# 10. The Public Health Ping-Pong Game

Public health in Ontario including protection against infectious disease is delivered primarily through 37 local Boards of Health, which are largely controlled by municipal governments. Public health funding has gone back and forth like a ping-pong ball between the province and the municipalities.

Before 1997, the province funded 75 per cent of public health expenditure and the municipalities funded 25 per cent everywhere except in the Greater Toronto Area where the province funded 40 per cent and the six separate boroughs funded 60 per cent.

Some public health programmes, however, were funded 100 per cent by the province. One local Medical Officer of Health put it this way:

> They [the province] always make exceptions when they feel like it so there were some stated provincial priorities that they paid 100 per cent for and they started with sexual health clinics back in the 1980's and then added tobacco prevention and control and then added teaching health units . . . healthy babies, healthy children is one of the most recent . . . They pick and choose what they want to pay for . . .

In 1997, Ontario introduced legislation to download all public health and many social services to the municipalities with the tradeoff that the province would assume full responsibility for education. Although public health financing was to be downloaded, the province was to maintain authority to set provincial standards. Although the province provided no funds for public health, it sought to retain control in the form of mandatory programme and service guidelines promulgated in 1997. This was dubbed the "all say, no pay" regime. It came into force in January 1998.

The rationale for downloading had nothing to do with the best way to run public health. As Mr. Tom Closson, President and Chief Executive Officer of the University Health Network in Toronto, noted at the Commission's public hearings:

> I think it's a big weakness in the Ontario healthcare system that Public Health is under the municipalities. As you might know, Public Health

> was put under municipalities as a tax issue, because taxation for education was moved out of the municipalities and into the province was a tax balancing effort. It had nothing to do with what would be the best way to run a healthcare system.
>
> Again, if you look at other provinces, you'll see that Public Health is part of the Regional Health Organizations and hospitals, community health, public health, are all under a single governance structure.[145]

Public health, a much smaller budget item than social assistance or public housing, did not bulk large in the controversies and the provincial-municipal negotiations that preceded the downloading. Despite the efforts of the public health community which included the Public Health Branch in the Ministry of Health, the Ontario Public Health Association, the local Medical Officers of Health and local health boards to whom they reported, public health remained relatively invisible and efforts to maintain a stronger provincial role were unsuccessful.[146]

The total downloading of public health funding to the municipalities lasted about a year. Since March of 1999 the provincial share has increased and the province and the municipalities now share public health funding 50-50: As one Medical Officer of Health noted:

> . . . typically the chronology is that the municipality approves our budget on the Board's advice or not and then that goes to the Ministry and they will cover 50 per cent of the eligible costs. Up until now they have not done it on a line-by-line basis; it has been a block grant.

Although the general funding rule is 50-50, some programmes like the Healthy Babies, Healthy Children Program are funded 100 per cent by the province. This means that the global provincial contribution in any particular health unit will likely be more than 50 per cent. To take one example, the 2001 Annual Report of the Muskoka-Parry Sound Health Unit recorded the following revenue breakdown:

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145. *SARS Commission Public Hearings*, October 1, 2003, p. 188.

146. For a helpful review see the following unpublished paper by a group of scholars at the University of Toronto: Kristina A. Millan, Howard Shapiro, Raisa B. Deber , *Who Did What to Public Health in Ontario: A Clash of Policy Communities.* (Subsequent footnotes will refer to this report as the Deber Report.)

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|---|---|
| Municipal Levy | 33.9 per cent |
| Provincial Public Health Programmes | 41.8 per cent |
| Provincial 100 per cent funded programmes | 24.3 per cent |

One difficulty with 100-per-cent provincial funding of specially picked programmes is the municipal fear that the province will start a programme at 100 per cent then withdraw the full funding, leaving the municipality holding the bag. A similar observation was made in the context of recent Toronto Public Health budget discussions:

> Past health board Chair Joe Mihevc (Ward 21, St. Paul's) said the province has a pattern of funding programs at 100 per cent initially and then requiring the city to pay 50 per cent once they're up and running.
>
> The liaison unit and West Nile virus are two prime examples.
>
> "They (province) can't seduce us into a program and then leave us holding the bag after they've paid the initial 100 per cent," Mihevc said.[147]

Another difficulty with the current structure of municipal funding, even though it attracts a matching provincial grant, is that there is not enough money to pay for basic programmes like infectious disease and infection control. As one local Medical Officer of Health pointed out:

> . . . if you look at control of infectious disease and infection control, which are the two programmes that apply here most specifically, the mandate is not strong enough and the resources are not sufficient . . .
>
> In hindsight, post SARS, the mandate in infection control is quite weak and even in its weakened form, we have not had the resources to implement it to a sufficient degree given the number of hospitals and doctors and number of germs and everything else.

Although the province now shares more than half the cost, it still lacks overall control over public health in Ontario. It is a basic fact of publicly funded programmes that he who pays the piper calls the tune. When the province funds public health directly, it

147. *Toronto Star*, "Filion Claims Cuts Will Hurt City's Health," March 10, 2004, p. B2.

controls the content and direction of public health. When public health is funded by the municipality, the province loses direct control and can only do its best to influence public health by indirect measures such as the mandatory guidelines published in December 1997.

So long as the municipalities fund public health to a significant degree, public health will have to compete with other municipal funding priorities. Communicable disease control is a basic public necessity that can affect the entire province if a disease gets ahead of the controls. Infectious disease control should not have to compete against potholes for scarce tax dollars. As one group of scholars noted:

> At the local level, public health is now in the position of having to constantly battle for funding, within a framework which makes it illegal for local governments to run a deficit . . . Such health protection services as food safety inspection are also vulnerable to political pressure: certainly, in the past, the provincial Medical Officer of Health has had to "back up" local health departments. Full municipal funding has also highlighted the fact that many public health units do not currently have enough resources to deliver even the existing mandatory programs, and some impetus for revising them downwards has lately begun. There is some concern that when difficult economic times recur, even communicable disease control may be seen as a lower priority – until the epidemics begin.[148]

The next section, "One Local Funding Problem" demonstrates in exquisite detail the problems that can arise through the present system of local funding of public health and the disinterest shown by some municipal politicians in the public interest in effective public health protection.

It is easy for the province to set minimum standards on paper, but difficult to enforce them on the ground when public health services are paid for and controlled by the municipality either completely or on the present 50-50 basis.

There are some institutional elements of provincial influence. The province must approve the initial appointment of the local Medical Officer of Health and the province appoints members to the local Board of Health, but never as many as the municipality. Although the Chief Medical Officer of Health for Ontario has some direct powers that can be exercised in an outbreak, if delegated to her by the Minister,

148. Deber Report, p. 13.

the limited degree of provincial funding and the indirect nature of provincial authority leads to less real day-to-day control and more reliance on time consuming and difficult processes of persuasion and informal mediation. These elements of provincial influence are indirect and give the province no daily operational or administrative control over the local Medical Officer of Health or the local health unit. As one local Medical Officer of Health put it:

> . . . the local Medical Officers of Health report to their local Board of Health which is the legal entity that makes sure that the mandate is delivered, the connection with the province being of pretty loose accountability for boards and Medical Officers of Health to make sure that the programs were delivered. That is about it; there is no administrative reporting requirement as employees or anything like that.

Although machinery does exist to impose provincial will on a local health unit, it is the machinery of last resort, akin to managing a local conflict through the threat of thermonuclear force. As the aforementioned group of scholars noted:

> New mandatory guidelines were released in December 1997; they provide the minimum standards and requirements for the provision of public health services. However, municipalities expect "pay for say" and are strongly opposed to rigid and prescriptive standards. Ultimately the Province has "absolute power when it chooses to utilize it," but will have to decide how much it is willing to antagonize municipal governments to enforce standards.[149]

As a practical matter, guidelines and standards have proved ineffective to ensure consistency of public health services throughout the province. Although the system may look good on paper, the Public Health Branch has conducted no regular assessments to ensure compliance. As noted above, the 2003 Provincial Auditor's report found that no checks had been done in five years to confirm compliance:

> . . . the Ministry had conducted virtually no regular assessments of local health units in the last five years to determine whether the health units were complying with the guidelines for mandatory programs and services. Such assessments were recommended in the *Report of the Walkerton*

149. Deber Report, p. 12.

> *Inquiry: The Events of May 2000 and Related Issues* (Part One of the Walkerton Report).[150]

While the Ministry of Health has begun some auditing of local health units, the historical lack of provincial enforcement of uniform standards leads some to suggest that the only answer is for the province to fund 100 per cent of public health programmes or at least 100 per cent of infectious disease programmes and to have a parallel uploading of provincial authority. This would thus ensure the imposition of uniform standards across the province under direct provincial control.

Others say that the need to upload funding and control to the province cannot be demonstrated at this time because the province does not at this time use its full powers to enforce the mandatory guidelines. Under this reasoning, the province should use all of its current powers before asking for more.

As noted below in the section "Central Control Over Health Protection," it is essential that the province assume greater accountability and authority over public health protection. The Interim Walker Report recommended that the province fund 75 per cent to 100 per cent of public health resources within two to five years. Views will differ as to the precise ratio and as to whether the funding for public health programmes other than infectious disease control should be uploaded to some extent.

There is a consensus that some provincial funding upload is required. One Medical Officer of Health said:

> . . . the 50-50 funding formula is killing us, and the Province needs to redress this issue ASAP. The province should pay at least 80 per cent. Furthermore, the Federal Government should contribute so we can maintain a surge capacity, especially if they expect us to do so much of the work in their pandemic plan. This could be part of the new deal for cities, because cities are where we are going to need the surge capacity.

Another Medical Officer of Health said:

> Overall, more funding is required within the Public Health system. I would suggest a decrease in municipal funding levels to 20 to 25 per cent.

150. Provincial Auditor of Ontario, *2003 Annual Report*, (Toronto; December 2, 2003), p. 219.

> This maintenance of some municipal input into funding would maintain interest and accountability.
>
> . . . 100 per cent provincial funding for some specific programs, for example, control of infectious diseases programs, seems appropriate.

Some regard a 75-per-cent provincial upload as a sensible compromise. To quote one Medical Officer of Health:

> The current public health funding has created a lot of dissatisfaction in spite of the fact that taking into consideration the Community Reinvestment Funds, the municipalities probably are accountable for 25 per cent and not 50 per cent of the funding. This however is not transparent and not well recognized. I think most people would be happy or could live with the pre-1998 formula of 75 per cent provincial and 25 per cent municipal. This is also a compromise between the current 50 per cent or the 100 per cent provincial funding advocated by certain people.

One Medical Officer of Health, asked whether the province should fund communicable disease protection 100 per cent, said:

> We are torn. The concern would be if infection control gets funded 100 per cent because it is somehow more important than a variety of other things that public health gets involved with. Others would argue and perhaps myself that there are going to be more people that are going to be adversely affected by our rising epidemic obesity and lack of physical activity and all of those things, and yet infection control and SARS have taken the spotlight, West Nile has taken the spotlight. Two men die of West Nile and all of a sudden you have a coroner's inquest. One hundred women die annually of cervical cancer in this province which is suppose to be a completely preventable cause of death and yet no one seems to want to do anything about them. So infection control, if it is funded 100 per cent because it is seen as being the most important thing that public health does, I think that the broader public health sector would have a problem with that because they do not necessarily see infection control as the most important thing that needs to be done for improvement of the public's health . . .
>
> It is ironic . . . as someone who has tried to get budgets approved at the local level, it is much easier to get local and municipal funding for a communicable disease program because it is concrete and people under-

> stand it. Voters may actually die within the current term of council as opposed to trying to get funding for something that is going to prevent mortality 20 years from now whether that is obesity or nutrition. In fact most Medical Officers of Health have found it easier to get local municipal funding for disease programs than other public health issues. So the ironic thing would be if communicable disease programmes were taken over and funded 100 per cent by the province . . .
>
> Reform has more to do with having a coherent system and the ability to dictate what the program and standards are across the province than adequacy of the funding . . . Especially when there is a demonstrated need, it is possible for local counsels to fund communicable disease control as much as anything else.

A similar view was expressed by another Medical Officer of Health:

> My council never said no to infectious disease programmes; tuberculosis, HIV would get attention, but the other stuff, health promotion, we would have more difficulty to get funding for that. It comes down to what scares people the most . . .
>
> Local Medical Officers of Health are leery of 100 per cent provincial funding. Although they complain about their local boards, the existence of the local board means the Medical Officer of Health is not entirely dependant on the province; they think it's better to stick with the devil they know.

There is no scientific way to determine the appropriate degree of provincial funding upload for infectious disease surveillance and control. Although a case can be made for 100-per-cent funding upload, the persuasive views of a number of local Medical Officers of Health suggest that it would be sensible to upload infectious disease control to a provincial contribution of at least 75 per cent.

Opinions will differ as to how the funding formula should be changed, and whether and how much co-coordinating or direct power over public health should be uploaded to the province. The one thing on which everyone will agree is that the shifting of funding and accountability back and forth between the province and the municipalities has impaired the stability of Ontario's public health system. It is time to stop the ping-pong game and to begin an era of stable public health funding relationships between the province and the municipalities.