Patients matter. Public health matters.

OPSEU response to the proposed amendment to Regulation 566 under the *Health Protection and Promotion Act*

Regulation 566: removing professional qualifications requirements in public health

On October 26, the Ministry of Health and Long-Term Care released 11 proposed amendments to regulations made under the *Health Protection and Promotion Act*, with the goal to "modernize them and ensure public health programs and services remain current to protect the health of Ontarians."

Under Regulation 566 – regarding qualifications of Boards of Health staff – the government has proposed the removal of "existing public health professional qualifications requirements for business administrators, public health inspectors, public health dentists, dental hygienists and public health nutritionists" as part of an effort to "provide Boards of Health with autonomy with respect to hiring staff with the proper qualifications and include updated requirements."

OPSEU is deeply concerned by the government's effort to remove qualifications in the public health sector, and questions the government's motives for proposing these amendments.

The *Standards Modernization* process

As part of the Patients First overhaul of Ontario's public health care system – or what the Ministry of Health and Long-Term Care (MOHLTC) has described as "broader health system transformation efforts," the MOHLTC launched a review of the *Ontario Public Health Standards* (OPHS) and *Ontario Public Health Organizational Standards* (Organizational Standards) - what they have termed collectively as "*Standards Modernization.*" The *Standards Modernization* process is meant to provide an opportunity to "define public health's role and contributions" within the broader health system changes that are happening.

Background

In 2008, the Ministry released the OPHS, and in 2011 the Organizational Standards. The OPHS and 27 incorporated protocols are guidelines issued by the Minister under the *Health Protection and Promotion Act* (HPPA); these establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health. The Organizational Standards established the minimum management and governance requirements for all boards of health and public health units and are operationalized via the *Public Health Funding and Accountability Agreement*.

In 2015, the *Standards Modernization* process began, with an Executive Steering Committee (ESC) established to provide leadership, oversight and guidance for this process. Based on input from a host of sub-committees (all strategically guided by the ESC), the ESC was tasked with recommending a set of "renewed program and organizational standards" to the MOHLTC for final review and decision-making.

But in the *Standards Modernization* process outlined here, it does not appear that Regulation 566 was part of the discussions held, including in the consultative process with representatives of Public Health Units. It is distressing that this was left off the table, seemingly until the last minute.

While limited information about the MOHLTC's future plans makes it extremely difficult to provide feedback, we wish to focus on three areas of concern in light of the information currently available to us.

1) That the removal of professional qualifications under Regulation 566 is an attempt to cut costs by allowing Boards of Health to hire less qualified staff, with no regard for public health and safety.

2) That the *Standards Modernization* process – in line with the broader health system transformations – is an attempt to facilitate the downloading of public health services.

3) That in light of the recommendations of the Minister's Expert Panel in Public Health, *Standards Modernization* is part of a much larger plan to restructure public health units in the image of LHINs (as brokers of services, but not direct providers of services), or perhaps even to integrate public health completely under the umbrella of the LHINs.

Issue #1: Cutting costs, lowering qualifications

According to Roselle Martino, Assistant Deputy Minister in the Population and Public Health Division of the MOHLTC, "high quality public health professionals remain the foundation of our public health system."

So why does Regulation 566 remove existing public health professional qualifications requirements?

According to the Public Health Agency of Canada, there are core competencies in the public health sector. These core competencies are the essential knowledge, skills and attitudes necessary for the practice of public health; they transcend the boundaries of specific disciplines and are independent of program and topic.[i] These core competencies help to improve the health of the public by encouraging service delivery that is evidence-based, population-focused, ethical, equitable, and client-centred. The education and relevant experience of public health staff make up an important part of these core competencies.
As an example, Public Health Inspectors must undergo a rigorous and effective certification process. The Certificate in Public Health Inspection (CPHI) is granted by the Canadian Institute of Public Health Inspectors to candidates who fulfill the requirements set forth in the regulations *Respecting the Certificate in Public Health Inspection and Governing the Board of Certification of Public Health Inspectors*. This certification process is not just rigorous; it ensures that PHIs have the most appropriate training and skills.

If the goal is to remove these qualification requirements in order to hire individuals with less training in an effort to cut costs, one need only look to past experience to understand the possible consequences.

Case study: Walkerton tragedy

In May 2000, contamination of municipal water by bacterial pathogens in Walkerton, Ontario resulted in the worst public health disaster involving municipal water in Canadian history. Seven people died, and at least 2300 others became ill. A public inquiry was called, and final recommendations made, in which Judge Dennis O'Connor detailed the events and causes leading to the outbreak.

While the tragedy in Walkerton was truly the result of a perfect storm of ineptitude, part of that perfect storm was the lack of training of the two men responsible for the public utilities commission (PUC). Both had been grandfathered into their positions and lacked formal training. According to a review done by M. Salvadori, "They had little understanding of how chlorination worked, or of the health risks associated with improper treatment and monitoring… Although they were required to have 40 hours of training each year, this training did not take place and no system was in place to enforce it."[ii]

Although problems had been identified by the Ministry of the Environment in years leading up to the tragedy, and an inspection report detailing

these problems was given to the PUC, "the commissioners were largely concerned with the financial side of the operations and did not address the MOE report. No follow-up occurred. Enforcement was made difficult given that the regulatory responsibilities were governed by guidelines as opposed to legally binding regulations."[iii]

According to Salvadori, "the most important lesson remains that the many layers that are put in place to protect public health cannot be peeled away without consequences. In all work that deals with human safety, experience is important but **formal training is fundamental**. Legally binding regulations are more effective than voluntary guidelines."[iv] The Walkerton tragedy shines a light on the reality that cutting costs, and removing training and qualification requirements, has consequences, especially for public health and safety.

At OPSEU, we are also troubled by the MOHLTC's move to remove qualifications requirements that exist by regulation. As per Salvadori's argument, legally binding regulations are more effective than guidelines.

The Assistant Deputy Minister has indicated that qualifications for public health professionals will be outlined in a new *Public Health Accountability Framework*, but details have not been released, and there is no clear explanation about what those qualifications will be. According to the ADM, "The policy guidance will outline expectations for boards of health to hire qualified public health professionals." The development of this policy guidance will take place "in the coming months" and the ADM's staff will "be reaching out to various professions to seek their best advice." The details about the consultation process and the policy guidance are vague at best.

What is clear is the MOHLTC's plan to remove qualification requirements from the legally binding regulation, and outline them in a policy guide. This is dangerous.

Issue #2: Public Health *Standards Modernization* used to facilitate downloading of services

Across the health care system, the trend has been to download services, often by way of contract with private, for-profit companies that siphon precious public dollars into private hands. Local Health Integration Networks (LHINs) are the brokers of health care; they do not provide any services directly, but rather manage Accountability Agreements with health service providers (these Agreements are essentially a funding mechanism).

In the public health sector, we've seen the administration of the Healthy Smiles Ontario program downloaded by contracting-out to a private company. We've seen a reduction in the flu shot program – as more and more private pharmacies deliver the service. And now, we are told that the objectives of the *Standards Modernization* process are to develop public health program and organizational standards that are "aligned with the government's strategic vision and priorities for public health within a transformed health system."[v]

In this "transformed health system," by way of the *Patients First Act*, the LHINs have been given more power, but not more accountability to the public or workforce. In fact, the LHINs have been given power to facilitate the endless restructuring and "integration" of services in order to facilitate more cuts and privatization; their mandate falls in line with the "strategic vision" of the MOHLTC, not with population need, nor the values of public health.

OPSEU is concerned that *Standards Modernization* will be used to make public health units more closely mirror the LHINs, as brokers of health care services, not deliverers of those services.

This concern has developed within the context of broader proposed changes to public health, especially with regards to recommendations made by the Minister's Expert Panel on Public Health (please see below for an excerpt from OPSEU's response to those recommendations).

It is interesting that the amendment to Regulation 566 has been proposed just months after the release of the Report of the Expert Panel. It raises questions about how the structure of public health is being reconceived and possibly reorganized.

Issue #3: Restructuring of Public Health Units to mirror LHINs

Public Health Units

Currently in Ontario, there are 36 Public Health Units, administering health promotion and disease prevention programs focused around prevention, screening, and education.

Each health unit is governed by a board of health, which is an autonomous corporation under the *Health Protection and Promotion Act*, and is administered by the medical officer of health who reports to the local board of health. The board is largely made up of elected representatives from the local municipal councils, ensuring accountability to the local communities they represent. The Ministry of Health and Long-Term Care (MOHLTC) cost-shares the expenses of Public Health Units with the municipalities.

Minister's Expert Panel on Public Health makes recommendations

In January 2017, the Minister's Expert Panel was established with a mandate to review the optimal organizational structure for public health in Ontario to "ensure accountability, transparency and quality of population and public health programs and services," and "support integration with the broader health system and the Local Health Integration Networks (LHINs)."

In early October, representatives from the Ontario Public Service Employees Union (OPSEU) met with representatives from the MOHLTC to discuss the final report of the Minister's Expert Panel on Public Health and the recommendations made by the Panel, which cover three areas: organizational structure and geography; leadership structure; and governance structure.

There are serious implications to the government's proposal to establish 14 regional public health entities, and the subsequent changes to their governance structure.

Regional Boards of Health to mirror LHINs: a disaster for democracy

The Panel has recommended that the existing 36 public health units be centralized into 14 new regional boards of health, in an effort to have them "relate effectively to LHIN boards." But like LHIN boards, this would dilute local authority and accountability, and threaten the capacity for local decision making in the best interest of the communities and patients being served, in favour of the provincial government's overarching strategy for health care services.

As identified in OPSEU's response to Bill 41, *The Patients First Act*, it is clear that, since their creation, the primary function of the LHINs has not centred on planning to provide services that meet population need. Rather, the LHINs have been called on to find opportunities to integrate and restructure health care services as a priority.

The LHINs are not accountable to the public. Their board chairs and vice-chairs are appointed by Cabinet, and they are not accountable to local communities. There is virtually nothing in the LHINs legislation that enables anyone locally to influence LHIN decisions. They answer upwards to the MOHLTC, not to the communities whose interests they are meant to represent. Under Bill 41, the "enhanced oversight and accountability" outlined by the ministry are actually tools for enhanced power for the minister and the LHIN, not accountability to the public.

The LHINs have been a tool for integrating and cutting services endlessly, all while diffusing responsibility away from the minister. The LHINs should not be the model by which the future of public health is envisioned in Ontario.

Democracy in health care matters

By centralizing the existing 36 Public Health Units into 14 "Regional Public Health Entities," each regional board will oversee more municipalities. Depending on the formula used to determine municipal representation on these boards (likely by population) the voice of smaller communities would be swallowed by the larger ones within the catchment area being served. These smaller communities would become the small fish within a regional body where elected representatives from larger communities are appointed through Orders in Council. This model dilutes the voice of smaller communities, and the residents that live within them.

OPSEU is concerned that the leadership and governance structure being proposed by the panel would facilitate future integration and cuts within public health, just as the LHINs have done.

The panel has recommended the establishment of mandatory appointments by Order in Council for designated positions on each regional board, as well as the "flexible combination of provincial and local appointments for remaining seats." Where Public Health Unit boards are largely made up of elected representatives from the local municipal councils, the panel recommends that regional public health entities would have greater representation for "provincial appointments." This would further erode the capacity for local decision-making, which would already be diluted by the structural centralization/regionalization of the Public Health Units.

OPSEU is also concerned that by mirroring the LHIN structure, the ministry is setting the stage for regional boards of health to be absorbed completely by the LHINs in the future – perhaps the next step in full health system integration and code for further restructuring and cuts.

The creation of 14 regional public health entities will dilute the voice of the communities represented within them, especially for small and rural municipalities whose voice will be overshadowed and whose representation will be weakened in regional health planning. Just like hospitals under the control of the LHINs, we are likely to witness cuts to health care that disproportionately affect small and rural communities.

This is not in line with the ministry's vision of putting patients first.

When it comes to the planning and delivery of health care services, democracy matters. Democratically elected boards are more accountable to their communities and more representative of the diversity of their communities. As entities focused on preventative health care, strong and effective Public Health Units actually help reduce negative health outcomes and costs in our province's hospitals and across the health care sector.

When it comes to putting patients first, there is strength in local decision making. That is why OPSEU is calling on the Ministry of Health and Long-Term Care to maintain the current organizational, leadership, and governance structure of our Public Health Units in Ontario.

Conclusion

By amending Regulation 566, the Ontario government will remove existing public health professional qualifications requirements. While the government has proposed outlining these requirements in a "policy guidance," they would no longer be legally binding through regulation.

OPSEU is deeply concerned that the removal of these professional qualifications is an attempt to cut costs by allowing Boards of Health to hire less qualified staff. This would have dangerous consequences for public health and safety.

Furthermore, we are concerned that the *Standards Modernization* process is part of a much larger plan to restructure public health units in the image of the LHINs – as a broker of services, but not a direct provider of services – so that like LHINs, they can facilitate further cuts, restructuring and

downloading of services within the public health sector. This position is informed by broader changes recommended by the Minister's Expert Panel on Public Health regarding the regionalization/centralization of Public Health Units.

LHINs have been constructed for the purpose of facilitating endless health care restructuring. They are not accountable to the public, and they answer upward to the minister, not to the communities whose interests they are meant to serve. *Patients First* has handed more power to the LHINs, but not more accountability, and OPSEU takes issue with the current plan to reconceive and reorganize Public Health Units in much the same way.

In addition to the concerns outlined here, OPSEU is also raising questions about how the boundaries of the LHINs (and the sub-LHINs within them) will impact upon the boundaries of regionalized Public Health Units. Currently, municipalities provide funding to Public Health Units. OPSEU questions how regionalization would impact municipal funding – especially where smaller and rural municipalities would have a weakened voice on the regionalized Boards of Health.
We will continue to monitor developments and look forward to more information being released, in order to provide a more fulsome and comprehensive response.

Endnotes:

[i] "Core competencies for public health in Canada." Release 1.0. Skills Enhancement for Public Health. *Public Health Agency of Canada*. 2008.
[ii] MI Salvadori et al. "Factors that led to the Walkerton tragedy." *Kidney International* (2009) 75 (Suppl 112), S33-S34
[iii] Ibid.
[iv] Ibid.
[v] "Highlights #1: Standards Modernization - Executive Steering Committee." May 2016. Public Health Standards, Practice and Accountability Branch, *Ministry of Health and Long-Term Care*.