TORONTO

Dr. Eileen de Villa
Incoming Medical Officer of Health

Public Health
277 Victoria Street
5th Floor
Toronto, Ontario M5B 1W2

Tel: 416-338-7820
Fax: 416-392-0713
Eileen.deVilla@toronto.ca
toronto.ca/health

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Ms. Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care
777 Bay St, 19th Floor, Suite 1903
Toronto, Ontario M7A1S5

Dear Ms. Martino:

Re: Standards for Public Health and Program Services Consultation Document

Toronto Public Health welcomes the opportunity to review and provide comments on the Standards for Public Health Programs and Services (SPHPS) released on February 17, 2017. We believe the strengths of the SPHPS include:

- Allowing boards of health to tailor programs to best meet the needs of their local community, thereby, building in flexibility for local health units;
- The explicit focus on health equity as a foundational standard, and mandating local health units to work with Indigenous populations;
- Explicitly stating the importance of multi-sectoral partnerships, including with education, transportation, housing, and labour, to address the social determinants of health; and
- Providing a stronger mandate for boards of health to address important public health issues, including mental health, natural and built environments and climate change.

We have also identified potential implementation challenges, as well as areas requiring clarification to ensure consistency in implementation. We suggest:

- Guidance on minimum requirements and accepted programs and services to be delivered locally is needed to maintain public health, ensure municipal funding within the current climate of fiscal constraint, and safeguard future provincial funding;
- Explicit and consistent use of the term "healthy public policy" and embedding healthy public policy in all standard requirements to provide a clearer mandate to address the social determinants of health through multi-sectoral partnerships;
- Clarifying the intent of the SPHPS by including definitions of key terms throughout the Standards or including a glossary; and
- Ensuring consistency in requirements across different program standards. For example, requirements related to health equity, priority populations, and healthy public policy should be identified in the requirements of each standard, rather than just some of them.

We understand that some of the requirements that were in the previous Standards will be moved to protocols and guidelines, and thus, our current review is limited because we could not simultaneously review accountability agreements, protocols, and guidelines. We would also appreciate the opportunity to provide input into these documents as they are developed.

Finally, the SPHPS outlines board of health requirements within the unfolding process of health system transformation. Most pertinent to our success in implementing some requirements are our relationships with the five Local Health Integration Networks (LHINs) covering the City of Toronto. We look forward to working with the Ministry of Health and Long-Term Care (MOHLTC) and LHINs to develop and finalize these relationships such that our respective roles and responsibilities are clear and organized in a fashion that promotes both optimal population health status and health care provision for the residents of Toronto.

The attached comments provide further clarification on these points and concerns identified above. Should you require any further information, please contact Jann Houston, Director, Strategic Support at 416-338-2074 or jann.houston@toronto.ca.

Yours truly,

Eileen de Villa, MD, MBA, MHSc, CCFP, FRCPC
Incoming Medical Officer of Health

Attachment: Toronto Public Health Feedback on Standards for Public Health and Program Services

Toronto Public Health Feedback on Standards for Public Health and Program Services

Comments Related to Operational and Organizational Concerns:

Relationship with LHINS

The Standards for Public Health Programs and Services (SPHPS) outline board of health consultation and collaboration with Local Health Integration Networks (LHINs) in the Health Equity; Chronic Disease and Injury Prevention, Wellness and Substance Misuse; and Healthy Growth and Development standards. More information is needed about the expectations for that consultation and collaboration. This is beyond the clarity needed in the Population and Health Assessment standard identified by the current placeholder.

Toronto Public Health has previously identified the misalignment of LHIN and health unit boundaries as a barrier to greater integration.[1] As there are five Toronto-area LHINs, consideration needs to be given on how to efficiently consult and collaborate with these five LHINs.

Financial and Other Resources

The Population and Health Assessment standard expands public health's mandate to the provision of population health data and public health expertise to the health care sector to inform health care planning and delivery. Given these are requirements in addition to existing ones, we expect financial and human resources will be necessary to carry out these new functions.

Without reviewing the associated accountability agreements, protocols, and guidelines we are unable to comment on the financial and other resources needed to implement the requirements.

Multi-Sectoral Collaboration

To support requirements of board of health collaboration with other sectors (i.e. with the Ministry of the Environment and Climate Change, Ministry of Municipal Affairs, Ministry of Education), Ministerial direction to those other sectors to collaborate with public health is essential.

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[1] Toronto Public Health. Healthy People First: Opportunities and Risks in Health System Transformation in Ontario. Toronto, ON: Toronto Public Health; 2016. Available at http://www.toronto.ca/legdocs/mmis/2016/hl/bgrd/backgroundfile-88525.pdf.

Comments Related to Clarity and Context:

Organization of the Standards and Topics within the Standards

Some foundational standards are reiterated in some program standards, but this reiteration is not done consistently throughout the program standards. As some program standards are task oriented (i.e. Immunization), some setting specific (i.e. School Health), and others related to life stage (i.e. Healthy Growth and Development), how topics have been organized is not always clear.

Some topics are duplicated across relevant program standards, but other topics are not, even though they are relevant to multiple standards. There is the need for considerable cross-referencing between standards. This creates confusion as sometimes the same topic seems to have different requirements under different standards. The following comments identify some examples of where this occurs.

- Annual Service Plan and Budget Submission is mentioned in the Effective Public Health Practice standard and some program standards (Chronic Disease and Injury Prevention, Wellness and Substance Misuse; Healthy Growth and Development; School Health) but not others (Healthy Environments, Food Safety, Safe Water, Infectious and Communicable Diseases). If this requirement is to be repeated in some program standards, it should be repeated in all of them.
- While health equity is a foundational standard, health equity language appears in some program standards and not others. To be consistent, health equity language should be embedded throughout the program standards. This could be done by having consistent wording of reducing health inequities and addressing the needs of priority populations within all program standards, rather than just in some of them.
- The requirement to implement a program of public health intervention related to harm reduction and healthy sexuality seems more strongly worded in the Chronic Diseases and Injury Prevention, Wellness and Substance Misuse standard than in the Infectious and Communicable Diseases Prevention and Control standard. Clarity on the requirement and consistency between the standards is needed. In a time when we are facing an unprecedented public health crisis related to opioid overdose, the SPHPS should provide a clear requirement on harm reduction. A clear requirement on the provision of sexual health clinics is also needed.
- Oral health is included in the School Health standard and Chronic Disease and Injury Prevention, Wellness and Substance Misuse standard, but oral health should also be in the Healthy Growth and Development standard. Oral health is relevant to all preschool children and children and youth not in school. Early Childhood Tooth Decay is an aggressive form of tooth decay that can negatively affect growth and development and is prevalent in young children aged 0-6. Injury prevention, physical activity, nutrition, and sleep could also be included in the Healthy Growth and Development standard.

- To provide a mandate for boards of health to address emerging health issues, for example cannabis legalization and regulation, topic lists in all program standards should include "other measures as emerging health issues arise," as is found under the Healthy Environments standard.

Definitions of Health Equity, Social Determinants of Health and Priority Populations

We are pleased that health equity, the social determinants of health, and priority populations have been given important consideration in the SPHPS. More clarity and consistency could be given by providing definitions of these terms. Specifically:

- A definition of health equity should be provided and reference the Human Rights Code's exhaustive list of 17 prohibited grounds of discrimination, with "disability" referred to as dis/ability.
- A definition of the social determinants of health should be included. Moreover, inclusion of social determinants of health topics in the program standard requirements would provide a clearer and more explicit mandate for this work.
- We suggest a clearer definition of the term priority populations be provided. As written, priority populations is not tied to the social determinants of health.

Definition and Consistent Use of Healthy Public Policy

The SPHPS contains requirements that could be interpreted as healthy public policy; however, this work would be better supported by explicit use of the term healthy public policy in the requirements of each standard, as was the case in the board of health outcomes for each one of the 2008 program standards. Building healthy public policy has been identified as a health promotion strategy since adoption of the Ottawa Charter for Health Promotion in 1986. Further, healthy public policy approaches are distinguished from public health policy in key ways that make them essential to reducing health inequities and addressing the social determinants of health.

In order for public health units to build or enhance capacity in policy development as a function and to effectively operationalize healthy public policy approaches, we suggest that that the MOHLTC build on existing resources on best practices for planning, developing, implementing and evaluating healthy public policy, specifically to address the social determinants of health.

Definition and Consistent Use of Public Health Intervention

A definition and scope of the term public health interventions is needed to guide public health work and also to communicate the requirements of this work to municipal government and other stakeholders. The requirement to implement public health interventions is in some standards (Chronic Disease and Injury Prevention, Wellness and Substance Misuse; Healthy Growth and Development; School Health) but not others

(Healthy Environments, Food Safety, Safe Water). In these latter standards, requirements that are interventions should be described as public health interventions to create consistent language throughout the SPHPS, e.g. develop strategies to promote healthy environments; review drinking water quality reports; increase public awareness of food-borne illness; etc.

Definition of Health Promotion

More language is needed to specify the scope of comprehensive health promotion strategies, e.g. capacity building, supportive environments, policy development, skill development, etc., as was provided in the previous Standards.

Comments Related to Foundational Standards:

Population Health Assessment

The population health assessment and surveillance requirements speak to the role of local-level assessment and surveillance, but more coordinated and consistent provincial assessment and surveillance is needed, as was recently stated in the *Children Count*[2] report. The risk is potential gaps in surveillance data and lack of comparable health status information.

The Population Health Assessment standard lists what boards of health are required to assess, including health status, health behaviours, and preventive health practices. It is important to add a requirement to assess risk and protective factors, as these have a significant influence on population health, e.g. proximity to traffic-related air pollution.

Health Equity

As written, the standard leaves room for interpretation.

Use of a health equity lens, such as the MOHLTC's Heath Equity Impact Assessment (HEIA), should also be considered for inclusion in all program standards. If this wording cannot be added, a guidance document on best practices for applying a health equity lens should be developed. The recent Locally Developed Collaborative Project (LDCP) Health Equity Indicators[3] project and the Public Health Ontario Priority Populations[4] report would provide a useful baseline from which to frame the document.

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[2]Population Health Assessment LDCP Team. Children Count: Assessing Child and Youth Surveillance Gaps for Ontario Public Health Units. Windsor, ON: Windsor-Essex County Health Unit; 2017.
[3] Health Equity LDCP Team. Health Equity Indicators for Ontario Local Public Health Agencies: User Guide. 2016.
[4] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Tyler I, Hassen N. Priority Populations Project: Understanding and Identifying Priority Populations for Public Health in Ontario. Toronto, ON: Queen's Printer for Ontario; 2015.

We would suggest that mandatory cultural safety or access and equity training of public health staff be a requirement of boards of health. Such training should be based on identified priority populations that includes at minimum working with Indigenous populations, and dis/ability and ableism. We would suggest that such training incorporate the legacy of colonization and residential schools as outlined by the Truth and Reconciliation Calls to Action.

The SPHPS references a guidance document on how boards of health will work with Indigenous communities. Such a guidance document should include how to work with urban Indigenous communities as well as those living in First Nations communities.

Emergency Preparedness, Response, and Recovery

Emergency management includes five pillars – prevention, mitigation, preparedness, response and recovery – however, this standard is currently missing the first two pillars. Public health units should be developing healthy public policy and developing community partnerships that support mitigation and preparedness, such as building resiliency within city governments and in the community related to extreme weather with a focus on vulnerable populations. This work needs to be explicitly included in the standard.

Boards of health are also required to have continuity plans which can be activated for business disruptions that are not necessarily events that would be classified as an emergency. Business continuity is a current industry recognized term instead of continuity of operations, which was more common formerly.

Comments Related to Program Standards:

Chronic Disease and Injury Prevention, Wellness and Substance Misuse

In an effort to allow for flexibility, there is a lack of a minimum standard. A minimum standard for public health is needed.

There is too much emphasis in the program standards on awareness and knowledge instead of skill development, which is necessary to develop healthy behaviours, environmental support, capacity building, etc.

The exclusion of the Nutritious Food Basket removes a key proxy measure of the social determinants of health and living affordability in geographic areas. An alternative way of measuring food security, quality of life, and affordability in geographic neighbourhoods should be developed and implemented across the province to replace the Nutritious Food Basket.

Healthy Growth and Development

The Population Health Approach encompasses populations from preconception to death; however, the SPHPS do not mention seniors or aging. This group should be included because they are a large demographic who are accessing the health system and public health is now supposed to play a role in health system planning. The standard could be renamed Healthy Growth, Development and Aging to reflect the life cycle approach.

Immunization

There is need for clarification about expectations related to children in schools, school-aged children, working with schools, and the rationale for including immunization in the School Health standard, as this topic crosses both the Immunization and School Health standards.

Infectious and Communicable Diseases Prevention and Control

In requirement number eight, specific reference is made to the Tuberculosis Prevention and Control Protocol, 2008 (or as current) but only for public health management of cases, contacts and outbreak. There is no mention in the requirements about LTBI or TB Medical Surveillance. While both these are addressed in the TB protocol, we strongly recommend that the requirements specifically include these areas to ensure that they are not completely discretionary.

There is also need for clarification for the TB component of the program outcome "there is reduced transmission of infections and communicable diseases including reduced progression of tuberculosis (TB)". Does this mean "reduce the progression from LTBI to active TB disease", "reduce the development of acquired drug-resistance among active TB cases", or "reduce long term disability from extensive TB disease for individual patients (through earlier diagnoses)"? We would recommend clarifying, and stating these outcomes explicitly – the first 2 definitions are probably the most important for public health.

School Health

Vision screening is included but there is conflicting evidence about the effectiveness of this type of program, and it is difficult to gain buy-in when evidence is weak. We need more specifics about what interventions are expected and a protocol will be required before being able to assess the implications for the health unit. We would recommend it be integrated into the other public health screening programs in consultation with MCYS and a similar model be applied.

Comments Related to Implementation Supports:

The SPHPS are considerably different from the Ontario Public Health Standards, 2008. A supplementary document that explains the rationale for and evidence supporting the changes would support the change management required and assist in implementation.

Additional resources will be required to implement the new assessment requirements, as well as other requirements in the SPHPS, however, the operational impact of the SPHPS is difficult to assess without the detail to be provided in the protocols. For example, without knowing the targets for coverage rates, including for vulnerable and underserved populations, we cannot comment on organizational impact.

Local health units will have to undergo significant changes to meet the requirements of the SPHPS. Funding for organizational change management, and for staff training and development will be needed to implement the new standards.