CITY OF HAMILTON

PUBLIC HEALTH SERVICES

Office of the Medical Officer of Health

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 19, 2015
SUBJECT/REPORT NO:	2015 Provincial Public Health Funding (BOH15035) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Elizabeth Richardson (905) 546-2424, Ext. 3502
SUBMITTED BY: **SIGNATURE:**	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

RECOMMENDATION

(a) That the Mayor and Medical Officer of Health be authorized and directed to sign and submit the attached Amending Agreement No. 3 to the Public Health Funding & Accountability Agreement;

(b) That the Medical Officer of Health, or delegate, be authorized and directed to execute all 2015 Provincial Program Service Level Funding Agreements and any ancillary agreements required to give effect thereto. This includes the authority to authorize the submission of budgets and quarterly/year end reporting;

(c) That Public Health Services staff continue to meet with Ministry of Health & Long Term Care staff to review the funding formula details, and get information on 2016 Ministry budget plans;

(d) That the Medical Officer of Health submit a request for additional funding from the Province to offset shortfalls in the mandatory program budget for 2015;

(e) That the Mayor write to the Minister of Health & Long Term Care to advocate for continued investment in local public health programming, stability in public health funding, and review and evaluation of the funding formula for public health programs.

EXECUTIVE SUMMARY

In early September 2015, the Ministry of Health & Long Term Care (Ministry) announced that it had accepted the recommendations of the Funding Review Working Group, which had been established in 2010 to recommend a funding model for provincial grants to local public health programs. The Ministry also announced that it would be implementing the new model for 2015, and holding public health units budgets at zero percent, unless they were shown to be underfunded according to the model.

Funding approvals were sent to each health unit shortly afterward, including an amendment to the Public Health Funding & Accountability Agreement (Appendix A). Based on 2014 funding levels, Hamilton was slightly overfunded by the province relative to its share under the model (4.16% actual share vs 4.11% model share – see Appendix C). Thus the province held their 2015 grant to 2014 levels for mandatory programs, and did not provide the 2% inflationary increase requested by Council. The shortfall for 2015 relative to the requested grant is approximately $470,000. When the shares are recalculated using 2015 provincial funding approvals, Hamilton is slightly underfunded relative to its share (4.08% actual vs 4.11% model).

The Ministry did provide additional base funding of $78,225 in 2015 for Smoke Free Ontario enforcement and programming for the new *Electronic Cigarettes Act*. A total of $345,300 in one-time funding was also received for the Public Health Inspector Practicum Program (50% of requested), *Electronic Cigarette Act* programming, smoking cessation aids, as well as office consolidations costs.

Ministry staff have indicated that they will meet with local staff to review the basis for the funding decisions, and discuss any local impacts.

There remains a lack of clarity about provincial funding for two other major budget pressures: costs related to the delay in uploading of the Children in Need of Treatment (CINOT) dental program, as well as overtime costs to reconcile duplicate immunization records created when Panorama was implemented last year. Assuming that these will be fully funded, and based on expenditures to date, staff are projecting a $298,000 negative total variance for Public Health Services in 2015. Mitigation measures continue to be explored, and where mitigation would impact service levels, staff will bring forward reports to the Board of Health.

Historically, public health unit budgets were set by local boards of health based on their understanding of local needs, and willingness and ability to pay. Provincial legislation introduced mandated programs that local health units must provide, as well as grants for this programming. The majority of grants required cost-sharing with the local municipalities, while some, that addressed provincial priority health issues, were 100% provincially funded.

In response to concerns about significant underfunding of the overall public health system raised during and after SARS, public health budgets were allowed to grow without provincial caps. With an environment of fiscal restraint and an emphasis on accountability, the Province has been looking for ways to rationally reallocate funding within the health system. Three reviews of public health funding have been commissioned by the Province over the past 20 years, with the goal of establishing a needs and service cost based model for provincial funding allocations. This is difficult to do in practice, with little evidence or experience to be found through the literature or discussion with other jurisdictions. There are gaps in understanding what influences public health costs and significant challenges in finding good quality data on which to base a model. Further, these reviews have looked only at how to share provincial allocations across Ontario's public health units, and not what funding is necessary to address health needs or fulfil the requirements outlined under the legislation.

The new funding model being used by the Ministry bases allocations on a per capita share of the total provincial grant for mandatory programs, adjusted by an equity factor. This factor is calculated using measures of local health needs and service costs. Under the formula, 8 public health units which received less than their equity adjusted share in 2014 will receive all of the growth funding being allocated by the Province for mandatory programs in 2015, while the other 24 health units will receive no increases to their budgets.

Alternatives for Consideration – See Page 10

FINANCIAL – STAFFING – LEGAL IMPLICATIONS (for recommendation(s) only)

Financial: The Province allocated 2015 public health mandatory program funding grants based on the relative position of each health unit on equity adjusted per capita shares for 2014. In 2014, Hamilton received slightly more than its equity adjusted share. However using 2015 budget allocations, Hamilton is receiving slightly less than its equity adjusted share of provincial dollars. Extrapolating from the information currently available, Hamilton would appear to be approximately $160,000 underfunded by the Province in 2015.

The mandatory program grant base request for Hamilton had included a 2% inflationary increase. The shortfall for 2015 is approximately $470,000. In other program areas, the Ministry approved additional base funding of $78,225 in 2015 for Smoke Free Ontario enforcement and programming for the new *Electronic Cigarettes Act* (annualized $91,200). For the CINOT Expansion program, the Ministry funded the program for a full year due to the delay in upload based on demand as reported in 2014, whereas the Council approved budget was for services to August 1, 2015.

Program/Initiative	2015 Approved Ministry Allocation	2015 Approved City Budget	Variance
Mandatory Programs (75%)	23,456,900	23,925,940	-469,040
Chief Nursing Officer Initiative (100%)	121,500	121,410	90
Enhanced Food Safety - Haines Initiative (100%)	78,300	78,260	40
Enhanced Safe Water Initiative (100%)	42,300	42,230	70
Healthy Smiles Ontario Program (100%)	1,448,300	1,448,210	90
Infection Prevention and Control Nurses Initiative (100%)	90,100	90,070	30
Infectious Diseases Control Initiative (100%)	1,111,200	1,111,140	60
Needle Exchange Program Initiative (100%)	109,900	109,810	90
Small Drinking Water Systems Program (75%)	41,100	41,100	0
Social Determinants of Health Nurses Initiative (100%)	180,500	180,450	50
Vector-Borne Diseases Program (75%)	718,900	718,880	20
Children in Need of Treatment Expansion Program (75%)	174,600	89,190	85,410
Electronic Cigarettes Act - Protection and Enforcement (100%)	38,925	0	38,925
Smoke-Free Ontario Strategy: Prosecution (100%)	10,000	10,000	0
Smoke-Free Ontario Strategy: Protection and Enforcement (100%)	374,200	334,890	39,310
Smoke-Free Ontario Strategy: TCAN Coordination (100%)	285,800	285,810	-10
Smoke-Free Ontario Strategy: TCAN Prevention (100%)	276,800	276,800	0
Smoke-Free Ontario Strategy: Tobacco Control Coordination (100%)	100,000	100,000	0
Smoke-Free Ontario Strategy: Youth Tobacco Use Prevention (100%)	80,000	80,000	0
	28,739,325	**29,044,190**	**-304,865**

A total of $345,300 in one-time funding was also received for the Public Health Inspector Practicum Program (50% of requested), *Electronic Cigarette Act* programming, smoking cessation aids, as well as office consolidations costs.

Two other major budget pressures exist related to the delay in uploading of the CINOT dental program, as well as overtime costs to reconcile duplicate immunization records created when Panorama was implemented last year. This budget pressure also comes at the end of a three year period during which Public Health expenses were reduced by $476,000 through operating efficiencies and reduced staffing.

Assuming that these will be fully funded, and based on expenditures to date, staff are projecting a $298,000 negative variance for Public Health Services in 2015. Mitigation measures continue to be explored, and where mitigation would impact service levels, staff will bring forward reports to the Board of Health.

Given that the Province has indicated that this funding model will continue to be the basis of any available future provincial public health growth funding allocations, and that

Hamilton appears to sit near the tipping point between being underfunded and overfunded based on equity adjusted share, it's not fully clear what the implications will be for the 2016 budget. Further, the Province continues to signal that local health agencies should anticipate no new funding in 2016. Public Health Services staff will be meeting with provincial staff on October 7, 2015 to discuss both the 2015 and 2016 situations in detail.

Staffing: If the provincial funding decisions lead to staffing changes to mitigate any budget pressures in 2015 or 2016 these will be reported to the Board of Health.

Legal: There are no new legal implications as a result of these recommendations.

HISTORICAL BACKGROUND (Chronology of events)

For the first half of the last century, public health in Ontario was municipally financed, based on local needs and ability and willingness to pay. The Province began to make grants for local public health services approximately 60 years ago, using these to encourage amalgamation of very small health units, as well as action on provincial health priorities. Today, program standards for health units are set by the Province under the *Health Protection & Promotion Act.* The *Act* gives responsibility for determining the operating budget of each health unit to the local board of health and requires local municipalities to pay the expenses of the board. The Ministry can contribute grants to public health units at the Minister's discretion. In addition, boards of health can institute local programs based on their communities' needs, and fund these 100% municipally.

Currently, the majority of provincial grants require cost-sharing with municipalities at a ratio of 75% provincial, 25% municipal, although a number of priorities (for example *Smoke Free Ontario Act* enforcement, infectious disease control, and health equity) receive 100% funding from the Province. The majority of cost-shared funding allocated to health programs has continued to be based on historical precedents and the local board's and Province's willingness to pay.

Three public health funding reviews have been done over the past 20 years in response to fiscal constraints. Two provincial auditor's reports have also recommended a rational basis for public health funding, as well as the institution of performance measures.

During the first funding review in 1996, the Ministry and external stakeholders agreed that modifiers should be included in the funding model for public health to address variations in health needs and service costs across health units. After the recommended funding model was implemented, there was a 2.6 fold difference in per capita funding across Ontario's health units.

In 1998, responsibility for funding local public health was entirely downloaded to municipalities. The following year, the Province agreed to pay 50% of board-approved

public health costs. From 1999-2004, there were no provincial caps on public health unit spending; the Ministry paid 50% of each board of health approved budget. However, a second funding review was initiated to find a model for allocating provincial grants to health units. Five modifiers, similar to those used in 1998 were recommended to be included in the funding model to reflect variations in health needs and service costs. The overall model under consideration was more complex than that of 1998. It included a base amount for administration and overhead costs (5%), the majority of funding to be allocated on a per capita basis, and modifiers of need and cost be applied to one-third of funding. Ultimately, the working group responsible for the review was unable to reach consensus on all of the modifiers, and the model was not implemented.

From 2004-2007, in response to commitments made after SARS, the government began to gradually increase its share of funding for mandatory public health programs, and by 2007 had returned to the 75% provincial, 25% municipal ratio. Provincial funding caps began to be implemented in 2006, and in 2007 health units started to report that municipalities were contributing more than their 25% share of local public health costs. By 2013, there was a 2.8 fold difference in provincial per capita funding for public health across the province, and 50% of public health units were reporting that they were paying more than 25% of the budget, including Hamilton. Differences in population growth across the province played a significant role in the variability of per capita provincial spending.

In 2010, a third funding review working group was established by the Province, and the group's recommendations were ultimately used by the Ministry to determine the 2015 provincial public health funding allocations that are the subject of this report. The group also included in its final report funding models for unorganized territories, however these are not reviewed here as they do not apply to Hamilton.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

This report reviews provincial funding policy for public health, as well as the legal basis for public health funding in Ontario under the *Health Protection & Promotion Act*.

RELEVANT CONSULTATION

Staff have been in group consultations and discussions with provincial Public Health staff, who have provided some of the information included in this report. There is a meeting scheduled on October 7, 2015 to discuss Hamilton's specific situation.

Discussions have also been had with the Council of Medical Officers of Ontario, Association of Ontario Public Health Business Administrators, as well as Hamilton's Intergovernmental Relations staff, all of which have helped to inform this report.

ANALYSIS AND RATIONAL FOR RECOMMENDATION
(Include Performance Measurement/Benchmarking Data if applicable)

The most recent public health funding review workgroup was established in 2010 with the objectives of:

- Developing a needs-based approach to public health funding,
- Improving funding responsiveness to service needs through the inclusion of equity and population adjustment factors, and
- Reducing funding inequities among public health units over time.

The new model was not intended to affect the provincial/municipal cost-sharing formula of 75/25 and related to provincial funding only. The workgroup was to investigate the current status of public health funding, provide advice to the Ministry on a future funding model and implementation principles. Work was to be done under the assumption that no new significant provincial funding would be available to implement the new model, and that funding adjustments would be implemented on an incremental basis using any future increases the Province may choose to make to public health funding.

Membership of the working group included representatives from:

- Boards of Health,
- Medical Officers of Health,
- Business Administrators,
- Program staff,
- Association of Local Public Health Agencies (alPHa), and
- AMO.

The group reviewed historical and current funding levels, sources of funding, current expenses and cost pressures of health units, as well as the findings of the two previous reviews. The academic literature was reviewed and the group undertook an inter-jurisdictional survey of public health allocation methods. Other Canadian jurisdictions did not allocate public health funding explicitly based on health needs or service costs. The model was also taken out for consultation through two forums that were restricted to Medical Officers of Health/CEOs and Business Administrators of public health units.

The ideal model was proposed to be equitable, transparent and simple to administer and communicate. It would result in stable funding and allow for multi-year planning. It would be needs-based, reflecting local provider and community characteristics and evidence-based, using measures of the demand for and cost of providing public health services.

Indicators used in the model would need to be resistant to manipulation, reproducible over time, and largely independent of each other to avoid double counting unless there was a specific rationale to do so. They needed to be based on available data, using valid proxies where direct measurement is not possible. Indicators had to be easily

explained and unlikely to change over time. The group decided to recommend an "upstream" approach to allocating funding, using indicators that focused on socio-economic determinants of health, rather than a "downstream" health outcome approach.

In the final model, the working group recommended that monies be allocated based on an equity adjustment to each health unit's per capita share of provincial funding. The equity adjustment was based on both service cost drivers and drivers of health needs. These indicators were weighted so that service cost drivers reflected 35% of the overall weight and health needs 65% of the weight. As there is very little research on funding model development for public health, the working group members based the weightings on their public health expertise and judgement. The indicators included in the final model, along with Hamilton's ratings included in the 2013 analysis done for the working group, is found in Appendix B.

To date, the Province has shared only the 2013 data used in the final report of the working group. Measures on each variable by health unit are detailed in the report, but the scaling of results for model construction is not disclosed, and final results for the equity adjusted share by health unit are given anonymously. The data show that, in 2013 the majority (75%) of health units were receiving slightly above their equity adjusted share, while 9 health units (25%) were receiving less than their adjusted share, with two significantly so.

Each health unit received a letter in September 2015, outlining their Equity Adjusted Factor for 2014 and 2015 (Appendix C), along with their amendment to their Public Health Funding & Accountability Agreement which includes their budget allocation for the 2015 calendar year (Appendix A). The Province increased the overall public health funding envelope for mandatory programs by approximately $11 million. A further $17 million was allocated to new program initiatives and one-time costs.

While appreciating the difficulty of the task the workgroup had undertaken, and that a rational basis for public health funding is a worthwhile goal, there were a number of concerns raised during the consultations with MOH/CEOs and business administrators in 2013 that remain to date. These included significant concern about the construction of the model, the fact that selection of variables is largely subjective, and that the chosen variables "double count" needs and services cost because they measure similar things, or were correlated with one another. It's noteworthy that the 1995 funding review and the 2013 review came up with very different solutions, while the 2001 review had a difficult time reaching consensus on a final model. It would have been, and remains, prudent at a minimum, for the Province to request an independent expert review of the model.

Another concern is about transparency. If the goal of the exercise is to bring about a rational basis for funding public health, it would be important that all stakeholders be able to review and understand the details as to how those funding decisions were made. The Province has not to date shared the scaled measures used in calculating

the funding shares in 2013, nor publicly released the actual funding decisions and calculations for 2015, citing confidentiality concerns. Only individual final share results have been given to each health unit for 2015 funding purposes. Overall, enough information was shared to know that increased funding is going to mainly larger southern urban health units (Middlesex London, Ottawa, Peel, Toronto, York, Windsor, with Peterborough and Eastern Ontario Health Unit being the exception).

A further concern is about the reliability of data if this formula is to be used over the coming years. As statisticians and planners have been raising for some time, the introduction of the voluntary National Household Survey (NHS) replacing Canada's Mandatory Long-Form Census in 2010, may have significant impact on the quality of the data being used in this model.

Other concerns relate to the fact that there are anticipated to be no increases in provincial funding to the majority of health units for the foreseeable future. With no increases from the Province, local boards will have to decide whether to allow local public health expenditures to rise with inflation and charge these costs only to obligated municipalities, or to cut services. On the other hand, those 8 health units who do receive increased provincial funding may not choose to keep their municipal dollars that have been paying more than their 25% share in the local public health funding envelope. They may choose to redirect these to other municipal programs and services. While the Province will be making a greater investment of dollars in public health services, there may not only be no actual increase in public health services available to the public, but a net decrease.

A further issue is that the model applies only to the mandatory programs, and not other public health programs. The stated rationale is that there are other funding formulas in place for the other programs. The funding formulas for these programs are not always disclosed by the Province, and its not clear that these are based in needs or service cost measures.

Several process issues also are evident. The first is the practice of providing funding approvals well into the fiscal year, and particularly with introducing a significant change in funding allocation methodology so late in the year. In previous discussions between public health and Ministry staff following the 2013 consultations, the Ministry had assured the field that there would be more consultation about the funding model, along with more transparency and better communication prior to implementation of any change.

Finally, these funding announcements have come during a time of transition for two large programs which have also created in year budget pressures: the uploading of the children's dental treatment has been delayed from August 1, and the implementation of Panorama has required significant overtime by staff in order to reconcile thousands of children's immunization records so that they are accurate and can be used in assessing immunization status. While the Province has made assurances that they will fund

these, there has yet been written confirmation of the amounts that the Province will cover, or if they will cover the costs in their entirety, while costs continue to add up. As well, changes to how the dental program is funded in 2016, which have not yet been fully communicated, will have a significant impact on the mandatory programs budgets for all local health units, and make it impossible for local health units to have the predictability and stability in funding that the model is purported to bring.

ALTERNATIVES FOR CONSIDERATION

(Include Financial, Staffing, Legal and Policy Implications and Pros and Cons for each alternative)

1. Council could direct staff to negotiate further with the Province for additional funding up to the full grant request, and hold off on signing the Public Health Funding & Accountability Agreement until such time as those negotiations are concluded. Given the current fiscal environment, this is not recommended. Delaying sign-off of the agreement will result in delays in flowing funding. Further negotiation and application for one-time funding is not precluded by signing off on the agreement.

2. Council could direct staff not to pursue further negotiations with provincial staff, not explore further efficiencies, and fund the shortfall from the public health and tax stabilization reserves for 2015, and approve a levy base adjustment to cover the shortfall for 2016 and beyond. This would allow staff time to remain focused on service delivery, and would not preclude further exploration of funding efficiencies to continuously improve public health services. This approach is not consistent with the current budgeting guidelines, and would cause a levy pressure for 2016.

ALIGNMENT TO THE 2012 – 2015 STRATEGIC PLAN

Strategic Priority #3

Leadership & Governance

WE work together to ensure we are a government that is respectful towards each other and that the community has confidence and trust in.

Strategic Objective

3.1 Engage in a range of inter-governmental relations (IGR) work that will advance partnerships and projects that benefit the City of Hamilton – negotiations will continue with the Province

3.4 Enhance opportunities for administrative and operational efficiencies - provincial decisions to hold funding at 2014 baselines will impact the sustainability of public health programs and services if not offset by local funding. Further processes will be explored to enhance efficiencies across Public Health Services.

APPENDICES AND SCHEDULES ATTACHED

Appendix A to Report BOH15035 – City of Hamilton Amending Agreement No. 3 to the Public Health Funding & Accountability Agreement

Appendix B to Report BOH15035 - Variables included in Final Recommended Funding Model and Hamilton's Score in the 2013 Analysis

Appendix C to Report BOH15035 - Public Health Funding Model Share Status – Mandatory Programs