSG standards; about half use the MPIQ as the basis for reporting their results. The data being used to assess performance across the system are neither reliable nor capable of identifying gaps and strengths. These data cannot be used to support system-wide planning or to provide health units with mechanisms to allow them to benchmark their performance against that of other comparable health units.

In the survey, health units identified a number of problems in meeting the current requirements for MPIQ reporting, including:

■ lack of both human and financial resources

■ lack of flexible evaluation tools

■ lack of understanding of the factors that make it difficult for health units to meet the data collection and reporting standards

■ the MHPSG themselves.

While all boards report to the public in some fashion, there is no standardized approach to reporting. This makes it difficult to compare one health unit to another let alone move towards an ability to report on system level performance. To improve accountability to the public, some health units recommend broadening the scope of what is reported and involving the community more in the reporting process.

Views on Accreditation and Quality Improvement

Participation in a public health accreditation program is voluntary. As of September 2005, 14 of the 36 health units were accredited. Based on the survey results, 12 of the 14 completed the accreditation process relatively recently (i.e., between 2001 and 2005). Although many health units see accreditation as a useful accountability mechanism, particularly because it is an external peer review of the health unit, they identified a number of concerns with the current accreditation process, including:

■ the cost
■ the focus on administration
■ the lack of Ministry support
■ the lack of board support
■ the low participation.

It is recognized that these observations could relate to accreditation in general, whatever the accrediting body. Health units have mixed opinions about whether to include accreditation as part of an accountability system.

Health units reported that they use a variety of other quality improvement processes, such as program reviews, program evaluations and operational planning processes. In general, however, formal quality improvement programs are not well developed and few health units have staff dedicated to quality improvement.

Possible Solutions

Over the past few months, the CRC has examined accountability mechanisms in other public health systems and in other sectors, such as police services, water quality and laboratory services, to identify lessons that would be relevant to public health.

The trend in most sectors is toward creating performance management systems, which focus on using reliable data and evidence to improve quality and accountability.

Based on that research, the CRC has identified the following elements of effective performance management systems:

■ a strong legislative or regulatory framework

■ program and/or service standards and performance measures

■ both ongoing and episodic monitoring

■ capacity to support continuous quality improvement at different levels of the system (e.g., training, interpretation, evaluation)

■ the ability for local users to make use of the information to guide their practice

■ the capacity and willingness to intervene in problem situations (e.g., a mechanism to deal with non-compliance).

A Public Health Performance Management System

The goals of a performance management system are seen as:

1 To ensure that Ontario's public health system (including local public health units, boards of health, provincial government) is meeting the standards and expectations set out in legislation and guidelines

2 To promote continuous quality improvement in Ontario's public health system.

In its deliberations, the CRC is looking at the responsibilities of individual health units and the system as a whole.

The CRC is working to develop a performance management framework that has the potential to ensure accountability and enhance the quality of public health services.

Improving Performance Through a Continuous Improvement Cycle

The CRC sees performance management as a cycle of continuous quality improvement – not a static, one time process. The following diagram (Figure 3) captures the multiple dimensions of this cycle:

FIGURE 3
Continuous Improvement Cycle

Continuous Improvement Cycle

- Measures
- Standards and expectations
- Data Collection and Quality
- Monitoring, Reporting and Surveillance
- Revision and Adjustment
- Analysis and Learning

FIGURE 4

Overview of a Draft Performance Management System for Public Health

FOUNDATION

Health Promotion and Protection Act

Mandatory Health Programs — REVISED

Community Health Status

Needs Assessment

Integrated Data Systems

Funding

Human Resources and Competencies

Quality Assurance and Performance Measurement PROCESSES

- Program planning monitoring and evaluation
- Accreditation-style organizational review
- Budgeting
- Auditor's Report
- Sporadic or random quality audits
- Prompted or complaints-based investigations

PROCESS

Program monitoring and evaluation
- Develop systems that meet internal needs
- Ensure that standards within MHSPG are covered
- Ensure that other parallel systems are integrated

Accreditation-style review
- Comprehensive — looks at both program and organizational requirements
- Focus on process and outcomes (as much as possible)
- Every 3-5 years

Budgeting/Auditor's Report
- Yearly financial review
- Both internal processes and external viewpoint (auditor)

Sporadic/Random quality audits
- Yearly random audit of small number of units (e.g. 5 of 36 PHUs)
- Very short notice and separate from accreditation-style review

Prompted/complaints-based investigations
- Occur based on a complaint or problematic review or audit
- Conducted by independent assessors who make recommendations to MOHLTC

TOOLS

Web-based electronic data collection/input tool

Compliance monitoring reports at the Public Health Division

Balanced scorecard — provincial

Annual Reports or Balanced scorecards — local

Accreditation status

Public Health Unit Budget

Provincial Auditor's Report

Auditor's Report-at the local unit level

Quality Audit Report — at the individual PHU level

Quality Audit Report — comparing all units reviewed for certain standard

Investigation Report — delivered to CMOH

Performance Management System Model

CRC has linked the accountabilities of all public health stakeholders into a performance management system which comprises multiple tools and processes that address all steps in the continuous improvement cycle.

Figure 4 provides an overview of a draft performance management system for public health. It indicates the sources of data and information, some of the different tools that could be used, and the types of performance assessment that could occur.

Building the System

Many of the components of an effective performance management system are already in place in some health units (e.g., logic model based planning). However, approaches vary significantly and they are not integrated or effectively coordinated across the system.

A series of tools and processes will be required to respond to the needs of various stakeholders. These include: program monitoring tools, program evaluation tools, organizational processes, reports to boards of health, reports to municipalities, reports to the various provincial ministries, and reports to the public. Each of these tools and processes may be slightly different, but they must draw upon the same data collection and processing systems. However, they must be utilized consistently across the system to allow for meaningful measurements of performance.

The CRC is looking at a continuum of mechanisms that are linked together to ensure ongoing performance improvement in public health:

Together, these tools and processes form a performance management system that can be continually monitored and adjusted.

Is there a Role for a Balanced Score Card?

Balanced score cards are a form of performance reporting that can be used to facilitate change, as a communication tool, to improve service quality and to increase program effectiveness.. While there is a lengthy tradition in Ontario of using hospital report cards, there is no systematic public reporting system for health units.

The CRC is considering the dimensions of a balanced score card that could be used to support effective public health planning and transparent public accountability. The Institute of Clinical Evaluative Sciences has previously proposed four quadrants of performance measurement for public health[29]:

- Health determinants and status
- Community engagement
- Resources and services
- Integration and responsiveness.

The CRC is considering whether these, or any additional dimensions, would be necessary in order to develop a uniform system of public health performance measures at the provincial level. It is also considering how a balanced score card would differ (or not) at the local level and content implications.

Public Health Human Resources – Issues and Options

"No attempt to improve public health will succeed that does not recognize the fundamental importance of providing and maintaining in every local public health agency across Canada an adequate staff of highly skilled and motivated public health professionals. Our national aim should be to produce a cadre of outstanding public health professionals who are adequately qualified and compensated, and who have clear roles, responsibilities and career paths."[30]

National Advisory Committee on SARS and Public Health (2003)

In the context of health human resources, the goal of Ontario's public health system is to be an employer of choice and to have the capacity to maintain a stable, highly skilled workforce. In order to accomplish this goal, the system must understand and address challenges related to recruitment and retention, leadership and mentorship, and quality of working life.

The Current Public Health Workforce

Staff Complement
According to the CRC health unit survey, there are 6358 full time equivalent (FTE) staff working in direct program delivery in public health across Ontario's 36 public health units. The workforce is a highly multidisciplinary mix of professionals, with over 20 different professions reported (see Table 1). It is apparent that public health is highly dependent upon multidisciplinary approaches to an extent likely found in few other settings. In addition to the program delivery staff, there are over 1400 FTEs who play a supportive role to direct program delivery. This includes administrative, information technology, librarians, evaluation and support staff. Specific data related to this group of FTEs continues to be analyzed by the CRC.

While the professional backgrounds of those working in public health is diverse, the overwhelming bulk of the public health workforce is made up of two categories: public health nurses (of varying categories) and public health inspectors. Beyond these two categories no other profession is reported as representing more than five percent of the workforce.

TABLE 1 – Program Delivery Staff in Ontario Health Units by Position and FTE

Position	FTE	Percent
Acting Medical Officer of Health	7.20	0.11
Associate Medical Officer of Health	24.10	0.38
Community Nurse Specialist	15.00	0.24
Data Analyst	15.70	0.25
Dental Assistant	168.64	2.65
Dental Hygienist	120.59	1.90
Dietitian	110.60	1.74
Epidemiologist	64.67	1.02
Family Visitor	304.84	4.79
Health Educator	67.08	1.06
Health Promoter	262.02	4.12
Medical Officer of Health	27.71	0.44
Nurse Practitioner	28.74	0.45
Nutritionist	98.96	1.56
Other Physician	12.98	0.20
Program Evaluation	42.23	0.66
Public Health Inspector	830.63	13.06
Public Health Nurse	2630.04	41.37
Public Health or Clinical Dentist*	60.04	0.94
Registered Nurse	199.81	3.14
Registered Practical Nurse	97.92	1.54
Speech Language	51.08	0.80
Other	1117.46	17.58
Total	6358.04	100.00

* An apparent data entry error by one health unit has required the aggregation of the public health dentist and clinical dentist rows for purposes of this analysis. This unfortunately masks a significant known recruitment and retention issue for public health dentists. The CRC will change and reflect this for purposes of the final survey reports.

Program Delivery Staff Vacancies

Given the size of the total program delivery staff workforce, the current vacancy rate across the system appears to be in the region of 4.6%, although this data has yet to be fully analyzed and vacancy figures may have been interpreted differently across health units. The professions with the largest proportions of vacant positions are associate medical officers of health (25%); nurse practitioners (18%) and clinical nurse specialists (13%). In terms of the total positions vacant, the greatest proportion of vacancies is found, not unexpectedly, in public health nurses and public health inspectors (see Table 2).

TABLE 2 – Vacancies in Program Delivery Staff Positions in Ontario Health Units

Position	FTE	Number of Vacancies	Percent of Positions Vacant	Percent of Total Vacancies
Acting Medical Officer of Health	7.20	0.00	0.00	0.00
Associate Medical Officer of Health	24.10	6.00	24.90	2.06
Community Nurse Specialist	15.00	2.00	13.33	0.69
Data Analyst	15.70	0.00	0.00	0.00
Dental Assistant	168.64	8.00	4.74	2.74
Dental Hygienist	120.59	2.00	1.66	0.69
Dietitian	110.60	8.00	7.23	2.74
Epidemiologist	64.67	4.00	6.19	1.37
Family Visitor	304.84	11.10	3.64	3.80
Health Educator	67.08	4.00	5.96	1.37
Health Promoter	262.02	10.00	3.82	3.43
Medical Officer of Health*	27.71	1.00	3.61	0.34
Nurse Practitioner	28.74	5.20	18.09	1.78
Nutritionist	98.96	5.00	5.05	1.71
Other Physician	12.98	1.00	7.70	0.34
Program Evaluation	42.23	0.00	0.00	0.00
Public Health Inspector	830.63	55.50	6.68	19.02
Public Health Nurse	2630.04	125.00	4.75	42.84
Public Health or Clinical Dentist	60.04	3.00	5.00	1.03
Registered Nurse	199.81	1.00	0.50	0.34
Registered Practical Nurse	97.92	4.50	4.60	1.54
Speech Language	51.08	4.50	8.81	1.54
Other	1117.46	31.00	2.77	10.62
Total	**6358.04**	**291.80**	**4.59**	**100.00**

* It is important to note that health units that did not have a full time medical officer of health did not identify this position as vacant for the purposes of this survey. The CRC considers these positions to be vacant for the purposes of its compositional analysis.

There is a high degree of local variability within the aggregate relatively low total vacancy rate. Of the 36 health units, only 5 did not report any positions as being persistently vacant for greater than three months over the past year. The remaining health units flagged many different positions as persistent unintended vacancies, with public health inspectors mentioned most often. The other professions mentioned included a wide range of program and service staff, including public health nurses, associate medical officers of health, dental staff, nutritionists, etc. One-fifth of health units also reported problems filling positions for program managers and project officers.

There are also reported vacancies for epidemiologists and dietitians. Although these disciplines represent a small fraction of the overall public health workforce, their absence may have a serious impact on the functioning of a health unit.

Of note, 25 health units have no distinct program evaluation staff. Sixteen health units have no nurse practitioners on staff. Four health units report no epidemiologists on staff, and four health units report no dietitians on staff. While some of these job functions may be filled by other employees with different job titles, these statistics do not necessarily represent vacancies, but appear to reflect operational local staffing decisions.

Program Delivery Staff Turnover

A number of health units are also experiencing high rates of turnover for program delivery staff. This appears to be particularly pronounced with public health inspectors and public health nurses. However, reported experience with high turnover also exists for the following professions: health promoters, epidemiologists, dietitians, nutritionists and program evaluators.

While some units reported turnover which reflected movement out of local public health (e.g., inspectors moving to a federal level), limitations of the survey do not permit conclusions regarding the degree to which staff are moving between health units within Ontario or leaving the local public health system altogether.

Projected Program Delivery Staff Retirements

As with other parts of the healthcare system, retirements will have an impact on public health units over the next five years (see Table 3). While the age profile of the bulk of the public health workforce is comparable or below that that of the health sector in general, there are several positions with a substantial proportion of projected retirements. Almost 30% of medical officers of health are projected to retire in the next five years. One acting medical officer of health is also projected to retire, representing 14% of that workforce. Eleven percent of registered practical nurse positions are also approaching retirement age.

Of the total projected retirements, public health nurse and public health inspector positions dominate, given the relative size of those pools.

TABLE 3 – Anticipated Retirements of Program Delivery Staff in Ontario Health Units, by Position

Position	FTE	Number of Impending Retirement	Percent of Positions	Percent of Total Retirements
Acting Medical Officer of Health	7.20	1.00	13.89	0.35
Associate Medical Officer of Health	24.10	0.40	1.66	0.14
Clinical Nurse Specialist	15.00	0.00	0.00	0.00
Data Analyst	15.70	0.00	0.00	0.00
Dental Assistant	168.64	6.00	3.56	2.11
Dental Hygienist	120.59	4.77	3.96	1.67
Dietitian	110.60	3.00	2.71	1.05
Epidemiologist	64.67	0.00	0.00	0.00
Family Visitor	304.84	5.00	1.64	1.76
Health Educator	67.08	2.00	2.98	0.70
Health Promoter	262.02	1.00	0.38	0.35
Medical Officer of Health	27.71	8.00	28.87	2.81
Nurse Practitioner	28.74	0.00	0.00	0.00
Nutritionist	98.96	0.00	0.00	0.00
Other Physician	12.98	0.00	0.00	0.00
Program Evaluation	42.23	0.00	0.00	0.00
Public Health Inspector	830.63	63.50	7.64	22.29
Public Health Nurse	2630.04	143.63	5.46	50.41
Public Health or Clinical Dentist	60.04	3.00	5.00	1.05
Registered Nurse	199.81	11.00	5.51	3.86
Registered Practical Nurse	97.92	10.60	10.83	3.72
Speech Language	51.08	3.00	5.87	1.05
Other	1117.46	19.00	1.70	6.67
Total	6358.04	284.90	4.48	100.00

The MOH Workforce

At the time of writing this report, there are three health units currently recruiting for an MOH due to recent resignations, and an additional eight health units who have an acting MOH appointed. The majority of acting MOHs are community physicians who have not yet undergone specific and formal training in public health, although a few are considering or actively engaged in such training. Acting MOHs generally work for the health unit on a part time basis. There are also six vacant AMOH positions.

To understand the issues related to recruiting and retaining MOHs, the CRC has commissioned a research study to review supply and demand issues for MOH and AMOH positions in Ontario. This study is also expected to examine the outputs of Ontario's Community Medicine Residency Training programs.

The Student Workforce

Efforts to provide for educational placements as a means of recruiting staff are commonplace across the province. Thirty one of 36 health units have formal arrangements with universities and colleges for public health placements. Most students in public health placements do not receive remuneration for their placement experiences.

The CRC continues to review the data relating to student placements in order to better inform recommendations for effective human resource recruitment strategies.

Challenges Recruiting and Maintaining a Public Health Workforce

Both the OPHA capacity mapping exercise and the CRC survey of public health staff and board members identified similar challenges in recruiting and maintaining the right mix of skills in public health units. It must be noted that the respondents were self-selected and survey results represent the perceptions of those who completed the survey.

System Issues

Some of the challenges identified in recruiting and maintaining a public health workforce are beyond the control of an individual health unit, and must involve a systemic assessment and response. These include:

Profile for Public Health: Public health has been largely invisible to the public and to other health professionals. As a result, it can be difficult for the public to understand the breadth of public health services. Public health career options have been less intensively marketed than careers in other health services. As a result, fewer people are aware of jobs in public health. Those who are aware may not seek out these jobs and those who work in public health often feel undervalued.

Shortages/Supply Problems: There is an overall shortage of qualified personnel to fill some positions within health units in addition to specific types of shortages (e.g., staff with advanced preparation, francophone professionals, specific disciplines in some parts of the province, staff with skills to work with culturally diverse communities). This creates greater competition among health units for limited resources and can contribute to a non-functioning system.

Job Instability: The many funding and organizational changes that have occurred within public health over the past eight years appear to have affected staff morale and

created the perception that jobs are not stable. Some staff perceive that lack of stable and predictable funding for health units has led to short-term, contract positions, which are not attractive to workers. This may impact both recruitment and retention efforts.

Compensation Issues: Staff perceive that public health salaries are not competitive. They can also vary significantly between disciplines and from one health unit to another, which creates competition within the field for limited staff resources. Staff will often leave jobs in one health unit for higher wages offered by another.

Lack of Time/Opportunities for Ongoing Professional Development: Staff report having few opportunities and little protected time for ongoing professional development. This view was reinforced by the OPHA capacity mapping exercise, which identified formal continuing education programs in the workplace as a key gap in the education and training system. Professional development can have a substantial impact on job satisfaction and lead to enhanced retention.

Lack of Career Paths and Opportunities for Advancement: The lack of career paths was a recurring theme in the staff responses across professions. The CRC is considering the issue of how career paths can be incorporated within public health.

Quality of Working Life

Some of the challenges reported are workplace specific, and can be addressed by quality improvements within the work environment, such as:

Staff Feeling Undervalued: A large proportion of staff who participated in the CRC survey reported feeling undervalued and unappreciated within their respective organizations.

Lack of Support in Their Professions: In most health units, professionals are organized into multidisciplinary program teams. While staff appreciate the opportunities to meet across program teams, they have identified the need for stronger discipline-specific communities of practice and more opportunities to meet with peers to discuss profession-specific issues. It is important to note that few respondents cited the need for improved discipline specific supports at the price of losing the multidisciplinary nature of public health.

Leadership: Staff survey indicated a substantial level of concern regarding leadership within health units and management skills at the senior management level.

Opportunities for Improvement: When asked what factors they would change in the workplace, survey respondents identified the organizational culture, a sense of being valued and appreciated, the quality of leadership, the quality of supervision and management, access to ongoing education and training, opportunities for advancement, opportunities for leadership development and the capacity to recruit specific types of professionals.

What Strategies Should Ontario Use to Enhance the Public Health Workforce?

Some of the issues that affect recruitment and retention could be addressed over time through potential changes in governance and funding, and through the development of more effective research and knowledge transfer and exchange activities. At this stage in its deliberations, the CRC is considering a number of strategies to address system issues and to improve the working environment within health units. These will continue to be explored during Phase II.

Possible System Strategies

The system strategies under consideration include:

- a marketing campaign designed to raise the profile of public health and brand it as a critical health sector. This campaign could be used as a way to retain existing staff and encourage them to promote their professions, attract skilled people from other parts of the health sector, and promote career opportunities to high school and university students.

- a comprehensive provincial strategy for public health human resources, including recruitment and retention, designed to anticipate and respond to current and future challenges. This could entail a more collaborative approach to recruiting scarce professionals, especially for filling gaps in high need professions and geographical areas. Public health could benefit from better and more focused approaches to HR supports and tools, such as recruitment fairs, common job descriptions, and central registry of vacancies – in short, greater system-wide approaches to health human resource needs.

- a salary/compensation strategy that will lead to better alignment of salaries across disciplines and health units

- funding and scholarships for students in certain key disciplines, development of funded preceptor/mentoring programs, and more clinical placements and summer students so health units can attract more people public health careers.

- enhanced partnerships with universities to strengthen public health curricula, negotiate student placements, improve programs, and promote cross fertilization of ideas. These approaches, if undertaken on a comprehensive basis, could provide health units with additional vehicles to address the professional development needs identified by many staff.

- development of a provincial staffing database to monitor staffing trends.

Possible Quality of Working Life Strategies

Quality of working life strategies under consideration include:

- a program to develop and enhance leadership skills within public health, which focuses on giving people in leadership positions the skills and experience they need to lead effectively

- providing more consistent opportunities for public health professions to meet and connect with colleagues in their disciplines, and share knowledge and skills

- more flexible approaches to ongoing professional development, such as distance education and reentry programs and protected time for learning

- initiatives that actively promote teamwork and professional development activities which support team performance, which, according to the literature, are a significant factor in work satisfaction and a positive workplace.

Research and Knowledge Transfer and Exchange – Issues and Options

"Applied research and translation of knowledge into practice are key support functions of the public health system. … [T]he investment in applied research is insufficient and what is known is not being fully implemented."[31]

National Advisory Committee on SARS and Public Health (2003)

Information, research, knowledge and tools are the currency of effective public health practice. Access to locally relevant data, timely access to evidence about interventions that work and lessons learned are the stock and trade of maintaining professional relevance and effectiveness in public health programming.

In many ways Ontario has made significant strides in the area of public health research and knowledge translation. The nationally recognized Public Health Research, Education and Development (PHRED) Program located across five sites in Ontario, has made effective inroads in attempting to bridge between academic research and public health practice.[B]

Despite the PHRED Program, there is currently no real province-wide mechanism for engaging research communities and setting priorities for a public health research agenda. This absence of coordination weakens the ability of public health in Ontario to increase the profile of public health research at the federal level, and to influence national research initiatives and priorities.

How Involved are Health Units in Research and Knowledge Transfer and Exchange Now?

The View from the Field

Health units across Ontario are extensively involved in research activities to support program planning, implementation and evaluation. The health unit survey identified that health units are frequently engaged in needs assessments, process and outcome evaluations, new program development and literature reviews and health status monitoring. They less frequently identify involvement in multi-site research initiatives and benchmarking activities.

PHRED Program sites report a greater degree of research and knowledge and exchange activities, including conducting research, publishing reports and findings, sharing results and integrating findings into programs planning. The PHRED sites are also conducting a significant number of ethic reviews and benchmarking studies. Although a number of non-PHRED units appear to be less research focused, some have established academic affiliations and are involved in a variety of research activities.

Staff involved in direct program delivery and program leadership ranked research as being more important to their practice than those at a senior management or, board level. Staff involved in research intensive professions (e.g., epidemiologists) reported higher levels of involvement in research.

What Research and Information do Health Unit Staff Need?

Health unit staff acknowledge the importance of research and knowledge transfer and exchange. They see it as a way to enhance practice and stay current in their fields. In their work, they particularly need access to:

[B] The PHRED sites are located in Hamilton, Kingston, London, Ottawa and Sudbury.

- the latest best practice guidelines and recommendations related to specific MHPSG

- relevant continuing education to develop and maintain PH skills and research and knowledge transfer and exchange skills

- data on local health indicators

- central coordination of public health research and knowledge transfer and exchange

- a network of specialists within sectors/discipline

- access to better models for program and service evaluation

- access to better models for program and service delivery.

In the staff and board member survey, respondents report a high level of need across all of the research and knowledge transfer and exchange activities probed. However, the level of access to these activities was markedly lower across all activities. This suggests a major system-wide gap between the need for research information to support public health practice and the ability to access it at the front-line level.

What are Health Units' Research Priorities?

The priorities for health units are similar to those identified by staff and board members. The top five are:

- access to the latest guidelines and recommendations related to meeting the MHPSG

- access to data on local health indicators

- developing capacity to conduct/improve research locally

- an up-to-date inventory of research and knowledge transfer and exchange tools

- access to survey and surveillance reports and results.

According to survey results, health units face a number of gaps and barriers in their efforts to meet staff needs for research and knowledge transfer and exchange, including:

- lack of time

- lack of coordination between health units and with the province

- lack of staff with appropriate skills

- lack of easily accessible and/or useful data

- lack of timely resources to respond to emerging research opportunities or participate in planned projects

- lack of an overarching public health research strategy

- lack of timely resources/support for planned projects.

According to survey respondents, one of the main weaknesses in the current approach to research and knowledge transfer and exchange is lack of coordination. Many people are involved in research activities, but there is no mechanism to coordinate research, share best practices or disseminate knowledge in a coordinated/conserted manner.

How Should Research and Knowledge Transfer and Exchange be Strengthened?

The View from the Field

When asked how to enhance health units' capacity for research and knowledge transfer and exchange, health unit staff and board members suggested:

- Increased professional development opportunities, networking and sharing of information

  – Better sharing of information/networking
  – Better and more access to training programs
  – Keeping staff informed and involved
  – Conducting more research
  – More links to academic centres

- Increased communications and information dissemination

  – Providing centralized resources and information (website portal or library)
  – Better and timely access to information and resources
  – Standardizing process
  – Developing consistent campaigns and promotion

- Increased and stable funding

- Better collaboration and more partnerships

- More resources (time, staff and access to technology).

There were some profession-specific differences in ideas for improving research. For example, epidemiologists were more likely to identify the need for more centralized resources while administrators were more like to identify better communications as a need.

What Role Should the PHRED Program Play?

As part of the discussions to strengthen research and knowledge transfer and exchange activities, the CRC has looked at finding the appropriate balance between local, regional and provincial supports. Effective research and knowledge transfer and exchange is a shared responsibility with local, regional, and provincial components, involving stakeholders internal and external to the public health system.

One option to strengthen research and knowledge transfer and exchange activities at the regional level is to strengthen and expand the PHRED Program. To assess the benefits of that approach, the CRC asked health units about their perceptions of PHRED. According to the survey results, the non-PHRED health units are aware of the PHRED programs and use many of their services. They find the library services and evaluation reports most useful. Other services are less useful, in large part because of lack of resources or because they are difficult to apply to local needs.

With regard to the overall PHRED Program, survey respondents report that more focus should be placed on:

- establishing partnerships and relationships with stakeholders

- providing sufficient and stable funding for the PHRED Program (100% provincial funding has been suggested)

- developing tools centrally

- developing more qualified and experienced staff

- involving health units in projects with local access to research

- giving all health units equal access and input so research initiatives reflect local interests and needs.

Based on this view from the field, the CRC notes there is a substantial variance between the needs expressed at a local level, and the current PHRED mandate and performance within a cost-shared environment. It is noteworthy that efforts to establish a greater regional resource capacity within the PHRED Program largely coincided with major restructuring (i.e., the downloading of public health funding to municipalities and the amalgamation of the six health units (which hosted three PHRED sites) in Toronto). As a consequence of the initial 100% municipal, and subsequent 50% municipal cost-shared funding, PHRED sites have had less ability to focus on regional or provincial needs. Quite rightly, boards of health for PHRED sites have wondered why local municipal dollars should be used to fund or offset a provincial or regional resource system. This has been suggested as the reason there is no longer a PHRED site in Toronto, and also why the PHRED Program is less able to address provincial or regional coordination issues than it did formerly.

What Role Should the Public Health Agency of Ontario Play?

The CRC believes that once the Agency is establised it should play a lead role in facilitating and supporting action-oriented and applied research and knowledge transfer and exchange that will support quality public health programs, policies and practices. The Research and Knowledge Transfer Subcommittee of CRC has also discussed possible roles for the Agency, many of which have been identified by the Agency Implementation Task Force's Part One Report.[32] Some of these roles include:

- establishing communities of practice which would be online communities of people who share the same profession, situation or vocation. These communities facilitate professional exchange, allow members to establish a bond of common experience or challenges.

- supporting a public health research agenda, and processes for setting research priorities

- coordinating research activities and acting as a broker, linking academics and practitioners

- conducting and supporting research

- playing a lead role in knowledge synthesis, and translating research into practice

- providing better tools, methodologies and best practices.

The Research and Knowledge Transfer Subcommittee presented these options at a meeting with the Reference Panel in August 2005, which supported a strong role for the Agency in coordinating research efforts and developing common tools. This type of role for the Agency was also reinforced by the survey results. Health units would like the Agency to concentrate on developing centralized research initiatives, disseminating information, coordinating and supporting research, and providing professional development.

Staff and board members also supported a centralized management, maintenance and coordination role for the Agency.

Based on the feedback from the field, the CRC is identifying principles for research and knowledge transfer and exchange in the Agency, such as:

- Research and knowledge transfer and exchange are part of a continuum of activities that includes continuous quality improvement.

- The Agency should have the in-house capacity for research and knowledge transfer and exchange.

- Partnership agreements with academic centres (e.g., time release to participate in research, cross appointments, secondments, mentorships) will strengthen the Agency's research and knowledge transfer and exchange capacity.

- The Agency should establish a process for setting a research and knowledge transfer and exchange agenda and priorities.

- The Agency should nurture a public health culture of science and inquiry.

- There must be a balance between generating knowledge at the local level and provincial research and knowledge transfer and exchange responsibilities.

The CRC continues to explore these issues with the intent of offering recommendations that will create a more comprehensive system to support research and knowledge transfer and exchange in Ontario.

What Role Should Public Health Units Play?

Research and knowledge transfer and exchange activities at the local level are key to supporting evidence-based public health practice. Public health units across Ontario have been engaged and led many activities in these areas. Learnings from these endeavours as well as preliminary deliberations from the Research and Knowledge Transfer Subcommittee point to key ingredients for supporting and enhancing research and knowledge transfer and exchange activities at the local level:

- **Leadership:** there must be strong leadership within health units to support an evidence-based approach to the planning and delivery of services.

- **Funding:** the allocation of monies within and for public health units should take into account the need to fund research at the local level and support knowledge transfer and exchange activities.

- **Partnerships and networks:** health units must have the capacity to develop, support and maintain research partnerships with academia (colleges and universities), with others in the healthcare sector and with other sectors (e.g., education, housing, environment).

- **Staffing:** adequate staffing must be dedicated and allocated to research and knowledge transfer (i.e., people designated and supported to promote research and knowledge transfer and exchange).

- **Training and education in research and knowledge transfer and exchange opportunities:** appropriate training must be accessible for those entering the field of public health as well as for those already practicing in it.

Phase II – Next Steps

Before outlining the work ahead in Phase II, the CRC wishes to sincerely express its appreciation for the exceptional effort and co-operation that has been shown by the public health field to date. The CRC is looking forward to the continued dialogue and engagement with the public health community that will ensue during Phase II of its work.

Scope of Phase II

Over the coming months, the CRC will undertake the second phase of its work. Of particular note, the CRC will travel to all regions of the province, visiting all public health units. During those site visits, the CRC will further explore issues that have been highlighted in this report as areas of consideration in the development of their final report and recommendations.

Phase II offers an excellent opportunity for public health stakeholders at all levels to engage directly with the CRC and offer their best advice and direction on enhancing public health capacity.

Methods

The results from the Phase I survey provided the groundwork for this further exploration. A consulting firm was hired in October 2005 to conduct and coordinate Phase II research activities which begins with day-long visits to health units in early November 2005. The purpose of the site visits to all public health units is to conduct in-depth interviews and focus groups.

Interviews/Focus Groups

On behalf of the CRC the consulting firm will be conducting five research activities at each public health unit:

1 Individual in-person interview with the MOH/CEO
2 In-person interview with members of the Board of Health
3 Focus group with members of management and senior professionals

4 Focus group with staff members
5 Telephone interviews with several partners

Roundtables

At this point in time, the CRC has planned to conduct three topic-specific roundtables in late November/early December 2005. One will focus on public health accountabilities and performance management, one on variables and methodologies for public health funding, and another on potential linkages with academic institutions.

Other Phase II Activities

In addition to the interviews, focus groups, and roundtables, the CRC is continuing its review of commissioned research and analysis of work to date.

The CRC will also be calling a meeting of its Reference Panel in early 2006.

Together the Phase II activities will allow for continued exploration of the possible options to enhance the capacity of health units and to better understand the opportunities and challenges experienced at the local level

Final CRC Report and Recommendations

The results and information obtained from Phase II activities will inform the CRC's ongoing deliberations and the development of its final recommendations to be submitted to the Chief Medical Office of Health in the form of a Final Report.

Comments and Suggestions

The CRC welcomes your feedback. If you wish to provide written input to the CRC please forward your comments by email to CapacityReview@moh.gov.on.ca

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CRC Terms of Reference

Capacity Review Committee

Background
As outlined in Operation Health Protection - An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario, the Ministry of Health and Long-Term Care (MOHLTC) has committed to undertake a capacity review of local Public Health Units in 2004/2005 to inform the development of long-term strategies to enhance capacity to plan and implement optimal Public Health programs and services that effectively respond to the current and emerging needs of Ontarians.

The MOHLTC has established a Capacity Review Committee to provide guidance and support in this endeavour.

Purpose
The Capacity Review Committee advises the Chief Medical Officer of Health and, through her, MOHLTC on options to improve the function and configuration of the local Public Health Unit system. The advice to be provided encompasses the following:

- core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);

- issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);

- identifying operational, governance and systemic issues that may impede the delivery of public health programs and services;

- mechanisms to improve systems and programmatic and financial accountability;

- strengthening compliance with the *Health Protection and Promotion Act*, associated regulations and the *Mandatory Health Programs and Services Guidelines*;

- organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

Responsibilities
The Capacity Review Committee has the following responsibilities:

- Consult with local public health units and with representatives of the MOHLTC and other appropriate ministries (i.e., traveling to local health units for meetings, focus groups, key informant interviews, call for submissions).

- Consult with key public health stakeholders (e.g., Association of Local Public Health Agencies, Association of Municipalities of Ontario, City of Toronto, Ontario Public Health Association, Ontario Council on Community Health Accreditation, and various professional associations).

- Commission appropriate external research to support the review.

- Review and integrate relevant information (both internal and external) regarding other significant health restructuring initiatives, as well as be guided by overall MOHLTC system and planning goals and priorities, drawing and building on cross-jurisdictional and other relevant initiatives.

Membership
The CMOH appoints the Chair, Vice-Chair and members of the committee.

Accountability
Through the Chair, the committee reports to the Chief Medical Officer of Health and Assistant Deputy Minister of the Public Health Division. An ad hoc internal Ministerial

Committee has been established to liaise with this committee.

Staff Support

The committee is supported by staff from the Strategic Planning and Implementation Branch of the Public Health Division of the Ministry of Health and Long-Term Care.

Term of Appointment

Committee members shall be appointed for a period of up to one year. This term may be extended, upon the needs of the Ministry of Health and Long-Term Care.

Time Frame

The committee will present interim recommendations to the Ministry of Health and Long-Term Care in June 2005. A final report will be presented in December 2005.

CRC Subcommittee Terms of Reference

Governance and Structure Subcommittee

The Governance and Structure Subcommittee supports the **Capacity Review Committee** (CRC) by sharing their expertise and providing recommendations to produce the following:

1 Recommendations for the overall sustainable governance and structure of the Public Health Units in Ontario as well as that of individual health units, having regard to the diverse needs of local communities and stakeholders.

2 Recommendations on the optimal configuration of the public health system in Ontario, with regard to factors such as funding, partnerships, shared services agreements and/or health unit consolidation, in order to maximize the efficient use of system resources.

3 Best practices for effective, accountable public health governance (including structure, recruitment, mandate, functions, leadership and relationships with obligated municipalities, ties with the Ministry of Health and other appropriate provincial ministries and the proposed Ontario Health Protection and Promotion Agency.

Membership
The Governance and Structure Subcommittee reports to the CRC and is chaired by Mr. Alex Munter, a CRC member. The Subcommittee will have a sunset date of December 31, 2005, unless the CRC and the Ministry agree to extend this date.

Public Health Funding Subcommittee

The Public Health Funding Subcommittee supports the **Capacity Review Committee** (CRC) by sharing its expertise and providing recommendations to produce the following :

1 Modernized, evidence based approach to public health funding in Ontario.

2 Transparent allocation mechanisms.

3 Modernized and needs-based allocation methodology.

4 Funding approach and methodology that is planned, appropriate and responsive to community needs.

Membership
The Public Health Funding Subcommittee reports to the CRC and is chaired by Dr. Liana Nolan, a CRC member. The Public Health Funding Subcommittee will have a sunset date of December 31, 2005, unless the CRC and the Ministry agree to extend this date.

Public Health Human Resources Subcommittee

The Public Health Human Resources Subcommittee supports the **Capacity Review Committee** (CRC) by sharing their expertise and providing recommendations to produce the following:

1 A map of the public health human resource landscape including systemic gaps and future forecasting regarding core public health human resource needs.

2 Sustainable recruitment, retention, and skills enhancement strategies that provide for an increased and sustainable supply of skilled public health professionals.

3 Strategies to promote public health careers in Ontario and prioritized assessment of professions requiring increased enrolment in public health programs.

4 A set of leadership skills for public health professionals.

The Subcommittee also liaises with the Ministry and OPHA on public health core competencies endeavours.

Membership
The Public Health Human Resources Subcommittee reports to the CRC and is chaired by Ms. Diane Bewick, a CRC member. The Subcommittee will have a sunset date of December 31, 2005, unless the CRC and the Ministry agree to extend this date.

Public Health System Accountabilities Subcommittee

The Public Health System Accountabilities Subcommittee (PHSA) supports the **Capacity Review Committee** (CRC) by advising and assisting in the development of:

1 Recommendations on accountability mechanisms and practices for individual health units which take into consideration current practices as well as new or innovative means to ensure accountability.

2 Proposed accountability mechanisms for the public health system as a whole.

3 Accountability mechanisms – at the local health unit or provincial level as appropriate – shall have regard to the following key stakeholders:

- Local boards of health
- Obligated municipalities
- Public Health Division
- Other ministries funding public health programs and services
- The public

The work of the PHSA subcommittee will draw on evidence-based practices and research. It will consider capacity issues tied to various mechanisms, both at the organizational and human resource levels.

Membership
The Public Health System Accountabilities Subcommittee reports to the CRC and is chaired by Ms. Lori G. Chow, a CRC member. The Subcommittee will have a sunset date of December 31, 2005, unless the CRC and the Ministry agree to extend this date.

Research and Knowledge Transfer Subcommittee

The Research and Knowledge Transfer Subcommittee supports the Agency Implementation Task Force (AITF) and the Capacity Review Committee (CRC) by sharing its expertise and making recommendations to produce the following:

1 An assessment of lessons learned from existing and former models of public health research and knowledge transfer in:

- Ontario (e.g., the Public Health Research, Education and Development (PHRED)).
- Other jurisdictions (i.e., British Columbia, Quebec, etc.)

2 An assessment of gaps and analysis of needs with respect to public health research and knowledge transfer.

3 An environmental scan of other key sources of research and knowledge transfer for public health units, such as universities, ICES, CIHI, Health Intelligence Units, Ontario Health Promotion Resource System members.

4 Recommendations for an appropriate vision to inform the design of the mandate and structure for a research and knowledge transfer system, including the potential roles of the Health Protection and Promotion Agency, that support and enable more effective public health programs and policies and that is anchored in public health needs.

Membership
The Research and Knowledge Transfer Subcommittee is Co-chaired by Mr. Brian Hyndman, Vice-chair of the CRC and Ms. Jennifer Zelmer, AITF member. The Subcommittee reports to the AITF and CRC via its Co-chairs. It will have a sunset date of December 31, 2005 unless the CRC, the AITF and the Ministry agree to extend this term.

Primary Healthcare and Public Health Working Group

The Working Group has the following objectives:

1 Identify/clarify different initiatives which are being designed to move forward primary healthcare reform in Ontario.

2 Identify and describe the aspects of primary healthcare in which public health currently participates.

3 Identify and learn from key pieces of literature regarding primary healthcare, particularly as it relates to or involves public health practice.

4 Identify potential and preferred roles for public health within primary healthcare reforms.

5 Develop and/or recommend strategies to support public health in their partnership and leadership roles within primary healthcare reform.

6 Identify channels of influence to move forward the public health agenda within primary healthcare reform.

Reference Panel

Purpose

The purpose of the Reference Panel is threefold:

- Provide a forum to update public health practitioners/associations on the activities of the CRC

- Provide a forum for public health practitioners/ associations to share their knowledge and expertise relating to public health and issues that emerge from the Local Public Health Capacity Review

- Provide feedback to the CRC on specific matters which require a system-wide perspective.

The MOHLTC will also establish linkages with other ministries (i.e., Agriculture, Children and Youth Services, Municipal Affairs and Housing, etc.) as well as others (i.e., AMO) to facilitate information sharing on the Local Capacity Review.

Terms of Membership

1   The RP will have a sunset date of December 31, 2005, unless the CRC and the MOHLTC agree to extend this date.

2   The RP will operate by consensus to the fullest extent possible.

3   The RP members will be reimbursed for travel expenses as per Management Board Guidelines.

4   The proceedings of the RP are intended to occur in an atmosphere where all members, including the Chair, can speak freely and where discussions and materials shared among the participants are kept confidential and are not discussed or distributed outside the proceedings of the RP. Any reports of the proceedings prepared by the Chair of the CRC will not attribute the contents of the discussions to any person. RP members must respect these confidentiality requirements unless disclosure is required by law. If a RP member believes that he or she may be required to make a disclosure by law, the RP member will notify the Chair prior to such disclosure being made.

5   Participation in the deliberations of the RP shall not be construed as limiting the ability of any organization to make whatever representations they so choose to other processes currently in place.

6   All documentation produced by the RP will be the property of Her Majesty the Queen in right of Ontario.

Support to the Reference Panel

The RP will be supported by the Strategic Planning and Implementation Branch (SPIB) of the Public Health Division of the MOHLTC.

Meetings

The RP will convene for a minimum of two meetings.

Membership

- ANDSOOHA — Public Health Nursing Management in Ontario
- Association of Local Public Health Agencies
- Association of Municipalities of Ontario
- Association of Ontario Health Centres
- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Canadian Institute of Public Health Inspectors (Ontario Branch)
- Community Health Nurses Initiatives Group
- Council of Ontario Medical Officers of Health
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Medical Association
- Ontario Public Health Association
- Ontario Society of Nutrition Professionals in Public Health
- Public Health Research and Education Development Program
- The Ontario Council of Community Health Accreditation