OPHA's Response to the Expert Panel's Report on Public Health

Ontario Public Health Association
l'Association pour la santé publique de l'Ontario
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Overview

On behalf of the Ontario Public Health Association (OPHA), I am writing in response to the report entitled *Public Health Within an Integrated Health System* that was written to provide advice to the Minister of Health and Long-Term Care by the Expert Panel on Public Health.

This response was developed based on feedback from our members who come from a wide range of diverse backgrounds and sectors. OPHA's membership is unique in that it brings together: 10 constituent societies representing different public and community health disciplines; 13 subject matter expert workgroups; and over 600 individual members who are stakeholders in public health, including public health staff working at various levels, representatives from other parts of the health care system, the non-profit, academic, public and private sector, students, retirees, the unemployed, as well as interested community members. Below is a summary of our feedback. More details are provided in the attached appendix along with some background about our organization.

First and foremost, our members were pleased to see the guiding principles that served to steer the work of the Expert Panel. Maintaining the core functions of public health and ensuring that public health has a strong independent voice during an incredible period of transformation within the health system is of utmost importance to our members and colleagues. It is believed that the guiding principles of the Expert Panel served to make recommendations in line with these intents.

We understand that the report was not intended to make operational recommendations, though the granularity of the report has in some instances contributed to a range of ambiguities from those with whom we have consulted in preparing this response. With this in mind, our attached response is limited to the scope of the report as it makes recommendations for the governance and structure of public health within an integrated health system.

Provided in ***Appendix A,*** we have summarised areas of the report where we see merit, areas where OPHA urges additional consideration is warranted, as well as recommendations that build off of the notion that changes are necessary within the current system as identified by the Expert Panel's report. Briefly, these include:

1. Areas of the Report that Garnered Support

i. Maintaining Core Functions and Independence:

OPHA is encouraged by the expectation that public health's core functions and independence would be maintained under the proposed system changes.

ii. Improving Effectiveness:

OPHA welcomes the idea of: fostering greater information sharing and collaboration across the health sector, including among public health units; and strengthening public health's expertise and surge capacity and governance, where needed; OPHA is also in favour of skill-based Boards

of Health while recognizing the need to reflect the diversity of the communities being served and representation of Indigenous Partners.

2. Areas of the Report that Warrant Additional Consideration

i. Geographical Boundaries:

OPHA strongly cautions against aligning public health units with LHIN boundaries since the former were developed based on a medical model to serve the public's care and treatment needs; we urge consideration for the potential loss of services, municipal relationships, and locally driven priorities; as well as intangible functions of public health that serve social justice and health equity mandates that may be devalued within a medical model.

ii. Governance:

OPHA is concerned that the creation of 14 Boards of Health would reduce local accountability for the municipal share of public health; over time, it could result in the disengagement of local government, a reduction in the municipal share of funding, in kind supports as well as the ability to influence municipal policies and programs and those of other local stakeholders whose activities address the determinants of health.

iii. Organizational Structure:

OPHA is also concerned that the proposed regional model may diminish local decision making, flexibility and responsiveness; any separation of roles between a Medical Officer of Health and a CEO would need to ensure that a population health perspective is paramount over business considerations and the Medical Officer of Health's authority and ability to act would not be lessened.

3. Recommendations and Alternative Approaches

In light of the Expert Panel's Report, OPHA makes the following recommendations and offers some alternatives in response to various propositions put forward:

i. Support a more prolonged period of consultation and alternative solution generation

Engage with local Boards of Health, public health units and stakeholders in a more fulsome discussion about the challenges facing local public health agencies and explore locally driven solutions to address these issues (e.g. mergers of smaller health units, changes to board governance where needed, support for leadership development as required, strengthening LHIN/health care collaboration as per MOHLTC's workstream deliberations), rather than applying a one size fits all approach.

ii. Apply an appreciative inquiry/strength based approach to build on effective models

Rather than undertaking a system wide reconfiguration of all Boards of Health and health units, assess what's working well across the public health system with respect to governance, structure, organization, and collaboration with LHINs and health care partners in order to identify approaches that could be expanded and applied to those areas that are experiencing challenges. A strength based approach could offer a more supportive and targeted approach to strengthening the public health system.

iii. Consider alternate models for strengthening capacity and providing strategic leadership and alignment of efforts

Rather than reconfiguring the existing public health system, there are both long standing as well as emerging models that could provide alternative ways of promoting greater efficiencies, coordination of efforts and resources, and a more strategic approach while reducing duplication and strengthening areas of limited expertise.

For example, The Tobacco Control Area Network structure used in Smoke-free Ontario could provide a cost effective alternate model for enhancing capacity, leveraging more centralized expertise and aligning regional resources, and efforts with provincial directions. Lead health units could be identified to act as a regional hub for health units in their area and liaise with provincial agencies and LHINs. Such a model would build on the strengths of the current structures and local and regional relationships while facilitating more consistency and collaboration across the public health system. Beyond the TCAN structure, the basis for such arrangements already exists, for example, through joint Memorandum of Understanding (MOUs) agreements to respond to emergencies, collaborate with school boards, family health teams, and forums such as the Traffic related Air Pollution Workgroup in the GTHA. OPHA's workgroups and Public Health Ontario's networks also provide provincial platforms that could be expanded.

iv. Consider municipal mapping as a basis for aligning geographical boundaries

While the move to 14 regional public health entities would appear to simplify Ontario's public health system and make it easier to collaborate with LHINs, it risks complicating the myriad of relationships outside of the health care system that are essential for the work of public health.

v. Conduct an analysis of the financial and other costs

Analyze the impact of any changes with a particular assessment of the cost implications given the financial constraints facing health units as well as the impact on service delivery, municipal relations, employees and other stakeholders.

Provide Regular Communication and Promote a Collaborative Approach:

While it is acknowledged that the report's recommendations would take a minimum of 18 months to fulfill, we are concerned that the report has already had an impact. For example, it has created

uncertainty among some municipal and sector leaders and staff, additional work through analyzing the changes and preparations that would be required and hesitancy about future plans. We ask that you devise a forum, and/or use existing forums that can keep key stakeholders informed of ministry plans and promote a collaborative approach to communicating and shaping any changes.

In summary, while our members and colleagues do not support various aspects of the proposed changes, we welcome the government taking steps that will open up conversations about how to improve public health governance, structure and ultimately services to ensure a sustainable, equitable system that Ontarians will enjoy for generations to come. We appreciate the work of the Expert Panel in tackling these complex issues and offering some novel ideas. The report has created a timely opportunity for new dialogues to take place.

We look forward to continuing these conversations with the Ministry of Health and Long-Term Care, as the recommendations made by the Expert Panel are considered and expanded upon by way of additional analysis and consultations. Throughout this process we are pleased to extend to your team the various networks of expertise stemming from the non-profit, academic, community, private and public health sectors that exist within our membership, workgroups, and constituent societies.

Thank you for your consideration,

Ellen Wodchis

President

Appendix A: Detailed Feedback

The following provides additional detail and context to the areas of support, concern, and recommendations made above.

1. Areas of the Report that Garnered Support

i. Maintaining Core Functions and Independence

Guiding Principles in support of core public health functions.

Our members and colleagues are pleased to see as part of the Expert Panel's guiding principles, a commitment to the preservation of core public health functions and a strong independent voice for public health. It is also a welcomed notion that the provincial government is looking to find ways that will facilitate better information sharing across health sectors and increase the effectiveness of current public health systems. OPHA's primary focus is to ensure that the health of Ontarians is put first throughout any and all changes. Public health must be viewed as a valuable entity by its own merit for the functions that it serves, which are unique from those of health care and treatment.

Public Health maintaining its independence from LHINs in decision making processes.

Public health has a mandate that is independent from that of LHINs and as such, while coordination and collaboration is encouraged, OPHA supports the idea that public health should remain independent in its governance and decision making processes.

ii. Improving Effectiveness

Skill Based Boards of Health

The notion of improving the capacity among Boards of Health to enable rigorous decision making processes more consistently across public health entities is anticipated to benefit public health. However, more information is needed about the skill sets that would be sought among Boards of Health. As an example, there is no mention of skills that bring expertise on matters related to health promotion, environmental health or health equity. Furthermore, it is unclear how Indigenous representation or perspectives of lived experience will be included among seemingly academic criteria. More information is needed to better ensure that Boards of Health can equally incorporate a diversity of perspectives into decision making processes.

For many in the public health sector who have experience working more closely with LHINs, the regular interaction with colleagues in health care (e.g. family health teams, community health centres, and hospitals) has enabled collaboration and improved work flow through effective communication mechanisms. OPHA is supportive of mechanisms that will formalize channels of communication across health sectors.

2. Areas of the Report that Warrant Additional Consideration

i. Geographical Boundaries

Geographical boundaries aligned to a medical model and the various challenges this poses for access to, and maintenance of existing services.

The proposition to align regional geographical boundaries to LHIN boundaries is surprising given that for public health to work well, it must be immersed within the communities that they serve. Public health programming must be accessible to reach all residents within geographical areas, and decision making about programming must ably reflect local differences. There can be a tendency to focus programming where people more densely reside, which poses an ongoing challenge for entities serving large rural areas. OPHA is apprehensive that this challenge may be exacerbated by widening certain regional boundaries even further. In addition, to many in our communities LHIN geographical boundaries are not intuitively associated to a particular function, making it more difficult for local communities to identify with their regional affiliation. It is recognized that some boundaries may need to be changed and mergers of smaller health units encouraged for certain areas to achieve critical mass, however it is not clear that all boundaries require such extensive realignment. Nor is it clear why the LHIN boundaries have been chosen as potentially more effective over other models. For many public health units, the current boundaries are perceived to be working well, and the extensive changes being proposed may result in a loss of services and could end up doing more harm than good.

Severing from municipalities may impose a loss of functional relationships and resources (including resources in kind) currently shared with many municipalities.

Public health units that are intertwined with their municipal counterparts, in many instances have cited a number of significant disadvantages to severing existing relationships. While some health units will lose access to corporate services like IT, human resources or legal services, others are concerned about losing resources in-kind and the productive relationships that help them to accomplish their work more efficiently (e.g. ability to influence municipal policies, programs, investments and by laws) . A cost-benefit analysis would be warranted in such cases to better understand what would be lost and gained by such extensive re-structuring.

Additionally, the current governance structure offers an important tool for public health via municipal by-laws. Through links that are either direct (where public health units are embedded within municipal structures) or indirect through municipal membership on Boards of Health, such links are important for healthy public policy. Municipally elected members on Boards of Health are also publically accountable to their councils and constituents, offering a trusted form of governance that is more accessible to the public than that of LHINs.

Promotion of the medical model (in aligning to LHINs) may undervalue intangibles at the core of public health services, such as considerations for social justice and health equity.

Fundamentally, form follows function, as mentioned in the principles that served to guide the Expert Panel. By aligning to a model that is designed to respond to illness, there is trepidation about the underpinning values that will be inherently assigned to public health as the biomedical model is further reinforced. Important differences that distinguish public health practice, such as health promotion and chronic disease prevention, may not be compatible to a form designed to suit medical functions that reside more downstream along the health continuum. In addition, considerations for social justice and health equity are not always measurable within the success indicators of a biomedical model, and therefore risk losing visibility among priorities when aligning to LHINs.

ii. Organizational Structure

There is concern that the proposed model is top-heavy and this may affect decision making at the local level.

As mentioned in earlier sections above, for public health programming to be effective and address disparities, an understanding of the local population must be achieved. Public health relies on epidemiological data, as well as relationships with community partners and stakeholders, to steer decision making processes and ensure that programming is reflective of local needs. With regional public health entities overseeing large service areas, there is risk that decision making processes may become disconnected from local priorities. In the proposed report, it is concerning to see strategic-engagement, decision making, and research priorities appearing to exist uniquely at the regional level. Furthermore, with the separation of roles of Medical Officer of Health and CEO, there is some concern that a business model may supersede decision making reflective of a population health perspective.

3. Recommendations

i. Engage with local public health units to share information about challenges and explore locally driven solutions

The notion of addressing critical mass for each public health unit, as well as establishing improved equity among public health units in their ability to attract and retain talented staff is important to our members and colleagues. In response, OPHA suggests more in depth consultations with the sector to explore the current challenges identified by the Ministry, and to allow for further analysis of possible alternate solutions. The sector would welcome the opportunity to put forward local responses upon obtaining more information about the challenges brought to light. For example, these could include mergers of smaller health units, changes to board governance where needed, support for leadership development as required and strengthening LHIN/health care collaboration as per MOHLTC's workstream deliberations rather than applying a one size fits all approach.

ii. Apply an appreciative inquiry/strength based approach to build on effective models

Rather than undertaking a system wide reconfiguration of all Boards of Health and health units, assess what's working well across the public health system with respect to governance, structure, organization and collaboration with LHINs and health care partners in order to identify approaches that could be

expanded and applied to those areas that are experiencing challenges. A strength based approach could offer a more supportive and targeted approach to strengthening the public health system.

iii. Consider the multiple perspectives required for effective leadership at the regional level and alternate models for strengthening capacity and providing strategic leadership and alignment of efforts

In addition to ensuring that a variety of skill sets are represented at the decision making table, be they from academic credentials or perspectives gained from lived experience, it is equally important to ensure that the many professions that comprise public health are also represented. In addition to nursing, these may also comprise public health expertise from environmental, health promotion, epidemiologists, dietetics, health inspection, oral health, accessibility, or other perspectives.

In all decision making processes, representation from expertise in health equity as well as Indigenous partners should be represented. While this is explicit in the Expert Panel's guiding principles, mention of how and where exactly these roles will be positioned is ambiguous and should be firmly outlined as components of proposed leadership models.

Rather than reconfiguring the existing public health system, there are both long standing as well as emerging models that could provide alternative ways of promoting greater efficiencies, coordination of efforts and resources and a more strategic approach while reducing duplication and strengthening areas of limited expertise. For example, The Tobacco Control Area Network (TCAN) structure used in Smoke-free Ontario could provide a cost effective alternate model for enhancing capacity, leveraging more centralized expertise, and aligning regional resources and efforts with provincial directions. Lead health units could be identified to act as a regional hub for health units in their area and liaise with provincial agencies and LHINs. Such a model would build on the strengths of the current structures and local and regional relationships while facilitating more consistency and collaboration across the public health system. Beyond the TCAN structure, the basis for such arrangements already exists for example through joint MOUs to respond to emergencies, collaborate with school boards, family health teams etc.

iv. Consider municipal mapping

Public health has the ability to bridge multiple sectors and work collaboratively to influence the determinants of health. In addition, working upstream in many instances requires collaboration with municipal governments to promote a health in all policies approach, as well leveraging links to municipal policy makers for the creation of healthy public policy. It can be argued that aligning to municipal boundaries may be more intuitive given the scope of public health and the connectedness required for collaborating with local populations and community partners. Therefore, should Ontario require a realignment of public health's geographical boundaries, alignment to municipal boundaries may be a more suitable approach worth exploring. While the move to 14 regional public health entities would appear to simplify Ontario's public health system and make it easier to collaborate with LHINs, it risks complicating the myriad of relationships outside of the health care system that are essential for the work of public health.

v. Conduct an analysis of the financial and other costs of the proposed changes

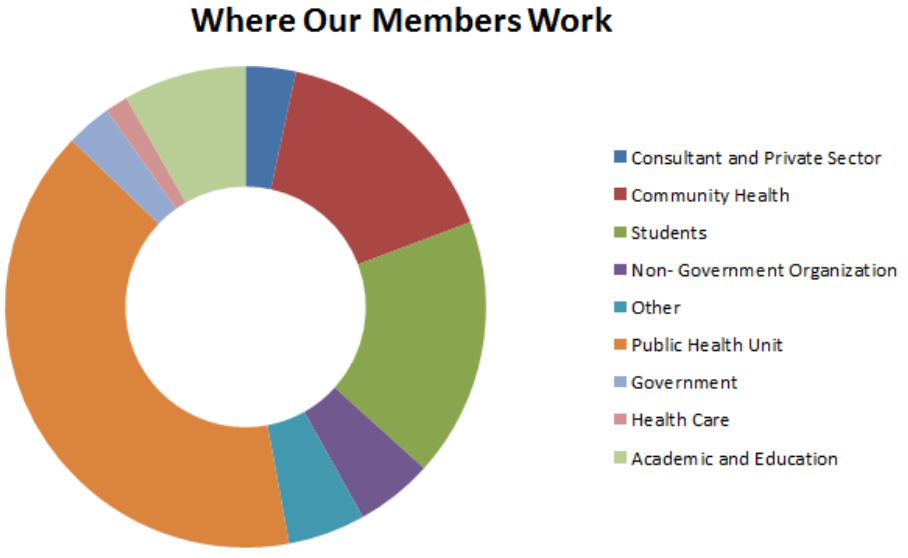
There are many areas of the report that propose changes associated with significant cost, be it through financial expenditures, disruption to programs and services, or reorganization of the labour force. It is however unclear that there are proven benefits to be expected and that they will outweigh the costs. At a time when resources are constrained within the public health system, OPHA strongly urges the Ministry of Health and Long-Term Care to examine the evidence and economic analysis associated with the proposed changes, along with the impact on service delivery, municipal relations, employees and other stakeholders.

With how to best serve Ontarians as a shared goal at the forefront of all priorities, short term outcomes and long term impacts need further analysis and communication with stakeholders.

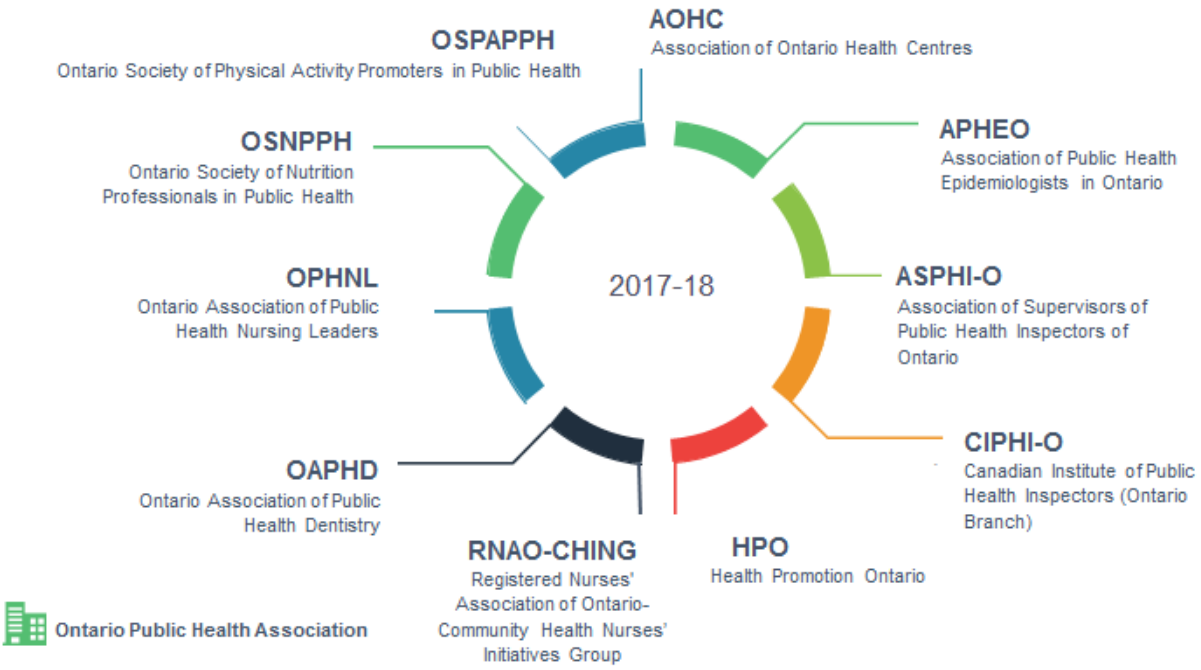
Appendix B: About OPHA

Created in 1949, the Ontario Public Health Association (OPHA) is a non-partisan, non-profit organization that brings together a broad spectrum of groups and individuals concerned about the health and wellbeing of Ontarians. OPHA's members come from various backgrounds and sectors - from the various disciplines in public health, health care, academic, non-profit to the private sector. They are united by OPHA's mission of providing leadership on issues affecting the public's health and strengthening the impact of people who are active in public and community health throughout Ontario. This mission is achieved through professional development, information and analysis on issues affecting community and public health, access to multidisciplinary networks, advocacy on healthy public policy, and the provision of expertise and consultation.

OPHA members have been leading change in their communities on a wide range of issues - tobacco control, poverty reduction, diabetes prevention, increased access to oral health care, immunization, supporting children and families, food security, healthy eating and nutrition, climate change and designing walkable communities, among others.



OPHA's 10 Constituent Societies



OPHA Member Workgroups and Task Groups