15. Public Health Restructuring

Whenever a system proves wanting it is tempting to blame its problems on structure and to embark on a course of reorganization, or centralization, or regionalization, or decentralization. It must be remembered that organizational charts do not solve problems. The underlying problems of public health in Ontario have to do with a lack of resources, years of neglect, and lack of governmental priority. As noted above, these problems developed during the regimes of successive governments and no government or political party is immune from responsibility for the decline of public health protection. These problems will not be fixed by drawing boxes on paper around public health units and moving them into other boxes. The underlying problems will only be solved by a reversal of the neglect that has prevailed for so many years throughout the regime of so many different governments headed by all three political parties.

One Medical Officer of Health stressed the importance of fixing the problems of the system instead of simply reorganizing it:

> I think that if anyone is going to come in and think that they will suddenly make this a new system in Ontario and it is going to be functional, I would argue that it will not be. It will not be functional for a decade or more. It would take a great deal of time and effort to start doing those things at a local level and that time and effort would be far better spent in terms of not a reorganization or restructuring or complete revamping of public health in Ontario but focusing on whatever is a big problem, whether it be infectious disease in institutions or something else. Let us focus the effort on trying to fix whatever people think is wrong with that portion of that system rather than trying to restructure everything across the province.

That being said, some attention must be given to the best way to structure and organize the delivery of public health in Ontario. Arguments are made to reduce the number of public health units from 37, on the basis that the smaller units cannot afford the critical mass of expertise required to deliver effective local protection against infectious disease. Those who advocate the reduction in the number of health

units point to many difficulties including the inability or unwillingness of the present system to comply with the recommendations of the Walkerton Inquiry that each public health region be required to employ a full-time Medical Officer of Health. To date there are eight Medical Officer of Health positions that have not been filled on a permanent basis. This demonstrates the remarkable inability of the present regional system, in the aftermath of a public health tragedy, to meet minimum standards. This inability to attract and retain the professional leadership it needs to protect the public shows that something is seriously wrong with the present regional system of local public health units.

The interim Walker report recommended that the existing number of public health units should be reviewed and, within two years, reduced from 37 units to 20 to 25 units.

Some question whether it is necessary to reduce the number of local units instead of providing the necessary critical mass of expertise to serve a number of individual units, on the argument that the problem is not the number of local units, but the lack of support and resources made available to the local units.

Is the problem simply the sheer number of local boards, or is it the functional inability of a local board to attract the critical mass of expertise necessary to manage public health programmes? Although it may be intuitively appealing to say that 37 is just too many, is there a way to preserve the value of a widespread local presence reflected in the present number of boards? Could a regional or centrally supportive structure be devised to give them access to the necessary critical mass of expertise and to consolidate control spans during a time of public health emergency?

No one who spoke to the Commission showed any appetite for a new regional structure, perhaps from fear of another layer of bureaucracy between the field and the Chief Medical Officer of Health. One Medical Officer of Health noted:

> History does not suggest that you need to have that regional level; I mean the concern of adding additional layers, the system is already decentralized enough.

While the last thing the public health system needs is another layer of bureaucracy, Ontario has had success over the years with non-bureaucratic structures of regional support including the Crown Attorney system, the Coroners' system, and the court system. One Medical Officer of Health noted the usefulness of an earlier system of

regional Medical Officers of Health serving as a local resource.[160] Before closing the book on the options for public health reorganization, consideration should be given to the development of a non-bureaucratic, supportive, regional structure to provide assistance to the field and to consolidate the control span of the Chief Medical Officer of Health.

Another general observation about the restructuring process is that no matter how public health is restructured, it will continue to be delivered at the local level. The local Medical Officers of Health and the people on the ground under their direction are the backbone of the public health system. The point of service is the local public health unit. It would be shortsighted to focus unduly on reform of the central organisms like the Chief Medical Officer of Health and the Public Health Branch of the Ministry of Health and the new CDC Ontario (whatever it is called) at the expense of reforms and increased resources at the local level.

One Medical Officer of Health expressed this view very succinctly:

> I'm worried that the public health system at municipal level may not be reformed to extent it should be; I think it's being lost in the shuffle. The primary focus for change and reform seems to be at the provincial level. The backbone of the public health system is the local boards of health and they aren't getting not getting the proper focus or attention.

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

> Everything happens at the local level. The local level is the point of service. Funds must flow to this level. Public Health saves the province money. Health is a provincial responsibility so the province should fund strong local units. There is also opportunity for the Feds, and it would be far more cost-effective to have funding and results at the local level than many of Health Canada's current activities.

160. This Medical Officer of Health stated: "There used to be regional MOH's that worked for the province, at one point three or four of them and at some point up to about six of them. They were resourced to a local MOH. They were individuals who spent the bulk of their time going around the area that they were serving, finding out what was going on and they were a resource that you could go to, but over the years, those positions went. They had no authority but they were consultants, people who had additional information that you could go to and they were of value and of help, perhaps more in the outlying areas than in Toronto."

Whatever is done by way of structural revision, two adjustments are clearly needed to the role of the local Medical Officer of Health.

The first is to ensure, as noted above, that the local Medical Officer of Health enjoys the same degree of political independence from the local power structure that the Chief Medical Officer of Health enjoys from the province. Both the local Medical Officer of Health and the Chief Medical Officer of Health require the ability to speak out on public health issues without going through a political filter, and need to manage outbreaks free from politically motivated interference.

The second is to ensure that the local Medical Officer of Health is not buried in the municipal bureaucracy. It has been suggested that some local Medical Officers of Health, as municipalities moved to consolidate, have been sucked into the corporate municipal entity instead of retaining the executive authority over their own operations that is necessary to ensure their accountability for the administrative machinery that makes public health work on the ground. As the Association of Local Public Health Agencies noted in October 1997 during the hearings on Bill 152**,** which significantly amended *the Health Protection and Promotion Act*:

> . . . it is essential for the local Medical Officers of Health to retain statutory responsibility to serve as executive officer of the board of health. Of necessity, this must include responsibility for the management and administration of health programs and services and the related business affairs of the board, as well as responsibility for direction of employees and others whose services are engaged by the board.[161]

As a result of these concerns, the present Section 67 was added to the *Act* to provide that those engaged by a Board of Health to deliver public health programmes are subject to the direction of the local Medical Officer of Health who, in turn, is responsible to the local board for the management of those programmes. The problem is that some municipalities have accepted neither the spirit nor the letter of Section 67 and the province has demonstrated little appetite to take on a fight against those municipalities.

Some Medical Officers of Health suggest that Section 67 has not prevented the apprehended danger that public health administration would become lost within the

161. Association of Local Public Health Agencies, *Position Statement Regarding Bill 152, Schedule* (Toronto: October 9, 1997), pp. 1-2.

municipal bureaucracies. One Medical Officer of Health described the current diminution in the authority of the local Medical Officer of Health over the administrative machinery that drives the delivery of public health protection:

> There is a sense that Medical Officers of Health lost out after the downloading to the municipalities reflected in Bill 152 in 1997, effective January 1998, when the Medical Officer of Health lost their position as the executive officers of boards of health and the administrative and business function was taken from the Medical Officer of Health and given to municipal government. In some cases staff necessary to deliver public health programmes have, since then, been taken away from the Medical Officer of Health and assigned to other areas of municipal work.
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> Boards of health and municipalities have taken great liberties as result of the powers and duties of the Medical Officer of Health being watered down. If we change the funding of public health so it is far more driven by the province; it makes sense to revisit those earlier decisions to give more power to municipalities over the Medical Officer of Health.

A Medical Officer of Health in one of Ontario's largest cities said:

> Most of us are lost deep down in municipal bureaucracies. This needs to be corrected. The Medical Officer of Health should be the Chief Executive Officer of a distinct service unit with accountability to a Board.

Because of the overall provincial interest in public health protection and because of the statutory obligations of the local Medical Officer of Health to ensure public health protection, the provisions of Section 67 should be enforced or if necessary amended to ensure that the Medical Officer of Health has direct administrative control over the personnel and administrative machinery required to deliver public health protection.

The big question, of course, is whether the present decentralized system should remain. Should public health in Ontario continue to be delivered and administered through local public health boards accountable in large part to local and regional municipal councils?

On the one hand, no other province in Canada has devolved so much public health responsibility to the municipal level. The Interim Walker Report noted that Ontario has the most widely dispersed and fragmented public health system in the country. In

an age of emerging and reemerging infectious diseases that can sweep across the world and across countries and provinces with no respect for boundaries, it is counter-intuitive to place a super-ordinate value on municipal autonomy in infectious disease prevention, surveillance, and outbreak management. Because infectious diseases can spread so rapidly and so widely, Ontario's protection against infectious disease is only as strong as the weakest local link.

On the other hand, many public health programmes such as chronic disease prevention and health promotion depend on local community partnerships with agencies, schools, nongovernmental organizations, and voluntary associations. There is a strong view that something of great value would be lost if local initiatives and local involvement in health promotion were destroyed through centralization of all public health functions under the province.

Ideally a structural balance can be struck which gives the province central control over infectious disease surveillance, prevention, and outbreak management, leaving with the municipalities some room to participate in those programmes, together with a significant financial and operational role in community-based health promotion.