- PUBLIC HEALTH GOVERNANCE AND STRUCTURE -

SUMMARY OF THE INTERIM REPORT OF THE CAPACITY REVIEW COMMITTEE

REVITALIZING ONTARIO'S PUBLIC HEALTH CAPACITY: A DISCUSSION ON ISSUES AND OPTIONS

March 2006

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I. BACKGROUND

Since the SARS outbreak in Canada, a number of key reports have been written on the state of public health and the need for public health renewal (National Advisory Council on SARS and the Walker, Naylor, and Campbell reports). Federal actions and highlights stemming from the recommendations have included: the creation of the Canada Public Health Agency, the appointment of a Chief Public Health Officer, and the recent launch of Operation Health Protection. The Government of Ontario has appointed a Chief Medical Officer of Health, committed to increasing the provincial share of public health funding from 50% to 75% by 2007, hired 180 Infectious Disease Control staff, and established the Provincial Infectious Diseases Advisory Committee to advise the Chief Medical Officer of Health on the prevention, surveillance and control of infectious diseases.

Mr. Justice Campbell's Second Interim Severe Acute Respiratory Syndrome (SARS) Report (April 2005) indicated that SARS demonstrated that Ontario's public health system is broken and needs to be fixed. The report raised a number of issues for discussion related to proposed legislative (Health Protection and Promotion Act) and governance changes between Municipal and Public Health Units relationships.

The Report's Vision is to have *"A revitalized system that supports the health of Ontarians, through concerted action to prevent disease and protect against known and emerging diseases"*.

In January 2005, the Chief Medical Officer of Health (CMOH) established a Capacity Review Committee (CRC) to review the state of Public Health Units across the province and bring forward recommendations that would provide ways to improve the governance, configuration, and capacity of the local public health system. The final report and recommendations will be forwarded to the Chief Medical Officer of Health, who, in turn, will forward it to the Minister of Health and Long Term Care.

II. PUBLIC HEALTH CAPACITY REVIEW – PHASE I

The CRC has prepared an Interim Report (November 2005) of the first phase of a two-phase process that provides their findings based on both a subjective (field surveys to Public Health Units and preliminary consultations with key stakeholders) and objective (literature review) approach to gathering information and data.

In addition, the CRC focused not only on public health's mandate in health protection and preventing disease but took the opportunity to look at how to strengthen our capacity to promote and enhance health and well-being. These longer term requirements include chronic disease, injury prevention, healthy child development, family and community health, and environmental health with a focus on the underlying determinants of health such as social, economic, and environmental.

The Interim Report indicates that the directions given are not conclusive but it does provide information that identifies the issues, options, and findings that need to be addressed. In order to "re-build" the local public health system, the report categorizes the primary areas and the issues accompanying these areas which require further investigation, review, and consultation with stakeholders in the Second Phase.

III. PURPOSE OF THE CAPACITY REVIEW

The purpose of the CRC was to do a comprehensive assessment of local public health units' capacity to provide services that Ontarians need in the most effective way possible. The CRC is also looking at what public health could be in the future and as a system from the perspective of better service, better managed, better governed, and better funded.

With this approach, the CRC will review how local public health can work effectively as part of an integrated provincial public health system. Finally, the review will state a vision of where public health fits within a health system.

IV. RESPONSIBILITIES OF CRC AND AREAS TO BE REVIEWED

The CRC is responsible for providing advice on options to improve the configuration and function of the local public health unit system including:

- Core capacities required (infrastructure, staffing, etc.) to meet local community needs and provide effective public health services including applied research and knowledge transfer
- Recruitment and retention and education/professional development of staff
- Address operational, governance, and systemic issues that have or may impede the delivery of public health programs/services
- Mechanisms to improve systems, programs, and financial accountability
- Strengthen compliance with the Health Protection and Promotion Act (HPPA)
- Organizational models for health units that optimize alignment with Local Health Integration Networks (LHINs), primary care reform, and municipal funding partners
- Staffing requirements and associated operating and transitional costs

V. SUMMARY OF PUBLIC HEALTH GOVERNANCE AND STRUCTURE

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

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"

The SARS Commission Second Interim Report (2005)

1. Introduction

The Capacity Review Committee (CRC) wrote that they believe that Ontarians "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."

The CRC is looking at receiving feedback regarding governance, specifically, a single governance model. The Committee has identified a set of Principles for effective governance and list of possible advantages of a single governance model (See sections 3 and 4 below). Since 2003, the Province has made major Ministerial changes that have both increased the complexities and service delivery relationships for public health programs. For example, in 2003, the Province established a new Ministry of Children and Youth Services (MCYS) that saw "Healthy Babies Healthy Children" program and Preschool Speech and Language being transferred to this Ministry from the Ministry of Health and Long Term Care (MOHLTC). Other examples, are the establishment of the new Ministry of Health Promotion in 2005 that is responsible for coordinating and delivering health promotion programs such as the Smoke-Free Ontario and Healthy Weights, Healthy Lives, the government commitment to create a Public Health Agency, and the transformation of primary care and the development of family health teams and networks through the MOHLTC.

As such, the governance model will need to be able to deal with multiple Ministries and accountabilities that fund these health promotion and prevention programs along with disease prevention and protection. However, it should be of great interest for municipalities to continue to want to be part of a governance model given the opportunities for health promotion, research, and education for their communities.

2. Findings From the Interim Report

The CRC has focused on "how" Ontario's public health system should be structured, resourced, and function rather than "what" the system does or does not do. Therefore, the issues and options identified in this interim report must somehow arrive at recommending how best to strengthen the public health system given the variety of issues identified in the report. For the municipalities, there are some key questions that the CRC are seeking answers that impact on both local service delivery and the province as a whole. To strengthen the public health system, the following are some of the key questions to be answered:

- How should health units be structured and governed?
- How can we ensure public health units be funded fairly to meet the local health needs?
- What mechanisms need to be in place to ensure that health units are accountable?

Public Health Governance and Structure Based on Survey Results:

Issues:

- Early analysis indicates that there is "pronounced" variation in both the type and form of Board structure in public health units (i.e. Board recruitment criteria, training, Board orientation, guidance available to Board members, Board self-assessment, strategic planning)
- Multiple models of public health governance
- Role of municipalities in public health (i.e. local versus provincial?)
- How do you achieve and define capacity and critical mass?

Strategies to Strengthen Governance:

- Better collaboration between Board and senior staff
- More autonomy from regional and municipal structures
- Staff and Board recommended more focus on health issues by Boards and greater visibility for Board members within health unit
- Clear expectations for Boards and accountability systems for assessing performance
- Consistent and effective orientation, training, and support
- Improved functioning and timeliness of the appointment and selection process for provincial appointees
- Consider single model of governance for public health (necessary for building a more systems-based approach to public health)

3. Current Governance Structures

Public Health Services, under the Health Protection and Promotion Act, must be governed by a board of health. In Ontario, there are three distinct board governance structures but all have a basic board of health composition as determined by the HPPA.

1. **Autonomous Boards of Health**
   There are 22 autonomous boards of health that operate separately from the administrative structure of their municipalities. These Boards have their own policies and procedures and solely focused on public health responsibilities and the local Medical Officer of Health is usually the chief executive officer.

2. **Boards of Health**
   There are 4 boards of health that have been integrated into the municipal administrative structures. These boards also are autonomous and focus solely on public health, **but they operate under the policies and procedures of the municipality.**

3. **Regional Government, Single Tier City or Restructured County (Oxford)**
   There are 10 such health units where the municipal council has the mandate and authority of a board of health. Here, public health services may be combined with other services or placed in other departments. The health unit reports to a separate or combined standing committee of regional council (i.e. health and social services). The MOH may or may not be the chief executive officer of the health unit.

4. Possible Advantages of a Single Model of Governance

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

5. Principles of Effective Governance

The CRC has begun to identify the principles of effective governance that will be used to guide the recommendations for a possible governance model and strongly agrees for the need to continue local governance, whatever the level of provincial funding or involvement.

Based on their literature review and expert advice, the following is a list of these principles:

- 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

Other principles that should be considered:

- alignment of geographical boundaries
- representation by population size
- recognize, reflect, and represent the diversity of the community and culturally appropriate
- equal access to services

VI. GOVERNANCE MODELS – POSSIBLE OPTIONS

Option #1 – District Board of Public Health
Option #2 – Regional Board of Public Health
Option #3 – Regional Board of Public Health aligned with Local Health Integrated Networks (LHINs)

VII. RELATIONSHIP WITH LOCAL HEALTH INTEGRATION NETWORKS (LHINS)

The Local Health Integration Networks (LHINS) are divided into 14 regions across Ontario and will be responsible for planning, funding, and coordinating a range of health care services. Currently, Public Health Units are not included in LHINS and there will be challenges as the public health units do not all geographically align with LHIN boundaries. The CRC is attempting to define how LHINS could interface with Public Health Units, specifically, with population health, health promotion, and health protection.

VIII. CONCLUSION

It is anticipated that in the spring of 2006, that the Capacity Review Committee will be making a number of recommendations including governance. The CRC is leaning towards a single governance model for all Boards of Health in Ontario. Locally based governance will be an essential feature of this model but it has been identified that the governance model provides for a Board that is composed of members with knowledge and skills that relate to the mandate of public health and with greater autonomy from municipal structures.

At the same time, with the establishment and implementation of the Local Health Integration Networks, the CRC will attempt to define how public health can best work given the different geographical catchment areas.

As mentioned in the CRC's responsibilities, the governance and structure of public health will and should be of great interest to the municipalities. The CRC has already identified the importance of local municipal government involvement. The Association of Municipalities of Ontario have taken position based on the principle of "pay for say". In other words, if municipalities are contributing funds to public health, they should have a say in the governance of public health and other related matters.

APPENDIX "A"

BACKGROUND

In 1974, the Health and Welfare Canada, Lalonde Report, described a framework of key factors that determine health status: lifestyle, environment, human biology, and health services. The population health approach builds on this framework and recognizes that health depends on more than access to a good health care system. Scientific research has established that factors such as living and working conditions and how we share wealth in our societies are crucially important for a healthy population. Commonly referred to as the determinants of health, these broad factors impact on individual and population health.

TWELVE DETERMINANTS OF HEALTH

1. **Income and Social Status**
   There is strong and growing evidence that higher social and economic status is associated with better health. These two factors seem to be the most important determinants of health.

2. **Social Support Networks**
   The health effects of social relationships may be as important as established risk factors such as smoking, physical activity, obesity, and high blood pressure.

3. **Education and Literacy**
   People with higher levels of education have better access to healthy physical environments for their families. People with lower literacy skills are more likely to be unemployed and poor, to suffer poorer health, and to die earlier than people with high levels of literacy.

4. **Employment/Working Conditions**
   Employment provides not only money but also a sense of identity and purpose, social contacts, and opportunities for personal growth. Unemployed people have a reduced life expectancy and suffer significantly more health problems. Conditions at work, both physical and psychosocial, can have a profound effect on people's health and emotional well-being.

5. **Physical Environments**
   At certain levels of exposure, contaminants in our sir, water, food, and soil can cause a variety of adverse health effects. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

6. **Social Environments**
   Effective social and community responses can add resources to an individual's choices of strategies to cope with changes and foster health.

7. **Biology and Genetics**
   The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide-range of responses that affect health status and appears to predispose certain individuals to particular diseases or health problems.

8. **Gender**
   Gender refers to the array of society determined roles, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis. "Gendered"norms influence the health system's practices and priorities.

9. **Personal Health Practices and Coping Skills**
   There is growing recognition that personal health choices are greatly influenced by the socioeconomic environments in which people live, learn, work, and play. Effective coping skills enable people to be self reliant, solve problems, and make choices that improve health.

10. **Health Child Development**
    The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills, and competence is very powerful. Positive stimulation early in life improves learning, behaviour and health into adulthood.

11. **Health Services**
    Health services designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.

12. **Culture**
    Some persons or groups may face additional health risks largely due to a socioeconomic environment which is determined by dominant cultural values that may perpetuate conditions such as marginalization, stigmatization, loss or devaluation of language and culture, lack of access to culturally sensitive appropriate health care and services.

Reference

Public Health Agency of Canada