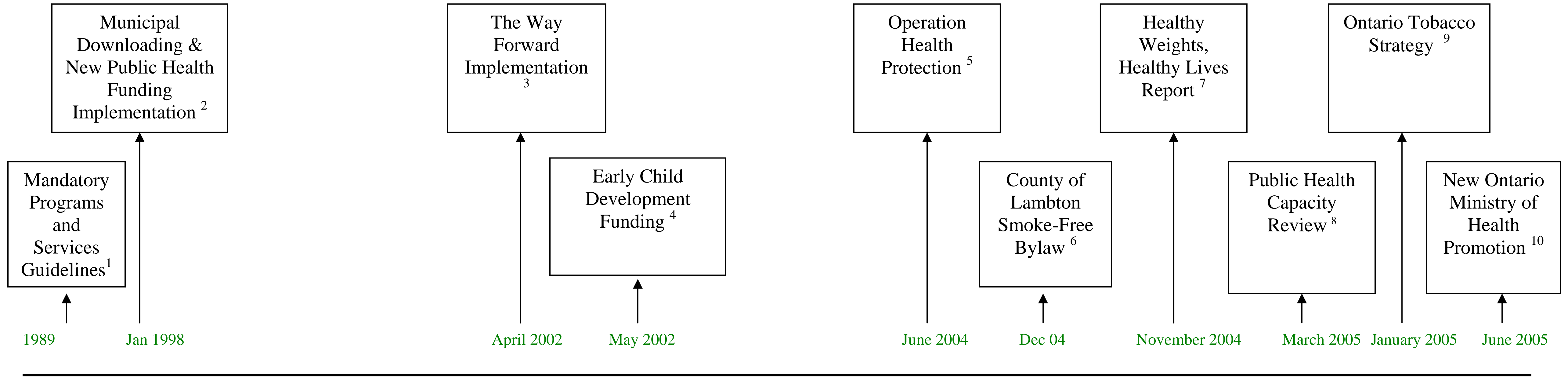
SOCIAL & HEALTH SERVICES DIVISION
COMMUNITY HEALTH SERVICES DEPARTMENT
HEALTH PROMOTION & PROGRAM SUPPORT

HISTORICAL IMPACTS TIMELINE



HISTORICAL IMPACTS BACKGROUND

Mandatory Health Programs and Services Guidelines (MHPSG) [1]

- In 1989, the Minister of Health published standards for fundamental programs and services targeted at prevention of disease, health promotion and health protection. The guidelines required all boards of health to provide as a minimum, various programs and services to address aspirations for health of all Ontarians.
- Boards of health plan for and deliver a variety of health programs and services pertinent to local circumstances and needs. However, only the minimum standards for public health programs and services that all boards of health must meet are included in this document.
- The MHPSG were revised in December 1997 for the main purposes of updating outdated protocols, objectives and outcomes referenced in the document. It is well recognized that there is a clear need for these standards and evaluation tools to be reviewed and modernized. Recent announcements from the Public Health Division suggest that this critical review is scheduled to be undertaken in 2005/2006.

Municipal Downloading & New Public Health Funding Implementation [2]

- In 1998, through Local Services Realignment, the province announced that funding and responsibility for the delivery of mandatory public health programs and services was transferred to municipalities. In 1999 the implementation took place and the responsibility for funding public health programs became a municipal responsibility.
- Prior to municipal downloading, the provincial share of public health funding was 75% for most health units. In addition, the province paid 100% of selected programs including tobacco control and sexual health. In 2000, the Ministry of Health and Long-Term Care (MOHLTC) committed to funding 50% of each local health unit's costs, up to a maximum of 50% of the health unit's locally approved budget for providing the mandatory programs and services detailed in the Ministry's guidelines.
- A recent analysis performed by the Ministry identified that significant variations in per capita funding for the mandatory programs still exist among local health units. While the 2002 average per capita rate for the province was approximately $37, the rate ranged from approximately $23 to $64 among local health units.
- Funding for public health programs continues to be a shared provincial-municipal responsibility. Currently funding is cost shared with the province paying 65%. Provincial funding levels will increase to 75% by 2007. The past ten years have been challenging ones for Ontario's municipalities as they have absorbed many new service responsibilities and financial obligations. There is ongoing work by the MOHLTC to examine if the current and projected funding model will sustain the efficacy of Ontario's public health infrastructure in the future.

Way Forward Implementation – April 1, 2002 [3]

- Way Forward Report released fall 2001; implementation January 2002.
- Restructuring of the Community Health Services Department saw the management team reduced by 2 positions. Five (5) management positions (Child Health, Family Health, Preventative Services, Environmental Health, and Business Administration) were reduced to three - Environmental Health and Prevention Services; Health Promotion and Program Support; and Children's Services. Business functions including Human Resources, Information Technology and Finance were transitioned to Corporate Services Division.
- On March 1, 2002, the Lambton Health Unit was renamed the Community Health Services Department.

Early Child Development Funding – May 2002 [4]

- In May 2002, 100% funding was made available to health units from the Ministry of Children and Youth to support initiatives aimed at enhancing early child development by targeting three areas of need: Healthy Pregnancy and Child Development; Injury Prevention for children aged 0-6; and Family Abuse Prevention.

Operation Health Protection – June 22, 2004 [5]

- **Operation Health Protection** is a 3-year Action Plan to revitalize the public health system by preventing threats to public health and promoting a healthy Ontario. The plan was announced by the Ontario Ministry of Health and Long-Term Care on June 24, 2004.
- The Plan sets out specific actions over three years. Acting on the directions in the reports on the SARS crisis by the National Advisory Committee on SARS and Public Health, the Expert Panel on SARS and Infectious Disease Control, and the Interim Report of Mr. Justice Archie Campbell, *Operation Health Protection* calls on the Ministry, the Chief Medical Officer of Health, municipalities, health providers and Public Health Units to work together to rebuild Ontario's public health system.
- The 3 key goals of Operation Health Protection are: Rebuilding Public Health Capacity; Enhancing Public Health leadership and accountability; Improving system collaboration and partnerships.
- In order to increase local capacity for public health, Operation Health Protection began phased in changes to the municipal/provincial cost-share funding formula.
    - Funding shifted to **45% provincial** / **35% municipal** effective **January 2005**.
    - Funding shifted to **65% provincial** / **35% municipal** effective **January 2006**.
    - Funding will shift to **75% provincial** / **25% municipal** in **January 2007**.

County of Lambton Smoke Free Public Places and Workplaces Bylaw – Sept. 4, 2004 [6]

- On September 4, 2004, the County of Lambton Smoke Free Public Places and Workplaces By-Law came into effect. The By-Law was the result of an extensive public consultation process, and the public demand for smoke-free public places.
- The By-Law served to replace the inconsistent bylaws in place in the individual municipalities, and brought Lambton County in-line with neighbouring municipalities Chatham-Kent, Huron, and London-Middlesex.
- 1.5 By-Law Enforcement Officers were hired to enforce the bylaw. An additional 100% provincially-funded 1.0 FTE was hired for the initial six months of the By-Law to improve compliance.
- The By-Law significantly reduced exposure of the public and workers to the harmful effects of second-hand smoke.

Healthy Weights, Healthy Lives – Report of Ontario's Chief Medical Officer of Health [7]

- This November 2004 report, reminded Ontarians that chronic diseases such as diabetes, cardiovascular disease, and cancer are the leading cause of illness and premature death in Ontario. The report highlighted the escalating rate of child obesity and overweight and called for action from all levels of government to stem the rising tide of overweight and obesity.

Public Health Capacity Review [8]

- One of the key activities under Operation Health Protection is the *Public Health Capacity Review*. The goal of this review is to assess the capacity of local health departments to deliver public health programs. The Capacity Review Committee advises the Chief Medical Officer of Health and, through her, MOHLTC on options to improve the function and configuration of the local Public Health Unit system.
- The advice to be provided encompasses the following : core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer); issues related to recruitment, retention education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);

    - identifying operational, governance and systemic issues that may impede the delivery of public health programs and services;
    - mechanisms to improve systems and programmatic and financial accountability;
    - strengthening compliance with the Health Protection and Promotion Act, associated Regulations and the Mandatory Health Programs and Services Guidelines; and

- organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and staffing requirements and potential operating and transitional costs.

- The review process included extensive surveys of staff, public health units, boards of health, as well as site visits to each health unit/department. The Capacity Review Committee released its Interim Report in November of 2005 and is expected to deliver its final report in February of 2006. Implementation of the final report recommendations is expected to take place in 2007.

Ontario Tobacco Strategy - January 2005 [9]

- The new tobacco control legislation, to be called the Smoke-Free Ontario Act, received third and final reading on June 8, 2005. The act will prohibit smoking in all enclosed workplaces and enclosed public places in Ontario as of May 31, 2006. The legislation will also strengthen measures to ensure only those 19 years of age and older can buy cigarettes and will phase out the display of tobacco products, with a complete ban beginning May 31, 2008.
- In June 2005, the Community Health Services Department received 100% provincial funding for staff and resources to provide a comprehensive approach to tobacco control and prevention, including ongoing enforcement of the county of Lambton By-law as well as enforcement of the provincial Smoke Free Ontario Act.

Ministry of Health Promotion - June 2005 [10]

- On June 29. 2005, **Jim Watson** became **Minister of Health Promotion**, marking the first time Ontario has dedicated a portfolio to promoting healthy living and illness prevention.
- The new Ministry will have responsibility for delivery of health promotion programs including Smoke Free Ontario, healthy living and chronic disease prevention, injury prevention, and substance abuse and addictions.

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EXECUTIVE SUMMARY

Since responsibility for public health program delivery devolved to the County of Lambton in 1998, there have been a number of events and initiatives that have had an impact on public health program delivery. Additional details regarding each event may be found in the footnotes contained in the accompanying *Historical Impacts/ Timelines and Background* document.

Mandatory Program Indicator Questionnaires

In 1997, the Ministry of Health & Long-Term Care (MOHLTC) revised the Mandatory Health Programs and Services Guidelines that describe in detail the minimum expected requirements and standards for 17 programs that Boards of Health are expected to deliver (Health Promotion and Protection Act (HPPA, RSO, 1997)). The Health Promotion and Program Support team is responsible for the following Mandatory Programs: Equal Access; Planning and Evaluation; Chronic Disease Prevention; Injury Prevention including Substance Abuse Prevention and Reproductive Health.

Compliance with these programs has been audited annually from 1998 through 2002 through the Mandatory Program Indicator Questionnaire. This questionnaire collects data from each health department and produces a report, as well as a provincial summary. MOHLTC has discontinued its use due to its questionable value. Cost-shared funding is allocated based on staffing and infrastructure demands to meet these mandatory programs (see program Based Funding Model).

Review of Staffing Levels

Staffing levels are reviewed annually through the budget process. All new positions, including those funded through 100% provincial grants, are approved by Committee and Council. Positions are reviewed and ranked by Human Resources Department staff to ensure that all positions are rated consistently across the Corporation, and compensated appropriately.

Alternative Service Delivery

Alternative service delivery methods have been implemented in several programs. Examples include: 1. the component for car seat safety which trains caregivers and volunteers from the police and fire departments to inspect and adjust child car seat safety. Training others builds capacity in the community and allows us to staff the program appropriately. 2. As a result of the 2005 Core Services review, the fee for prenatal classes was raised in order to cover the costs of delivering the classes. Other delivery methods for these classes have been investigated, including weekend sessions and online class materials. 3. In the nutrition area, the training of “peer nutrition workers” was introduced in 2001 as a means of passing on skills in meal preparation and healthy eating. This program delivery method was introduced as a way of meeting mandatory program minimum standards without increasing staff. Sharing knowledge in this way - training community people to train others - is a more sustainable practice.

Benchmarking and Performance Measures

Measuring program effectiveness is a key component of health promotion program planning. Benchmarking initiatives have been conducted for specific Mandatory Programs by four regional Public Health Research and Development (PHRED) centres. The PHREDs have established benchmarking reports for the following programs: Food Premises Inspection, Immunization Record Process, STI Contact Tracing, Breastfeeding Support, Heart Health Coalition and Dental Screening.

The use of benchmarking data by an Epidemiologist to evaluate programs against provincial levels and local needs is a standard practice within public health. The results of evaluations are used to assess program effectiveness and adjust goals and objectives.

Evidence-Based Practice

Evidence based practice, which can be defined as basing program decisions and delivery methods on established needs (data) and scientific knowledge of effectiveness (best practice), is a fundamental value of public health program design and evaluation. A wealth of data is available to Ontario public health departments/units from various sources including hospital records, the Canadian Community Health Survey, census data, and the Rapid Risk Factor Surveillance System. This information allows qualified staff, including the Medical Officer of Health, Managers, Epidemiologist and Health Promotion Specialist to design and deliver programs where they are greatest in need and can be effectively measured.

Program Based Funding Model

Introduced as an accountability and performance measurement system and implemented in 2004, the Program Based Budgeting funding model is a process that allocates every cost-shared dollar of provincial/municipal funding to one of the 17 Mandatory programs. The allocations may be used by the Ministry to assess equitability across the province as well as performance according to the Mandatory Program Indicator Questionnaire.

Public Health Capacity Review

As described in the Historical Impacts document, the Public Health Capacity Review[8] is expected to recommend fundamental changes to the way public health programs are governed, delivered, managed, and funded. The 2005 Annual Chief Medical Officer of Health Report, *Building the Foundation of a Strong Public Health System for Ontarians*, Dr. Sheela Basrur has identified as an area of concern the need to ensure that “every local public health unit has a critical mass of expertise and resources to fulfill core public health functions including the ability to respond to public health emergencies.” This subject will be the focus of a February 2006 Committee report.