STAFF REPORT
ACTION REQUIRED

Commission on the Reform of Ontario's Public Services (Drummond Report): Implications for Public Health

Date:	February 24, 2012
To:	Board of Health
From:	Medical Officer of Health
Wards:	All
Reference Number:	

SUMMARY

The report of the Commission on the Reform of Ontario's Public Services (Drummond Report) was issued by the Province of Ontario on February 15, 2012. The report contains over 360 recommendations. The Commission was established by the Province of Ontario in early 2011 with the objective of identifying cost-saving and efficiency measures across all major areas of provincially funded programs and services.

This report to the Board of Health provides an initial overview of a number of the key recommendations directly relating to the organization and funding of public health in Ontario.

The Commission report proposes a series of measures aimed specifically at achieving cost savings, greater integration and efficiency in the Ontario health system. Almost one third of the 362 recommendations in the report pertain to the health sector. Included in these are a series of recommendations specifically regarding the funding and structure of public health in Ontario including; the need to explore 100% provincial funding for public health, the need for greater coordination between public health and other sectors, the need for enhanced emphasis on health promotion, and a recommendation to "integrate public health into the broader health system (i.e. LHINs)".

The legal and administrative strengthening of the provinces 14 Local Health Integration Networks (LHINs) forms a key part of the report recommendations on health care, with a strong set of recommendations advocating that greater power and control over funding decisions be vested in the LHIN structure as a vehicle to achieve savings based upon advancing integration. In addition, the report highlights the need for Ontario to place greater emphasis on a range of health promotion measures, develop a chronic disease

prevention strategy, and take greater action on childhood obesity to improve longer term health outcomes and reduce hospital expenditures.

This report contains an initial assessment of the implications of the recommendations directed at the public health sector and outlines issues to be considered by the provincial government if it should pursue these recommendations. This report also proposes that the Medical Officer of Health actively monitor and report to the Board on any provincial government responses to the Commission report with direct implications for public health or the health of the population of Toronto.

RECOMMENDATIONS

The Medical Officer of Health recommends:

1. That the Board of Health recommend to the Minister of Health and Long-Term Care, that the following steps be undertaken prior to considering implementation of any recommendation pertaining to public health funding, organization or governance:

    a. A comprehensive assessment of the implications of the public health recommendations of the Commission report in light of the detailed recent third party reviews of the Ontario public health system previously commissioned by the government of Ontario and the federal government. Specifically, this assessment should review the prior recommendations of the three volume independent SARS Commission report chaired by the late Justice Archibald Campbell; the report of the Expert Panel on SARS and Infectious Disease Control chaired by Dr. David Walker; the report of the National Advisory Committee of SARS and Public Health, chaired by Dr. David Naylor; and the final report of the Ministry of Health and Long-Term Care commissioned Capacity Review Committee.

    b. A full and open consultation process including Boards of Health, the Council of Ontario Medical Officers of Health, the Association of Local Public Health Agencies, the Ontario Public Health Association and other key public health stakeholders.

2. That the Medical Officer of Health monitor the provincial government response to all recommendations contained within the Commission report with the potential to impact upon the health of the population of Toronto and to report to the Board as appropriate.

3. The Board of Health forward this report to the Ontario Boards of Health; the Association of Local Public Health Agencies; and the Ontario Public Health Association.

Financial Impact

There are no financial implications arising from this report.

ISSUE BACKGROUND

The Commission on the Reform of Ontario's Public Services was established by the Government of Ontario in March 2011 with a five point mandate to advise the Government of Ontario on the measures to be considered for the Province to be able to balance expenditures and revenues on or before the fiscal year 2017/18.

The background to the Commission's mandate is the stated intent of the Province of Ontario to eliminate the provincial deficit on or before 2017/18 and to make sustainable progress in addressing the approximately $14 billion provincial deficit (2011). In summary form, the five point mandate of the Commission was stated as follows;

1. Advise on how to balance the budget earlier than the 2017/18 fiscal year.

2. Once the budget is balanced, ensure a sustainable fiscal environment.

3. Ensure that the government is getting value for money in all its activities.

4. Do not recommend privatization of health care or education.

5. Do not recommend tax increases.

The Commission report is comprised of 20 chapters and 362 specific recommendations covering virtually all aspects of Ontario public expenditures including social programs, environmental programs, the health system and other areas with potential implications for the health of the public. This report focuses on the recommendations with direct implications for the structure and funding of the public health system. The full Commission report can be found at http://www.fin.gov.on.ca/en/reformcommission/.

The Current Model: Public Health in Ontario

Currently the public health services provided to Ontarians according to the Ontario Public Health Standards under the Health Protection and Promotion Act are delivered through 36 Boards of Health across Ontario.

While the governance model of local public health agencies varies somewhat between local jurisdictions depending on the structure of local government, overall the public health structures are aligned directly or indirectly with municipalities. The municipal linkage in public health has been a fact of public health delivery since the creation of the first Board of Health over 128 years ago in Toronto.

The municipal linkage of public health in Ontario is now unique in Canada. In all other jurisdictions, public health functions are integrated into varying forms of provincially funded regional health authorities which also deliver other health services, such as hospitals and long-term care.

The Current Model: Local Health Integration Networks (LHINs)

LHINs were introduced in Ontario between 2005 and 2006 under the previous Liberal government. LHINs were established with the goal of decentralizing decision making in health care to the local level and promoting improved planning, coordination and integration among health care service providers within a given region.

The 14 LHINS are currently organized on planning boundaries derived from hospital catchment areas, which, for the most part do not align well with municipal boundaries. One practical implication of the LHIN regions is that the City of Toronto is currently dissected by five separate LHIN planning areas, making operational coordination for Toronto Public Health (TPH) with the broader health system considerably more complex than if the planning boundaries were congruent with the City.

The LHINs are established by legislation and are governed by Boards of Directors appointed by the Minister of Health and Long-Term Care through order-in-council. While the LHINs currently have a mandate to promote integration, their efforts to achieve this goal have, the Commission report argues, been constrained by limitations in their legal power to require service amalgamation, and a funding role which has largely been dictated by the Ministry of Health and Long-Term Care (MOHLTC). These factors, combined with inadequate staffing levels and a power imbalance between the boards of LHINs and the boards of major hospitals and other health care organizations, have, the commission argues, impeded the pace of integration and reform in Ontario health care.

Currently the LHINs flow funding allocated by the Ministry of Health and Long-Term Care through to hospitals, Community Health Centres, Community Care Access Centres (CCACs) and a host of community agencies. Public health is currently funded and enters into accountability agreements directly with the provincial government, primarily with the Ministry of Health and Long-Term Care.

The Commission on Health Care

The Commission recommendations pertaining to health care emphasize greater integration and reform, not simply to reduce costs, but also to improve service delivery and to reduce fragmentation of health services. It is in this context that a number of recommendations are made regarding the need for greater local control through LHINs and specifically for increasing the legal authority and power of LHINS and expanding those areas of the health care under LHIN governance or funding.

The Commission Vision: A 20 Year Plan for Health Care

The Health chapter of the Commission report advocates for Ontario to adopt a 20 year plan for health care in Ontario. This plan, the commission recommends, should be grounded in eight basic principles. These proposed principles include a number of frequently stated goals for the health care system and include the following points:

- The system should be centred on the patient, not on the institutions and practitioners in the health care system;

- The plan should focus on the coordination of services for patients in a fully integrated, system wide approach;
- There should be a heightened focus on preventing health problems, including the role of public health in meeting this goal;
- The quality of care can and should be enhanced despite the need to restrain increased spending; the objectives of quality care and cost restraint must go hand in hand;
- Policies should be based on evidence that provides guidance on what services, procedures, devices and drugs are effective, efficient and eligible for public funding.

Within the context of the proposed 20 year plan, the commission then lays out a series of proposals designed to create a more efficient and more integrated health care system. At the heart of these proposals is "(T)he Commission's intent to further strengthen the existing system, moving forward with the original intent of integrated regional health delivery." Essentially what is proposed is a regional health authority based model within which all health care providers/organizations are brought under the planning, funding and potentially governance domain of the LHIN.

According to the Commission, LHINs should be reduced in number from the existing 14 (though no desired number is specified) and strengthened in terms of legal powers, degree of autonomy for the Ministry of Health and Long-Term Care, resourcing and mandate. Of specific note is an observation made in the report that consideration be given to realigning the boundaries of the Toronto LHIN to make it correspond to the boundaries of the City of Toronto.

In the body of the report, the Commission notes that "three quarters of the influences that account for health outcomes barely register in the health care debate" and considerable emphasis is placed upon the need for greater investments in health promotion and disease prevention as a means to both improve outcomes and reduce long-term cost pressures on the system.

In addition to a wide range of cost saving or efficiency measures such as increasing the use of telemedicine, decreasing reliance on physicians in favour of other (lower cost) providers, increasing the use of collective purchasing and consolidation of back office functions in hospitals, the report proposes a number of fundamental changes with large implications for public health if adopted.

Key Commission Recommendations with Potential Implications for Public Health:

The Commission report notes that "In our Status Quo Scenario … Ontario's health care budget rises from $44.77 billion in 2010-11 to $62.46 billion by 2017-18, for an average

annual increase of 4.9 per cent." The Commission comments that such growth is unsustainable and results in a 3.5% increase per year in the proportion of total government spending taken up by health care. In short, the Commission argues, health care costs are unsustainable and are, over time, eroding all other areas of program spending by the Province.

The Ontario health care system is depicted in the Commission report as not a system but a set of service delivery silos which are inefficient and disjointed. The impact of this lack of integration, the report states, is felt most keenly, by those with multiple chronic conditions requiring interaction with multiple service providers. System reform is therefore seen as essential not only to ensure that the health care system is sustainable, but to improve patient experience, care and health outcomes.

The key Commission recommendations with direct or indirect implications for public health are summarized below:

Health Care Funding:

- Overall health care program spending should be capped at a maximum annual increase of 2.5% a year until 2017/18.
- *Explanatory:* Total health expenditures would be capped at 2.5% a year, all other areas of program expenditure outside health would be capped at a maximum 0.8% increase. Given the current rate of annual increase is 4.9% and traditionally has ranged from 5-6%, this goal would represent a considerable tightening of the MOHLTC budget. It is also important to note that areas of high growth in health (e.g. Provincial Drug Program) will impact upon the available transfer payment funds for all health care providers.

Governance and Structures:

- "Grant Local Health Integration Networks the authority, accountabilities and resources necessary to oversee health within the region, including allocating budgets, holding stakeholders accountable and setting incentive systems. The LHINs should have clear powers to deal with all aspects of the health system's performance in their area, including primary care (physicians), acute care (hospitals), community care and long-term care. This would include setting budgets and/or compensation for all players." (Recommendation 5-27)

Toronto LHIN:

- "Attention could be paid to the confusion caused by the five LHINs in the Greater Toronto Area; the boundaries of some cut across those of the municipalities they must deal with, especially on matters of public health." (Recommendation 5-11)

Consolidation of Agencies and Boards:

- "Consolidation of health service agencies and/or their boards should occur where appropriate, while establishing any new consolidated agencies as separate legal entities to limit major labour harmonization and adjustment costs." (Recommendation 5-13)

- "Establish a Commission to guide the health reforms … There is a precedent for this approach; the Health Services Restructuring Commission was given power from 1996 to 2000 to expedite hospital restructuring …" (Recommendation 5-104)

Integration of Public Health

- "Integrate the public health system into the other parts of the health system (i.e., Local Health Integration Networks). Much public health work is done outside the primary health care sector, for example, in matters of settlement and housing. The potential impacts of budget integration should be taken into consideration as the funding sources for public health are strongly linked to municipal budgets." (Recommendation 5-78)

Public Health Funding

- "Review the current funding model that requires a 25 per cent match from municipalities for public health spending. Many municipalities are now considering reducing their funding, which puts public health units at risk of losing provincial support as a result of the municipal cuts." (Recommendation 5-79)

- "Consider fully uploading public health to the provincial level to ensure better integration with the health care system and avoid existing funding pressures." (Recommendation 5-80)

Public Health Service Coordination

- "Improve co-ordination across the public health system, not only among public units, but also among hospitals, community care providers and primary care physicians. With the advent of LHINs, hospitals refocused on acute care and core services, but as an unintended result, they began pulling back on public health functions such as diabetes counselling." (Recommendation 5-81)

Chronic Disease Prevention

- "Replicate British Columbia's Act Now initiative, which has been identified by the World Health Organization (WHO) as a best practice for health promotion and chronic disease prevention, in Ontario. There appears to be some correlation between health outcomes and the amount provinces spend on public health … This apparent correlation between public health spending and health outcomes needs to be further explored through research to determine the benefit-cost ratios." (Recommendation 5-82)

- "Do more to promote population health and healthy lifestyles and to reverse the trend of childhood obesity, especially through schools. In addition, the government should explore regulatory options for the food industry. This would require the integration of health promotion activities with municipalities and school boards, among others. It will be important to take a whole of government

approach to population health and include population health in planning considerations." (Recommendation 5-84)

- "Work with the federal government on nutrition information and, where appropriate, regulation … Ontario should act alone in areas such as restricting the amount of trans fat and sodium permissible in restaurant and manufactured foods, and establishing a provincial chronic disease prevention strategy, including nutrition, tobacco, alcohol and physical activity measures." (Recommendation 5-85)

COMMENTS

The public health system in Ontario was extensively reviewed and recommendations were made in numerous reports in the aftermath of the 2003 SARS outbreak. Comprehensive and detailed studies of the system included the three SARS Commission Reports produced by the late Justice Archibald Campbell, the interim and final reports of the Expert Panel on SARS and Infectious Disease Control, chaired by Dr. David Walker and Expert Panel report at the Federal level chaired by Dr. David Naylor.

All of these prior reports concluded that major strengthening was required in the Ontario public health system, in terms of funding levels, independence, organization and structure. None of these reports advocated an integrated regional model of public health service delivery along the lines of the Commission report.

In response to the post-SARS reports the Ontario government in 2004 launched a major series of reforms to public health. Grouped under a framework entitled Operation Health Protection, significant legislative changes were undertaken, new public health program standards put in place, a new provincial public health agency was created, and a significant change was made in the funding formula for public health from 50% to 75% Provincially funded.

The Commission on the Reform of Ontario's Public Services, in crafting the recommendations pertaining to the "integration of public health into the broader health system" appears not to have taken into consideration the findings of these extensive and detailed independent reviews, or indeed government policy initiatives in public health over the past decade.

Public Health and LHINs

Very limited data currently exists to adequately determine the superiority of one form of organization of public health governance over another; not only is the form of organization hard to objectively evaluate, the programs and services provided by each province and territory vary based both upon population need and organizational history.

In the integrated regional delivery systems in place in other jurisdictions, such as the regional health authorities in British Columbia; a case can be made that coordination and linkages between public health and other health care services is potentially enhanced by

having the public health governance, management leadership and staffing for a region integrated into the regional health care management structure.

However, only a relatively small portion of the full range of public health services benefit from closer integration with hospital and other treatment services. These include some aspects of communicable disease control and early childhood interventions. An effective working partnership with other major sectors, such as education, municipal services and social services is arguably equally if not more important for the effective delivery of a wide range public health interventions and the achievement of public health objectives.

A commonly noted concern regarding the integration of public health into a regional health authority is the loss of proximity and engagement with municipally based services such as school boards, economic and social services, housing, parks and recreation, and urban planning. Missing in the analysis undertaken in the Commission report is how these important relationships could be retained in an integrated regional health model.

It is also important to note that Toronto Public Health already has numerous collaboration and service initiatives underway with the broader health care sector including community health centres, hospitals, long-term care and family health teams, the vast majority of which existed prior to the creation of LHINs and have not been dependent upon LHINs for success.

The Ministry of Health and Long-Term Care sponsored Capacity Review Committee (CRC) established in early 2005, specifically included in its mandate a detailed examination of the optimal number and better geographic alignment of public health units with the emerging LHIN structures.

The final report of the CRC, issued by the Ministry of Health and Long-Term Care in May 2006 contained detailed recommendations for the amalgamation of a number of the smaller public health units in the province which would allow for critical mass of public health capacity across Ontario and improved geographic alignment between LHINs. The CRC supported recommendations would also have strengthened the public health system as a whole by addressing ongoing concerns regarding a lack of capacity at smaller health units - while retaining the critical non health care related linkages (municipal structures, school boards etc.) that constitute the majority of public health linkages.

Toronto Public Health has experienced the impact of the multi-year City of Toronto amalgamation process and is uniquely aware of the major direct and opportunity costs, service disruption and destabilization that arises with major organizational and structural change. Given the risks inherent in this form of major structural reorganization in an area such as public health, it is critically important that a clear and convincing case be made, with appropriate evaluative criteria, that the reorganization itself would benefit the programs and services provided to the population of Toronto.

The proposals contained in the Commission report do not build on the extensive and detailed body of previously commissioned provincial work on public health in Ontario, and critically, do not provide a sufficiently detailed analysis to make clear how

integrating public health into the LHINs would actually improve public health services and outcomes in Toronto or the province as a whole.

Public Health Funding in the Regional Model

The Commission proposal for 100% provincial funding of public health through the LHIN system is couched as a way of protecting public health funding at a time when municipal budget reductions are impacting the ability of public health to access provincial funding, due to the current cost sharing arrangement being dependent upon the municipally approved contribution.

The concern about the impact of municipal budget constraint on provincial funding and public health service levels is relevant. The Board of Health has repeatedly identified the considerable provincial revenues foregone in recent years as a result of budgetary constraints imposed at the municipal level.

However, 100% provincial funding also carries with it associated risks.

In the current Provincial economic climate, it is unclear whether 100% provincial funding would deliver more predictable and sustainable funding for public health services than the current cost-sharing arrangement. As the Board of Health has repeatedly pointed out to the provincial government, several large 100% provincially funded public health programs have had funding frozen at levels insufficient to meet mandated service levels and community needs.

A second important concern is that, without appropriate protection of the public health budget within a regional structure, there is a considerable risk that the more visible and apparently urgent public cost-pressures of the Acute Care and Primary Care sectors may over time erode the funding and resources available to public health to focus on longer term prevention and health promotion. There is some evidence of this trend in other Canadian jurisdictions where public health is part of a regional system. As the Commission report accurately notes, in times of fiscal constraint, certain hospitals in the system have already constrained areas of more preventive care such as diabetes counselling.

Finally, there is the issue of "pay for say". Removing municipal funding for public health carries the risk of severing the municipality from active engagement and influence of public health services and initiative which help make them more relevant to local community needs and priorities.

Chronic Disease Prevention

The recommendation made by the commission regarding the importance of increasing expenditures in chronic disease prevention and for the Province to develop a chronic disease prevention strategy are broadly consistent with positions previously taken by the Board of Health.

The recommendations made by the commission regarding the need for federal regulation of trans fat and sodium in manufactured foods are also consistent with positions

previously taken by the Board. From the perspective of many food processors, the natural preference would be that any regulation in these areas be undertaken nationally, for reasons of a national market. However, given the burden of risk posed, particularly by elevated sodium levels, there is merit in the Province taking action in the absence of federal movement.

CONCLUSION

The public health system in Ontario has benefited from at least four major reviews in the past decade. These reviews, commissioned by the Province of Ontario and the federal government, have provided comprehensive and detailed analysis of the public health system and approaches to strengthening and enhancing the functioning of the system. Each of these reviews has been led by external experts in their field and has built upon extensive consultation, research and literature reviews. The provincial government has made significant progress in acting upon these recommendations to strengthen public health.

The mandate of the Commission on the Reform of Ontario's Public Services was exceedingly broad in terms of the areas of provincial expenditures to be examined, and the timeframe was short. Given these challenges it is not surprising that some recommendations are insufficiently developed and fail to sufficiently recognize an extensive body of prior work.

If the provincial government should decide to pursue any of the Commission recommendations concerning the structure and function of Ontario's public health system, it should conduct a comprehensive review of the implications of the recommendations in light of the previous extensive work described in this report. The province should also ensure that all major public health system stakeholders are effectively consulted prior to any decisions being considered.

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