York Region

Office of the Commissioner
Community and Health Services Department

Memorandum

To: Chairman and Members of Regional Council

From: Katherine Chislett, Commissioner of Community and Health Services
Dr. Karim Kurji, Medical Officer of Health

Date: September 12, 2017

Re: **Public Health within an Integrated Health System: Report of the Minister's Expert Panel on Public Health**

We are writing to inform you about some significant changes that have been proposed to the governance and operations of public health units across Ontario. Although these proposals have not been endorsed by the Province, if implemented, they will significantly transform the delivery of public health services in the Region.

The Province is moving forward with their mandate to transform Ontario's health care system, and established an Expert Panel on Public Health to provide advice on changes for Ontario's public health sector

In February 2015, the Province launched its "Patients First: Action Plan for Health Care" to transform the Ontario health care system. Patients First includes a goal for the public health sector and the Province's Local Health Integration Networks (LHINs) to work together in an integrated health system, one that actively promotes health and reduces health disparities as well as improves access to health care services. On February 4, 2016, Committee of the Whole received a report on Patients First.

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel (the panel) on Public Health to provide advice on changes for Ontario's public health sector as part of this requirement. The panel included representation from the Province, public health units, LHINs, hospitals, municipalities, First Nations and academia. The panel was asked to consider:

1. The optimal organizational structure for public health in Ontario, and

2. How best to govern and staff the optimal organizational structure

In line with this transformation mandate, on July 20, 2017, Ontario's Ministry of Health and Long-Term Care released "Public Health within an Integrated Health System: Report of the Minister's Expert Panel on Public Health." The recommendations, if implemented, have far reaching implications for the governance and operation of public health units.

While the panel report is light on implementation details related to the recommendations put forward for consideration, it does provide a framework for the implementation of the Ministry's Patients First mandate. The Province has indicated that it intends to consult on the panel's recommendations through targeted consultations and a dedicated email account to collect feedback until October 31, 2017. The Board of Health Chair has been invited by the Ministry to an in-person consultation on September 29 and by the Association of Local Public Health Agencies (alPHa) to provide written feedback for their feedback to the Ministry.

The primary recommendation in the Expert Panel's report is to restructure current public health units into a smaller number of regional public health entities with free-standing autonomous regional boards of health

The Panel's primary recommendation was to restructure the current 36 public health units into 14 regional public health entities with free-standing autonomous regional boards of health, generally in alignment with the boundaries of the existing 14 LHIN boards. These proposed boards of health would include municipal members, provincial appointees, citizen members and other representatives to reflect the communities that they serve. The proposed framework would also have each board directing a regional public health entity that is comprised of local public health service delivery areas. The regional public health entity could be led by a Chief Executive Officer, Regional Medical Officer of Health and other senior public health leadership. Local public health service delivery areas that are aligned with sub-LHIN boundaries could include a Local Medical Officer of Health leading local program and service management, and multi-disciplinary teams.

Currently, Ontario's Boards of Health are divided such that 22 are fully autonomous bodies and 14 that are integrated with municipal structures, to varying degrees; however, they all have the same responsibility in terms of delivery of public health programs and services within their communities. Of the 14 integrated boards:

- 4 autonomous boards that are integrated into municipal structures;
- 4 boards that are councils of single tier municipalities; and
- 6 boards that are councils of regional municipalities.

Recommendations include a proposal to revise catchment areas for new regional public health entities

The panel aimed to establish catchment areas for the new regional public health entities based on a set of criteria. The panel is of the view that having fewer regional public health entities will result in more frequent and effective interactions among regional medical officers of health and between them and the province. The panel also indicated that maintaining local public health delivery areas will ensure a strong local presence and effective relationships with municipalities.

Proposed changes could impact the current funding model for public health units

The panel noted that the current public health funding model may be a barrier to implementing the proposed structure. Under the *Health Protection and Promotion Act*, municipalities have an obligation to provide for public health funding while the provincial grant of funding is discretionary. Currently, the Ministry provides funding for:

- Up to 75% of ministry approved allocations
- 100% of certain programs (e.g., Healthy Smiles Ontario, Infectious Disease Control Initiative, Smoke-Free Ontario Strategy, etc.)
- 100% of services in unorganized territories

Municipalities provide funding for:

- At least 25% of ministry approved allocations
- Other public health programs and services beyond those provincially mandated

The proposed model would separate Public Health from the Region

York Region Public Health is one of six branches within the Community and Health Services Department. In the proposed restructuring of public health, Public Health would be separate from the Region in governance and organization, and would be restructured within the proposed regional public health entity and local public health delivery areas model.

- The proposed catchment areas for the restructured model would extend beyond the boundary of York Region to also include the former City of North York, currently part of Toronto Public Health, in a single regional public health entity. The proposed catchment area for Public Health covering York Region could have one or more local public health service delivery areas within it.

The disruption may temporarily or permanently interrupt progress being made on addressing the Social Determinant of Health

Initial potential impacts identified include the following:

- Financial implications relating to the separation of the Board of Health from the Region, including costs related to changes in administration, staffing, resource needs, strategic priorities, etc. Staff and services in other Community and Health Services branches and Regional departments funded as a result of Public Health being part of the Region may also be impacted;

- The proposed regional public health entity would provide its own corporate structure (e.g., human resource, communications, information technology, etc.). Both Public Health and the Region would lose varying degrees of the economies of scale from sharing these functions as a single organization;

- Public Health would operate externally from the Region. With respect to public policy and other initiatives, unlike some other public health units, York Region Public Health is further along in integration within the Regional corporate structure and operation. This has facilitated collaborative opportunities, such as the Seniors Strategy, Mental Health Initiative, Healthy Built Environment, Outreach Van program, Community Hubs Initiative, and the Human Services Planning Board. These collaborations benefit multiple clients and partners, and support a strategic and holistic approach to service planning and delivery;

- Separation of Public Health would impact the Region's ability to align with the provincial direction for integrated human services, and its ability to implement a social determinants service delivery model in York Region. Research suggests that 50% of population health is determined by our social and economic environment (Canadian Medical Association 2013). Many of the social determinants of health are strongly influenced by the actions and decisions of Regional and local municipal governments (for example, water and sanitation, and housing);

- Separation from the Region would also impact the collective bargaining units, Canadian Union of Public Employees (CUPE) Local 905 (York Region Unit) and Ontario Nurses Association (ONA).

Funding obligations of municipalities and regional governments with the proposed model are not addressed in the Expert Panel's report

The funding obligations of municipalities and regional governments under the proposed model are not addressed in the report. At present, autonomous and municipally-integrated boards of health have the same funding model. Funding for public health programs and services beyond those provincially mandated are funded by the municipality. Public Health has a 2017 operating budget of $70.978 million gross

($23.301 million net) including departmental and corporate support costs. About $8.404 million (11.8%) of the $70.978 million gross budget goes towards departmental ($2.773 million) and corporate ($5.631million) support costs.

Public Health comprises about 461.3 approved permanent budgeted full time equivalent (FTE) staff, working out of 10 locations in Regionally owned or leased buildings. In terms of head count, Public Health has 578 employees in total, including 465 permanent, 46 temporary and 67 casual individuals. Of the 578 employees, 52 are non-union and 526 are members of the two collective bargaining units.

Staff will continue to monitor and provide updates on the status of the panel recommendations

Following release of the report, Community and Health Services Department undertook a number of steps to ensure that key stakeholders were made aware of the report including communications from the Commissioner and Medical Officer of Health to Department staff and meetings with CUPE Local 905 (York Region Unit) and ONA to inform them of the panel report and internal actions being taken.

We will continue to monitor the positions of the Province and other relevant groups, such as the collective bargaining units, AMO and others, with respect to the panel's recommendations and prepare to provide feedback to the Province.

A proposed consultation response will be provided to Council / Board of Health for its endorsement in October

Staff will provide feedback on any provincial consultations related to the recommendations in the report. A proposed consultation response will be prepared for consideration by Council/Board of Health at its meeting on October 19, 2017. Consultation responses are due to the province on or before October 31, 2017.

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Katherine Chislett
Commissioner of Community and Health Services

KC/jt

Attachment 1

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Public Health within an Integrated Health System

Report of the Minister's Expert Panel on Public Health

June 9, 2017

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I. About the Expert Panel

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

Mandate

As part of their recommendation, the Expert Panel was asked to consider:

1. The optimal organizational structure for public health in Ontario to:
   - ensure accountability, transparency and quality of population and public health programs and services
   - improve capacity and equity in public health units across Ontario
   - support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
   - leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.
2. How best to govern and staff the optimal organizational structure.

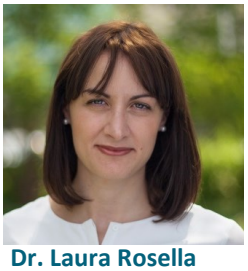
Membership

Members were chosen for their knowledge, expertise and perspectives and appointed by Order in Council. They were appointed as individuals and not as representatives of organizations or associations.

Dr. David Williams
Chief Medical Officer of Health, Ontario

Susan Fitzpatrick
Chief Executive Officer, Toronto Central Local Health Integration Network (LHIN)

Dr. Valerie Jaeger
Medical Officer of Health, Niagara Region Public Health



Dr. Laura Rosella
Canada Research Chair in Population Health Analytics, Assistant professor, Dalla Lana School of Public Health, UofT

Solomon Mamakwa
Health Advisor, Nishnawbe Aski Nation

Dr. Nicola J. Mercer
Medical Officer of Health and CEO, Wellington-Dufferin-Guelph Public Health

Gary McNamara
Mayor of the Town of Tecumseh, Chair of the Windsor Essex Health Unit

Carol Timmings
Director, Child Health and Development, Chief Nursing Officer, Toronto Public Health

Dr. Jeffrey Turnbull
Chief of Staff, The Ottawa Hospital, Chief - Clinical Quality, HQO

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

It is the view of the Expert Panel that Ontario will benefit most from a highly skilled public health sector embedded and highly visible in communities across the province. Public health will continue to nurture strong relationships with municipal governments and other local organizations to positively influence the social determinants of health; and create safe, supportive, healthy environments. Its work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities and share and promote a strong commitment to public health.

The public health workforce in all parts of the province will have access to specialized public health knowledge and resources. Public health practitioners will share a commitment to evidence-based practice and achieving population health outcomes.

The work of public health will be guided by provincial policy and legislation, and supported by province-wide efforts to collect and analyze data on health status. Public health will continue to champion health equity, identifying groups within the population whose health is at risk and developing targeted universal programs so that all Ontarians have equal opportunity for good health outcomes. Public health will also ensure that Indigenous communities have an active voice.

At the same time, the public health sector will have the capacity to work much more effectively with the rest of the health system. Its understanding of local health needs will help identify health system priorities and shape health policy and services. Stronger relationships with other parts of the health system will make it easier to integrate health protection and promotion into all health services. Working with other parts of the heath system, public health will identify more effective ways to deliver population level interventions that will improve health and reduce health inequities.

Ontarians will recognize and value the work of public health and will access local public health programs and services within an integrated health system.

Goals of Patients First

- Effective integration of services and greater equity
- Timely access to, and better integration of, primary care
- More consistent and accessible home & community care
- Stronger links to population and public health
- Inclusion of Indigenous voices in health care planning

Principles Guiding the Panel's Work

To guide its work and deliberations, the Expert Panel developed the following principles:

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- The federal government will continue to have responsibility for health services for Indigenous people in Ontario, including First Nations communities; however Ontario's public health sector also has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Form follows function: structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.
- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

Process and Deliberations

To fulfill its mandate, the Expert Panel:

- reviewed background information, including past reports on Ontario's public health sector
- examined the functions of public health at the regional, local, and provincial levels
- reviewed the current organization of the health system
- discussed possible models and scenarios for reorganizing public health based on input received during consultation for Patients First, and various other submissions, letters, etc.
- looked at ways to align services and determine geographical boundaries
- reviewed the literature on various leadership roles and structures and models for governance
- discussed the potential implications for legislation, including the *Health Protection and Promotion Act* and the *Local Health System Integration Act*, and others.

II. The Opportunity

Public Health as Part of an Integrated Health System

As part of Patients First, all health programs and services – hospitals, home and community care, primary care and public health – are strengthening connections and working together to enhance Ontarians' health and well-being at all ages and stages of life.

Historically, public health and health care have operated as distinct systems. Public health largely focuses on the health of populations and providing upstream community-wide interventions, while health care services are designed to diagnose, treat, and improve individual health outcomes. A key goal of Patients First is to strengthen linkages and partnerships between the health care system and public health.

Close collaboration and formalized relationships between public health and LHINs will mean that:

- A population health approach will be integrated into local planning and service delivery across the continuum of health care
- health services will address and be responsive to population health needs and will seek to promote health and achieve health equity
- health promotion, health protection and health care will be more connected
- public health services and other health services will be better integrated

Preparing Public Health for its role in an Integrated Health System

To maximize its impact in the transformed system, public health must change and the health system must adapt to allow and support true integration.

Over the past year, three public health transformation initiatives have been focused on addressing key questions that will help public health be an effective partner in an integrated health system:

1. **What is the work of public health?**
   The **modernization of the Ontario public health standards** will provide a renewed framework for public health programs, services, and accountability in the 21st century.
2. **What is the role of public health in integrated planning?**
   The **public health work stream** is a collaboration between public health and LHINs working to provide guidance on formal engagement parameters for LHINs and public health across the province.
3. **How should public health be organized across the province to function effectively within an integrated system?**
   The **Expert Panel on Public Health** was asked to provide advice on what the structure and governance of public health should be to enhance its capacity to fulfill its health promotion and protection role and work effectively with partners within a transformed health system.

The Impact of Public Health within an Integrated System

What impact will the strengthened relationship between public health and LHINs have on all health system partners and on Ontarians?

Strong relationships outside the health system to protect and promote health.
Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

More focus on the social determinants of health and greater health equity.
Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

More comprehensive targeted health interventions.
Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

Better care pathways and health outcomes.
A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.

Greater recognition of the value of public health.
With public health as part of an integrated health system, Ontarians will better understand the importance of investing in health protection and promotion across the life course. They will see how public health benefits themselves, their families and their communities and, at the same time, helps contain health care costs and make the universal health care system more sustainable.

Improving access to care is one priority for the integrated system, but the vision of Patients First is much broader. It is also about promoting health, reducing health disparities and helping all Ontarians lead long healthy lives.

III. A Strong Public Health Sector in an Integrated System

The impetus for the Expert Panel's work is the government's Patients First Strategy. The key question for the Expert Panel was how to best organize public health to function effectively within an integrated system. However, the Expert Panel also viewed their task as an opportunity to strengthen the public health sector and support more efficient and effective operations.

Members worked to identify an optimal structure and governance model for public health in Ontario for the 21st century and beyond. In developing recommendations, the Expert Panel did not attempt to "retrofit" the current system.

1. The Optimal Organizational Structure for Public Health

Background

Ontario currently has 36 public health units. They range in size from 630 to 266,291 square kilometres. The smallest serves only 34,246 people dispersed over a geographic area as large as France, while the largest serves 2,771,770 people concentrated within 630 square kilometres. (See Appendix A: map showing current health unit areas and LHIN boundaries)

Public health units are responsible for delivering programs and services in accordance with standards established by the Ministry of Health and Long-Term Care. Public health units are responsible for identifying local health priorities and population needs and addressing those that fall within their mandate. Much of the work in public health is done in close collaboration with municipal partners. There is a cost-sharing relationship between the Ministry of Health and Long-Term Care and municipalities for delivery of public health programs and services.

Key strengths of the public health sector include its focus on health protection, health promotion, and health equity, its local presence, relationship with municipalities, its highly trained workforce, its collaborative relationships outside the health care system, and its in-depth understanding of and capacity to assess population-level health.

Challenges of the current structure – particularly felt in smaller health units – include a lack of critical mass and surge capacity and challenges recruiting and retaining key skilled public health personnel, which make it difficult to deliver equitable services across Ontario. A lack of mechanisms to coordinate across health units and lack of alignment with LHINs also make it challenging to collaborate, share resources and maximize effectiveness both within the public health sector and within the broader health system.

Criteria

The Expert Panel's goal was to recommend an organizational structure for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, in order to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

Members of the Expert Panel agreed with findings and observations of a series of reviews over the past 20 years, which all determined that Ontario's public health sector would be stronger if:

* there were fewer health units with greater capacity
* there was a consistent governance model
* the sector was better connected to other parts of the health system.

Responsibilities and Functions

To ensure strong local programs and services, every effort should be made to locate the right mix of management and program staff in local communities. Depending on the size of the communities/populations they serve, local service delivery sites may have public health physicians, directors, managers/program leads, front-line staff and staff responsible for using local population health data to develop local initiatives that are reflective of community needs.

The optimal locations for regional and local public health activities should be determined within the region and based on the distribution of the population and geography. The regional public health entity could potentially look for opportunities to co-locate public health services with other health and/or municipal services, thereby increasing the potential for service integration.

Table 1 on pages 12 –15 outlines public health responsibilities and functions at provincial, regional and local levels.

Figure 1: Organizations Described at Each Level

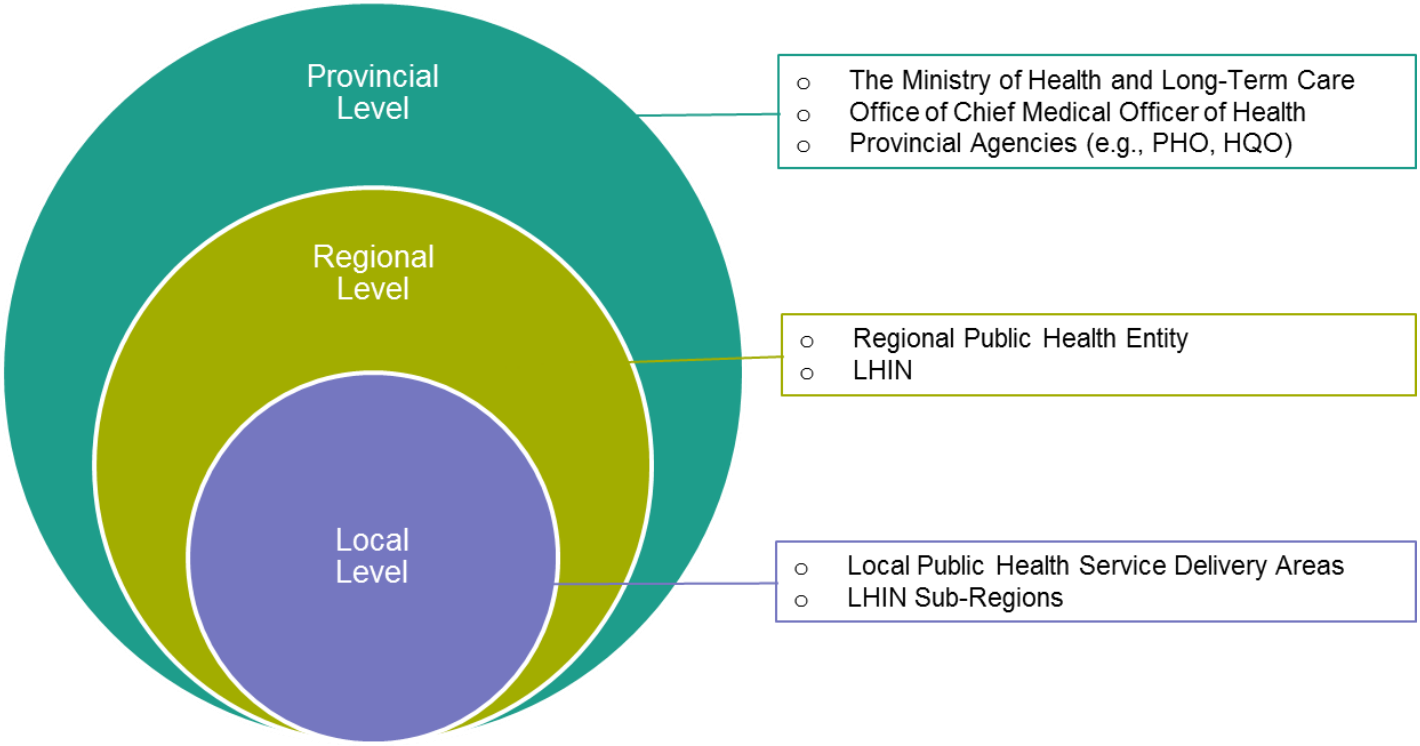


Table 1: Public Health Responsibilities and Functions

Category	Function	Regional	Local	Provincial	LHIN
Corporate Services	**Funding and Accountability**	• Accountability agreements with province • Performance management approach • Accountability for local public health entities	• Continuous quality improvement • Performance management initiatives	• Transfer payments • Overall provincial accountability with 14 regions	
	Human Resource Management	• Workforce strategy • Human resource policies and procedures	• Local oversight • Staff development	• 100% funded positions (e.g., social determinants of health nurses) • Medical Officer of Health/ Associate compensation	
	Administrative	• Risk management • Procurement • Service level agreements • Facilities planning and administration	• Local facilities management and input		
	Communications	• Strategic communication planning • Guidelines for use of relationships with media channels • Guidelines for public reporting	• Local issues management and correspondence with the media • Strategies for educating community partners and the public		
	Information tech-nology	• Corporate IT			

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Performance, Quality, and Analytics	**Surveillance and Monitoring**	• Collect and consolidate pertinent health-related data • Detect and notify of health events • Appropriate reporting of data to province, local offices, LHINs, etc.	• Apply surveillance data to guide public health policy and strategies • Document impact of an intervention or progress towards specified public health targets/goals • Investigation and confirmation of cases or outbreaks • Coordination and sharing of information with LHIN sub-regions	• Ongoing, systematic collection, analysis and interpretation of health-related data	• Receive surveillance information and assist with dissemination
	Information Management	• Responsible for common regional systems • Decision making • Data governance	• Systems designed to address local needs	• Centralized data systems • Data governance	• Potential integrated databases
	Performance and Evaluation	• Regional metrics and dashboards • Data repository • Inform /contribute to LHIN planning	• Local data collection and insights • Application of data in local planning and delivery • Program accountability • Quality of practice	• Provincial dashboards • Provincial level data • Coordination of data sharing with other jurisdictions and First Nations	• Coordination/ bridging work with public / population health data
	Research	• Set research priorities • Lead and/or participate in regional research projects • Review and incorporate research and evaluation findings into planning	• Conduct research projects • Help inform research proprieties • Partner with other organizations undertaking research • Stay up to date on latest studies • Ongoing program review and evaluation	• Set research priorities • Research grants	• Interpretation of population health research to inform planning

Table 1: Public Health Responsibilities and Functions (continued)

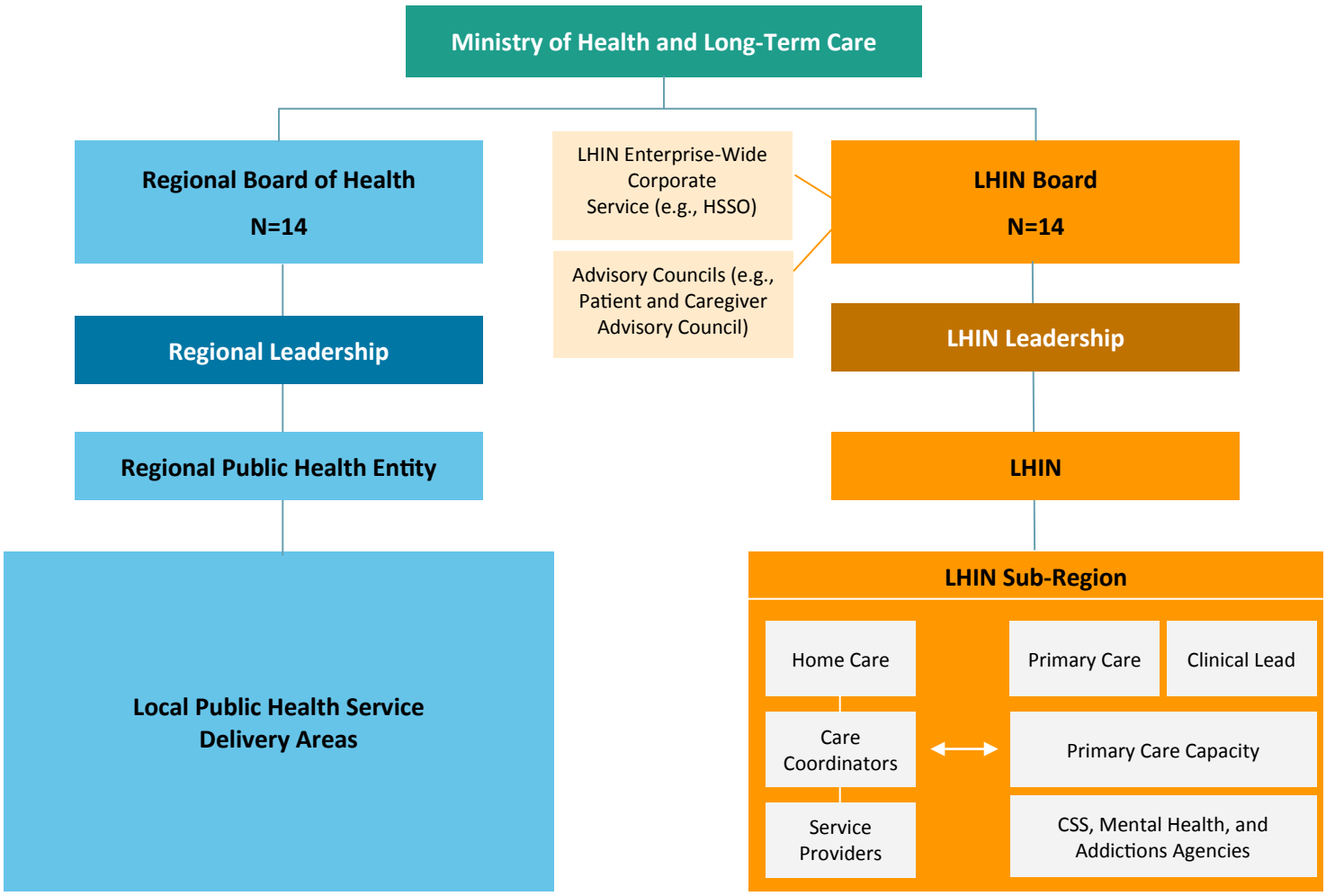
Category	Function	Regional	Local	Provincial	LHIN
Public Health Practice (Programs and Services)	**Planning**	• Annual service plan • Strategic plan • Health equity lens • Corporate planning • Resource allocation planning	• Operational plans • Implementation plans • Provide context, data, and costing inputs • Local perspective and considerations (including First Nations)	• Review and approve annual service plan • Mandate letters • Program and policy planning	• Regional input and alignment with other health services • Service planning
	Delivery	• Management of after-hours on-call system	• Implementation • Ongoing program and service delivery • Coordination of after-hours on-call system	• Provincial program implementation and oversight	• Coordinated delivery / optimization of services
	Coordination	• Work with leadership at all levels of government, throughout the public health organization, the 13 other regional MOHs, the LHIN, and across sectors • Functional integration and consistency with LHIN business plan	• Work with local leadership to execute public health services and delivery • Participation on local committees and in community meetings	• Chair provincial public health table with MOHs • Provide guidance and leadership on public health topics and issues	• Functional integration and consistency with public health business plan

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Strategic Engagement	**Health System**	• LHIN (cross-linkages) • Health regulatory colleges	• LHIN sub-regions (when applicable) • Primary care • Hospitals	• Public health accountability and reporting to province • Receive information/ direction/ mandates from province (when applicable)	• Information sharing • Inform planning at a LHIN and LHIN sub-region level • Consultation through LHIN committees (when applicable) • Routine collaboration between public health and LHIN leadership (at both regional and local/ LHIN sub-region levels) • Other health service providers e.g., hospitals, Community Health Centres and Family Health Teams
	Public Health System	• Chief Medical Officer of Health • Other MOHs and CNOs • Academic / research institutions • Public Health Ontario • Associations	• Regional public health • Other public health units • Academic / research institutions	• Regional MOHs (e.g., standing meetings)	• MOHs
	Governments	• Province	• Municipality	• Federal government • First Nations • Agencies	• Province
	Cross-Sector	• Leadership from all social deter-minants of health disciplines (e.g., environment, transportation, housing, children and youth services)	• Local community and social services • Education, transportation, housing, settlement, etc.	• Health in all policies approach	• Social services • Community and home care • Family services • Community and recreation services

Figure 2: Proposed End State — Public Health within an Integrated Health System

The Expert Panel recommends that Ontario establish 14 regional public health entities .



The proposed structure of 14 regional public health entities will allow public health to:

- **Centralize** administrative and specialized public health functions at the regional level
- **Be Accountable** for public health standards set provincially
- **Collaborate** with LHINs and other partners to plan and tailor health services in their regions
- **Establish** local public health service delivery areas within regions, based on population and geography
- **Locate** public health programs and services in local communities to maintain local engagement

The Expert Panel believes that having fewer regional public health entities will result in more frequent and effective interactions among regional medical officers of health and between regional medical officers of health and the province. At the same time, maintaining local public health delivery areas will ensure a strong local presence and effective relationships with municipalities.

For the proposed structure to succeed, it will be essential to establish strong working relationships, develop effective communication mechanisms and undertake shared projects and activities:

- within each regional public health entity
- between the regional public health entity and the municipalities in the region
- between the regional public health entity and the LHIN
- among the regional public health entities
- with the province.

2. Optimal Geographic Boundaries

Background

Ontario's existing 36 public health units are organized based mainly on municipal boundaries. The current configuration of health unit areas make it difficult to operate as a unified system with LHINs and other health system partners following LHIN boundaries.

The current organization of public health units has a negative impact on the capacity of smaller health units. Boundary changes are necessary to enhance public health capacity and effectiveness, and to help public health be more integrated with the rest of the health system. At the same time, it is important to maintain the strengths associated with public health's close relationship with municipalities.

Criteria

To determine the number of regional public health entities and their recommended geographic boundaries, the Expert Panel used the following criteria:

- create regional public health entities that would serve a large enough population to achieve critical mass to be able to operate efficiently and effectively and attract skilled staff
- support effective linkages with LHINs by aligning with LHIN boundaries
- respect municipal boundaries and relationships as much as possible
- whenever feasible, move existing health units in their entirety into the same regional health entity catchment area
- when it is not feasible to move entire existing health units together, divide health units based on municipal boundaries

Proposed Geographic Boundaries

The Expert Panel recommends that Ontario establish catchment areas for the 14 regional public health entities that are consistent with LHIN boundaries and respect existing municipal boundaries.

Figure 3: Proposed Boundaries Mapped Against Current Public Health Unit Boundaries

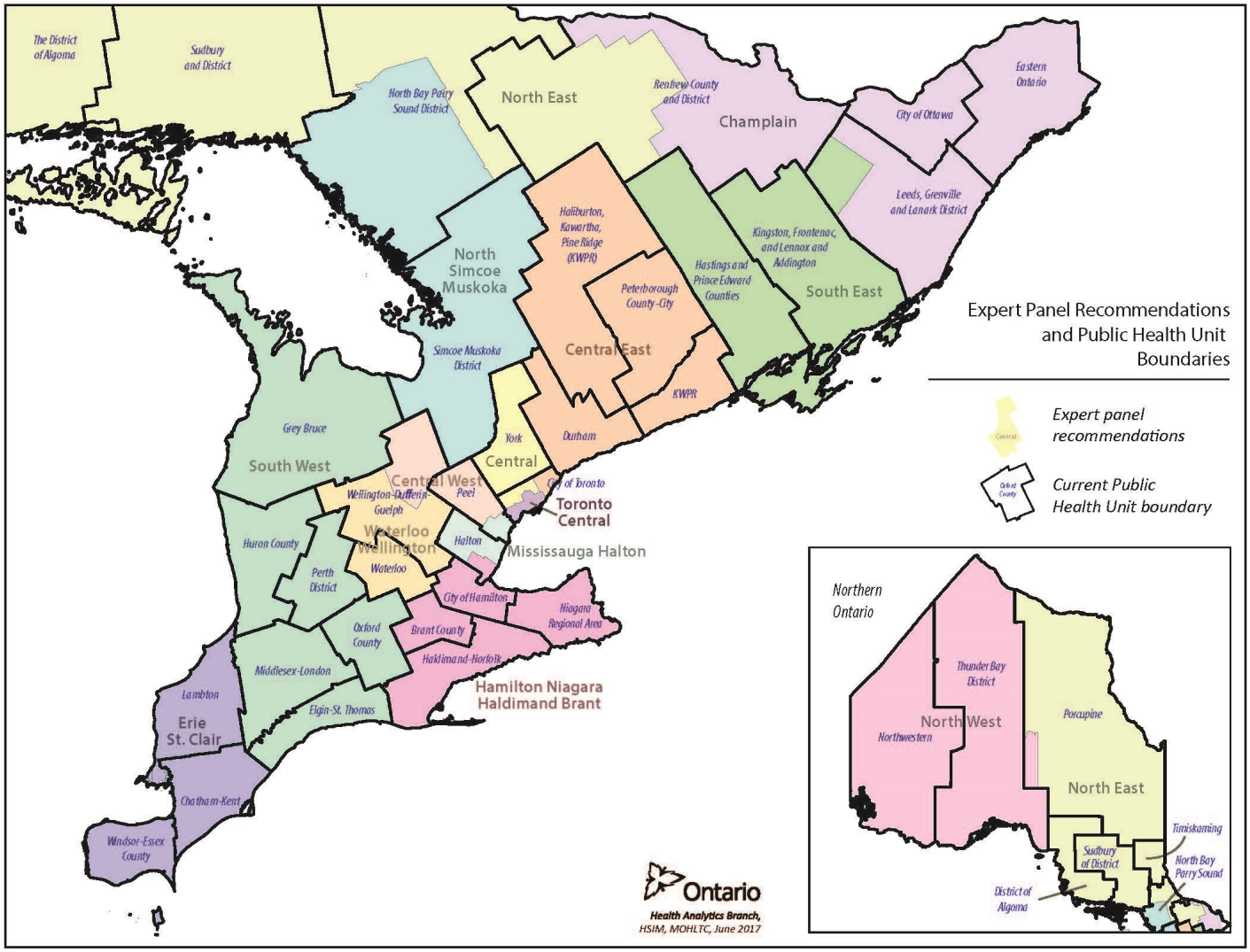
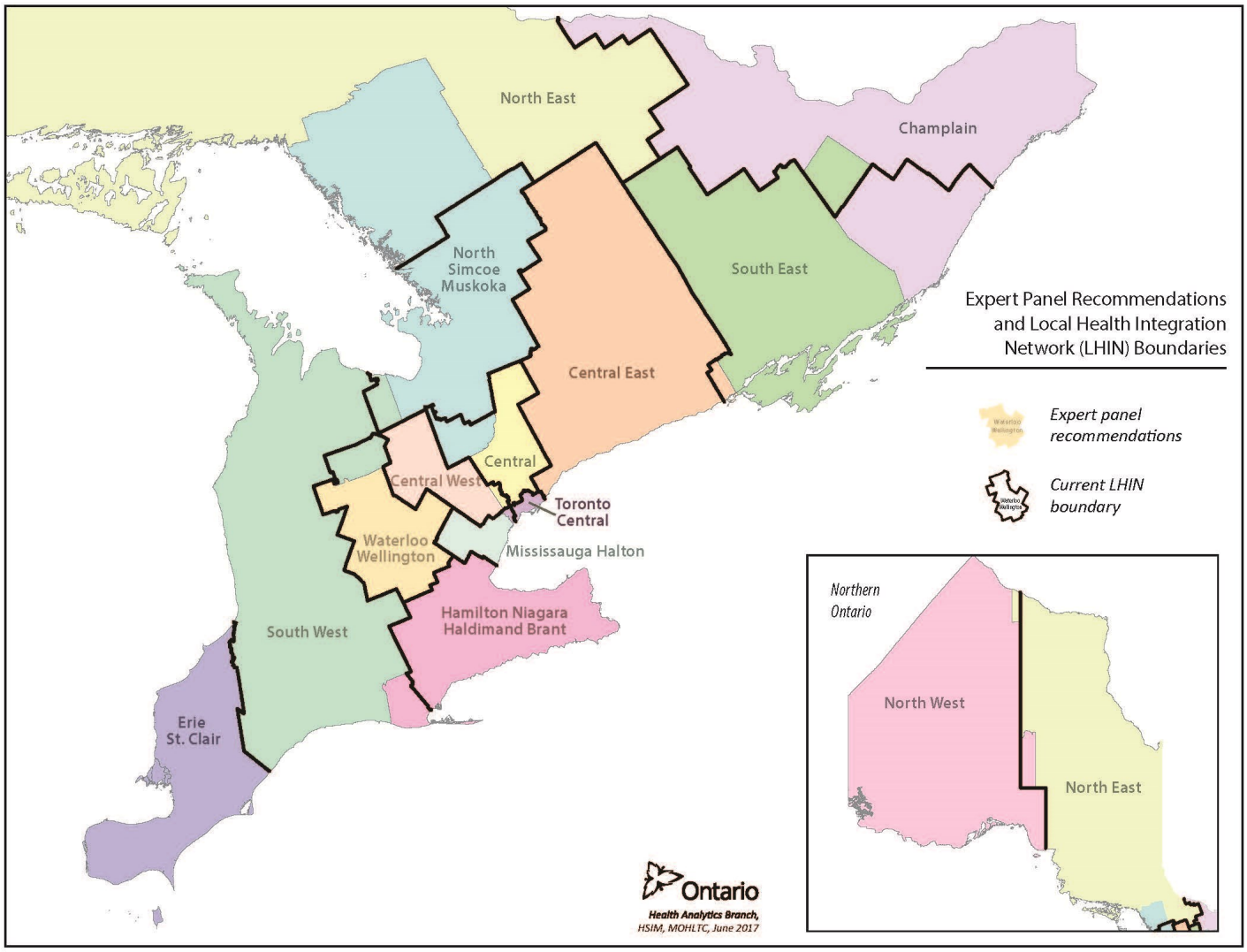


Figure 4: Proposed Boundaries Mapped Against Current LHIN Boundaries



With the recommended boundaries, the populations served by the regional public health agencies would range from about 0.25 million to 1.8 million.

3. Optimal Leadership Structure

Background

The proposed regional public health entities will be complex multi-million dollar organizations with staff spread across multiple local sites. The leadership structure and the quality and competence of public health leaders will be critical to the success of the proposed organizational structure.

Public health units of the future will require leaders with broad-based skills that encompass strong demonstrated organizational and business management, relationship management, strategic planning and performance management skills as well as extensive public health experience.

The literature indicates that, for large health organizations, a single leader as opposed to a joint leadership model is more effective – when the leader has the right mix of experience and competencies. It also indicates that it is essential for that single leader to have both content expertise – in this case, public health knowledge – and management expertise.

Criteria

The Expert Panel's goal was to propose a leadership structure that would:

- Reflect best practices in the leadership of health organizations
- Reinforce and capitalize on strong public health/clinical skills
- Be able to support geographically distributed programs and staff
- Maintain strong expertise and skills at both the regional and local levels
- Capture all the roles and functions of current leaders
- Operate efficiently and effectively

Proposed Leadership Structure

Figure 5: Proposed Leadership Considerations

Regional Public Health Entity	
CEO	• Direct report to the Board of Health
Regional Medical Officer of Health	• Public health physician • Ability to report directly to the Board of Health on matters of public health and safety
Senior Public Health Leadership	• E.g., nursing (Chief Nursing Officer), associate medical officers of health, other content-specific leaders, corporate management (e.g., Chief Administrative Officer, Chief Operating Officer, Chief Information Officer, etc.)

Local Public Health Service Delivery Areas	
Local Medical Officer of Health	• Local public health physician • Report to regional Medical Officer of Health • Number—variable, e.g., based on population and geography
Local Public Health Program and Service Management	• E.g., nursing leadership, public health inspection management, etc. • Program managers • Multi-disciplinary teams

Regional Public Health Entity—Functional Departments

Corporate Services

- Funding & Accountability
- Human Resource Management
- Administrative Services
- Communications
- Information Technology

Public Health Practice (Programs and Services)

- Planning
- Delivery
- Coordination

Performance, Quality, and Analytics

- Surveillance and Monitoring
- Information Management
- Performance and Evaluation
- Research

Strategic Engagement

- Strategic Planning and Integration

Engagement:

- LHINs
- Health System
- Public Health System
- Governments
- Cross-Sector
- Community

4. An Optimal Approach to Governance

Background

All public health units are governed by a board of health. While the *Health Protection and Promotion Act (HPPA)* requires that all health units be governed by a board of health, the legislation does not set out a specific model of governance. Currently, public health governance models vary considerably across the province (i.e., some are autonomous boards, others are part of the structure of the municipal or regional government). While variation is not necessarily a problem in and of itself, it can result in inequities.

A number of reviews and reports have highlighted challenges with current public health governance, including the wide variety of governance models, gaps in skills on some boards and challenges with both provincial and municipal appointments to the boards. Over time, this may affect public health's ability to work effectively with the LHIN boards, which have a consistent governance model.

Although the HPPA sets out a process for appointing members of the boards of health that reflect both the municipal and provincial responsibility for public health (i.e., some members are appointed by the municipalities and some by the Ministry of Health and Long-Term Care through orders in council), there are no specific requirements related to the skills or experience that board members should have. As a result, there are significant skill gaps on some boards of health.

In terms of appointing board members, boards of health experience high vacancy rates among provincial appointees. Vacant seats can make it difficult for boards to optimally function. Furthermore, there can be gaps in appointment of elected municipal officials as a result of elections.

Criteria

The Expert Panel's goal was to recommend a public health governance structure that would:

- Ensure greater consistency in governance of public health
- Maintain public health autonomy and independence
- Maintain a strong municipal voice and representation
- Relate effectively to LHIN boards
- Reflect best practices in governance
- Address issues related to board vacancies
- Reinforce the roles and responsibilities of board members
- Ensure accountability and effective oversight

Proposed Governance Model

The Expert Panel recommends that Ontario establish a consistent governance structure for regional boards of health in Ontario with the following features:

	Board of Health Governance Characteristics
Governance	Free-standing autonomous board
	Consideration for appropriate secretariat support for board operations
Appointees	Municipal members (formula for representation to be defined in Regulations – e.g., by population, by upper tier etc.)
	Provincial appointees (including OIC appointments for specific position(s) such as board chair, vice chair, finance – to be nominated by the board)
	Citizen members (municipal appointees)
	Other representatives (e.g., education, LHIN, social sector, etc.)
Size	Varied: 12-15 members
Indigenous Representation	Meaningful opportunity for representation to ensure Indigenous partners have an active voice (based on population demographics)
Francophone Representation	Representation for the Francophone community (based on population demographics)
Diversity and Inclusion	Boards should reflect the communities which they serve, including but not limited to inclusion of: • Gender and sexual orientation • Visible minorities • Lived experience • Diverse ages
Qualifications	Skills-based
	Experience
Appointment Process	Flexibility for combination of provincial and local appointments (for non-specific positions) to address varying capacity across province
Board Compensation	Apply consistent approach for board member compensation
	Consideration of equitable compensation across public boards (e.g., public health, LHINs, agencies, etc.)
Committees	Establishment of standing committees (e.g., good governance and nomination committees, finance and audit, HR, etc.) to be defined in Regulations
	Committees are responsive to community needs
Succession Planning and Implementation	Staggered transition/appointments for new board structures
	Tenure
	Targeted recruitment

Considerations for Proposed Regional Board of Health

The regional board of health should be small enough to be efficient but large enough to support strong standing committees (i.e., governance, finance/audit, quality). The literature shows that doing certain work in standing committees is more functional and effective than doing it as an entire board.

The goal is to attract highly skilled and competent individuals who will speak for the interests of public health to serve on the board. It is critical that:

- the board have the right mix of skills, competencies, and diverse perspectives
- all board members understand and accept their role
- the boards have a process to manage attendance and to remove people from the board who are not fulfilling their responsibilities.

Furthermore, when recruiting members to the regional board of health, the governance committee should look specifically for people who want to work on a team and share a commitment to improving the health of the population.

Because of past challenges with timing Order in Council (OIC) appointments, the Expert Panel recommends a smaller number of provincial appointees; however, to ensure accountability to the provincial government, those seats should be key positions (e.g., chair, vice-chair, chair of the finance/ audit committee). The governance committee should recommend the candidates for OIC appointments, and those candidates should be able to include elected municipal officials.

To address continuity of service challenges with municipal officials, the Expert Panel recommends that when an elected official appointed to the board of health is not re-elected, he or she continue to serve on the board of health until the municipality makes a new appointment. Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity, and to reduce the challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health.

IV. Implementation Considerations

The Expert Panel recognizes that if implemented, the recommendations will mean large organizational change for the sector. The Expert Panel was not asked to make specific recommendations about implementation, however, they have identified elements that should be considered in developing an implementation plan.

Legislation

The proposed health unit boundary changes and implementation of regional public health entities will have implications for public health and other related legislation. A detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.

Funding

While public health funding was not within the scope of the Expert Panel's mandate, they have flagged that the current public health funding model may be a barrier to implementing the proposed structure.

Under the HPPA, municipalities have legislated authority for public health and provincial funding for public health is discretionary. Public health units receive an annual grant from the Ministry of Health and Long-Term Care– and the amount the province contributes has varied over the years.

The Ministry of Health and Long-Term Care provides funding for:

- up to 75% of ministry approved allocations

- 100% of certain programs, such as Healthy Smiles Ontario, the Infectious Disease Control Initiative, nursing initiatives and the Smoke-Free Ontario Strategy

- 100% of services in unorganized territories (i.e., areas without municipal organizations)

Municipalities provide funding for:

- at least 25% of ministry approved allocations (many provide more)

- other public health programs and services– beyond those provincially mandated

The ministry's contribution recognizes the challenges many municipalities – particularly smaller ones – face in funding public health services.

The proposed shift from local health units, whose costs are shared by local municipalities, to a regional public health entity will likely raise questions about the funding obligations of each municipality in the region.

As part of implementation planning, the ministry will need to re-visit funding constructs in order to implement the recommendations.

Transition Planning/Change Management

The proposed structure will have a significant impact on the 36 existing health units and boards of health. Although the transition may be more straightforward for the public health units that move in their entirety into a regional health entity than for those divided across two or more regional agencies, all will require assistance with change management. Given the complex nature of municipal government (i.e., upper tier, lower tier, independent), it may be helpful to engage consultants with a strong track record in change management to help with transition planning.

The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognize and protect municipal interests, while recognizing the potential for competition for municipal seats.

To ensure greater consistency across the province, it may be helpful to work with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.

Effective Linkages with LHINs and the Health System

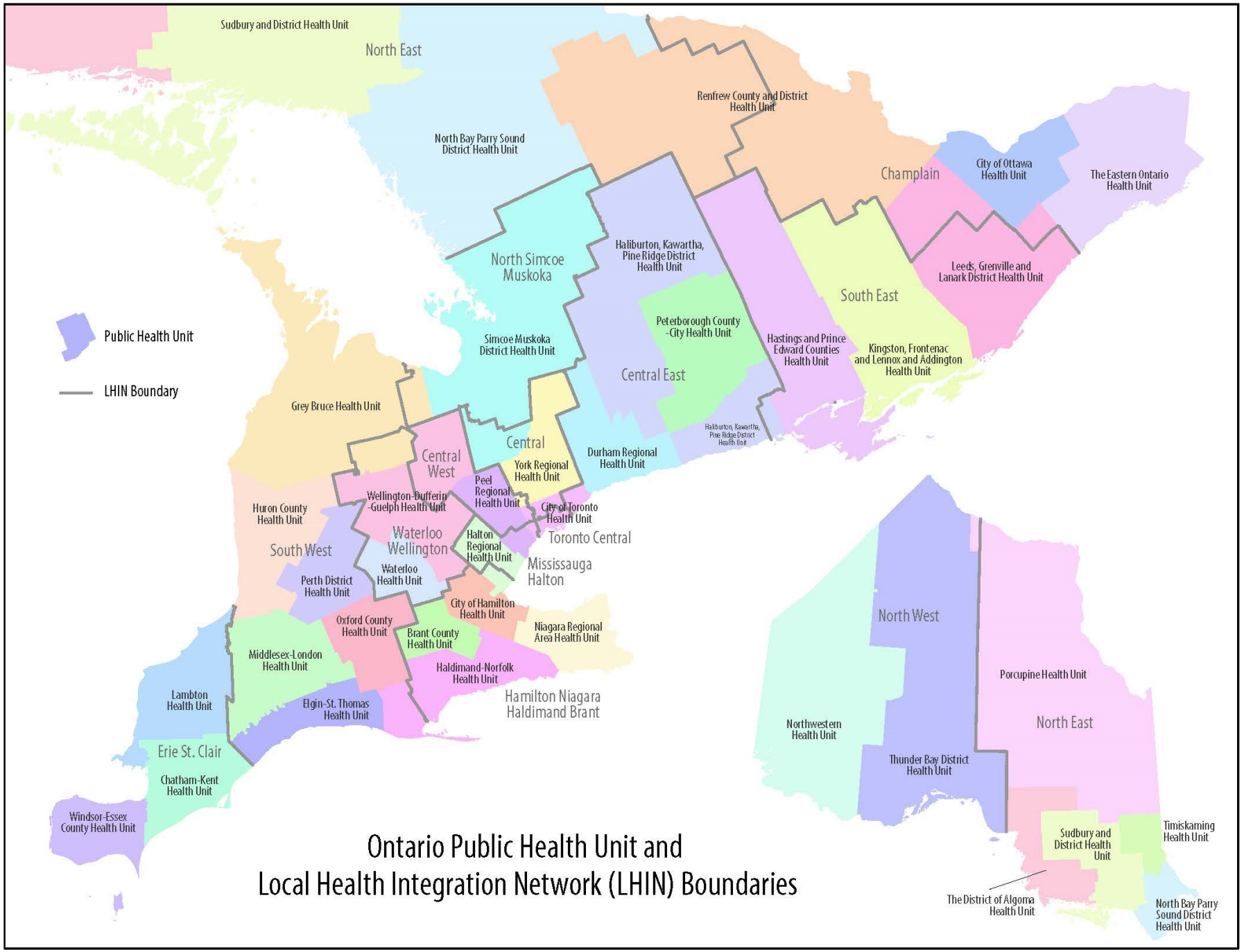
During its deliberations, the Expert Panel identified a number of strategies that, in its view, could enhance linkages with LHINs, such as:

- potential cross appointments (or ex-officio) to the regional Board of Health and the LHIN board
- regular meetings between the Regional Board of Health chair and the LHIN board chair
- regular meetings between public health and LHIN leadership as well as shared projects and activities.

Structured relationships will also be necessary with all health system partners including primary care, hospitals, and home and community care to develop stronger linkages between disease prevention, health promotion and care, maximize system efficiencies and support a fully integrated health system.

Appendix

Appendix A: Current LHIN and PHU Boundaries



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