



**Northwestern  
Health Unit**

[www.nwhu.on.ca](http://www.nwhu.on.ca)

210 First Street North  
Kenora, ON P9N 2K4

September 27, 2024

Dr. Kieran Moore  
Chief Medical Officer of Health and Assistant Deputy Minister  
College Park, 5th Flr, 777 Bay St  
Toronto, Ontario M7A 2J3

via email: [Kieran.moore1@ontario.ca](mailto:Kieran.moore1@ontario.ca)

Dear Dr. Moore,

**Re: Perspectives from Northern Ontario for the Public Health Funding Review**

At its meeting on September 27, 2024, the Board of Health for the Northwestern Health Unit passed the following resolution (#69-2024):

*WHEREAS the Office of the Chief Medical Officer of Health and the Ministry of Health is undertaking a review of the funding approach for local public health agencies; and*

*WHEREAS the Perspectives from Northern Ontario on the Public Health Funding Review letter, authored by the Northern Ontario Medical Officers of Health, outlines many of the significant considerations related to the funding approach for local public health agencies in northern Ontario;*

*NOW, THEREFORE, BE IT RESOLVED THAT the Board of Health for the Northwestern Health Unit endorses the Northern MOH letter on funding as presented, and*

*FURTHER, BE IT RESOLVED THAT copies of this resolution and the letter be sent to:*

- *Dr. Kieran Moore, Chief Medical Officer of Health*
- *Hon. Sylvia Jones, Minister of Health and Deputy Premier*
- *Hon. Greg Rickford, MPP Kenora -Rainy River*
- *Hon. Kevin Holland, MPP Thunder Bay-Atikokan*
- *Sol Mamakwa, MPP Kiiwetinoong*
- *Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health*
- *Brent Feeney, Director, Accountability and Liaison Branch*
- *Colleen Kiel, Director, Public Health Strategic Policy, Planning and Communications Branch*
- *Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health*
- *Dr. Wajid Ahmed, Associate Chief Medical Officer of Health*

- *Ontario Boards of Health*
- *NWHU Obligated Municipalities*
- *Association of Local Public Health Agencies (aPHa)*

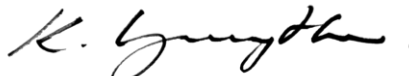
The Board of Health wishes to emphasize the challenges and inequities impacting the health of northern communities that require different metrics and solutions. We ask that the context outlined in the letter *Perspectives from Northern Ontario for the Public Health Funding Review* issued by the seven Northern Medical Officers of Health be carefully considered as the funding review is completed.

Thank you for your continued support of northern health units and for the opportunity to offer what we feel is important context to the review process.

Respectfully,



Douglas Lawrance  
Chair, Board of Health



Dr. Kit Ngan Young Hoon  
Medical Officer of Health



Marilyn Herbacz  
Chief Executive Officer

CC: Dr. Kieran Moore, Chief Medical Officer of Health  
 Hon. Sylvia Jones, Minister of Health and Deputy Premier  
 Hon. Greg Rickford, MPP Kenora -Rainy River  
 Hon. Kevin Holland, MPP Thunder Bay-Atikokan  
 Sol Mamakwa, MPP Kiiwetinoong  
 Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health  
 Brent Feeney, Director, Accountability and Liaison Branch  
 Colleen Kiel, Director, Public Health Strategic Policy, Planning and Communications Branch  
 Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health  
 Dr. Wajid Ahmed, Associate Chief Medical Officer of Health  
 Ontario Boards of Health  
 NWHU Obligated Municipalities  
 Association of Local Public Health Agencies (aPHa)

August 16, 2024

---

**To:** Kieran Moore  
Chief Medical Officer of Health & Assistant Deputy Minister

**From:** Medical Officers of Health  
for the 7 Northern Ontario Local Public Health Agencies

**Subject:** **Perspectives from Northern Ontario for the Public Health Funding Review**

---

We are writing to you as the seven local public health agencies in Northern Ontario to share some perspectives unique to the North regarding the current Public Health Funding review.

Before we outline our perspectives, we do wish to note our support of the government undertaking a funding review. It has been our perspective, and that of the local public health field, that a funding approach that enables stable and predictable funding is needed so that we can adequately plan and deliver our services.

We understand that the provincial government is quite concerned by the difference in per capita funding between local public health agencies. We agree, this is something needing to be addressed, but that the goal should not be *equal* (per capita) funding across local public health agencies, but rather *equitable* funding which accounts for the circumstances of each health unit.

The following are some equity considerations that can strengthen and improve the validity of the funding approach for public health in Northern Ontario.

For clarity, our comments are intended to relate only to the base funding grants; we do not intend to make comment on the Unorganized Territories Fund, which we believe requires its own review (we welcome the opportunity for further discussion of this at a future date).

## Considerations for Funding Public Health in Ontario

### 1. Geography

Northern Ontario has much larger service areas than in the rest of the province. Northern Ontario spans 90% of Ontario's land mass, but has only a minority of the province's population. [1] That has major implications in terms of service delivery:

- Our staff must travel long distances to deliver service. That has implications in both transportation costs as well as opportunity costs of staff time. Inflationary pressures have exacerbated these costs.
- Given some of our communities are very remote and inaccessible by roads, travel in many cases is not just by car, but by charter flight or boat. This further increases our travel costs.<sup>1</sup>
- Since the populations we serve in Northern Ontario are distributed over a large area, we do not benefit from the population density that facilitates economies of scale. That means we must plan and organize a service many times over. In Northern Ontario, we have 142 municipalities plus many other communities in unorganized territories, as well as First Nations communities. If delivering a vaccination program, for example, a northern local public health agency must plan, organize, travel, set-up, and deliver clinics in many locations, taking into account the lack of public transportation in and between most northern communities. These clinics will ultimately serve fewer people and cannot take advantage of the economies of scale possible in a southern Ontario city where only 2 or 3 fixed locations might be need.
- Our rural geography impacts the nature of services we must deliver as well. For example, since much more of our populations are living in rural and remote areas as compared to the rest of the province, we are much more involved with inspecting small drinking water systems and private drinking water testing. Unlike a municipality in southern Ontario that may have a few large municipal water treatment plants that aren't inspected by local public health, northern communities have a plethora of small drinking water systems that do need regular inspections. This adds significant costs to our budgets to travel to and conduct inspections as well as to transport well water samples to the lab. As well, even where a community may be on municipally treated water, these are smaller plants befitting the size of the municipalities without large public works departments operating them. Larger municipalities enjoy economies of scale

---

<sup>1</sup> While it may be argued that the Unorganized Territories Grant accounts for serving this population, and this does not impact the broader funding approach, we highlight (1) that some fly-in/boat-in communities are organized municipalities (e.g. Moosonee), and (2) in 2008, when local public health associations were asked to account for their true costs of delivering services to unorganized territories, it was concluded that costs were 99% higher than what the Unorganized Territory Grant provided [15], and so the cost-shared budget heavily supported delivery of services to these communities. Since 2008, the Unorganized Territory Fund has increased 41.3% [15] while cumulative CPI in Ontario has increased 47.1% [16], implying that the role of cost-shared funding has increased since then, especially after accounting for population growth.

from running large plants that foster expertise and sophistication, and comparably lower maintenance costs. Most northern Ontario municipalities don't enjoy these economies of scale, resulting in more common problems and interruptions to operations, and so more involvement by public health to assess risk, monitor water quality, and issue boil water advisories, and drinking water advisories.

- Technology, which may sometimes allow bridging distance through virtual delivery of services, is often not possible in Ontario's North or is very expensive to support. In 2023, the Canadian Government-sponsored Northern Ontario Broadband Report [2] found that only 26% of Northern Ontario communities met the standard of 50% of the population of the community having 10/50 Mbps internet speed. In many communities, and particularly spaces between them, mobile phone service is also spotty. The residents we serve in Northern Ontario therefore frequently do not have the ability to be served virtually.

## 2. Breadth, Diversity, and Complexity of Populations and Partners

The vast land area of the North also brings with it greater diversity in a few different dimensions:

- The North has 32% (142/444) of Ontario municipalities, but only 20.5% (7/34) of Ontario's health units.
- The North has 107 of the 134 First Nations Communities in Ontario (80%), and 78% of the on reserve population in Ontario (recognizing that the Census is an undercount of Indigenous population, so these numbers may underrepresent the true number). [3] Alongside these populations are Band Councils and Indigenous organizations with whom we engage to ensure we can provide services in a way that is welcome and meaningful, while navigating complex jurisdictional ambiguity.
- People in the North have much lower socio-economic standing. Between 2009 and 2018 Northern Ontario had an annual average of GDP growth [1] of 0.1% compared to 1.7% for Ontario as a whole [4]. Other social determinants of health track similarly in Northern Ontario, and so health outcomes are worse. For example, in 2021 if looking at Mortality from Avoidable Causes [5], the Northern health units had an average avoidable mortality of 323 deaths per 100,000 versus 204 for the rest of Ontario. In fact, the seven Northern health units rank in the top 8 health units for avoidable mortality, and occupy all of the top six positions. Worse social determinants of health put a greater burden on Northern local



public health agencies in terms of the number of clients needing our intervention, and the efforts we need to invest per person to mitigate inequities.

- For Indigenous populations in particular, in Ontario the median income for First Nations people living on reserve is \$32,400, \$44,000 for those living off reserve, and \$50,400 for non-Indigenous people. [6] Similarly, “Low income” status is more prevalent among Indigenous people who live on reserve (33.7%) and off reserve (16.9%) compared to non-Indigenous people (9.9%). [7] With 78% of the on reserve Indigenous population of Ontario, this is a significant pressure on Northern local public health budgets.
- Northern Ontario has disproportionately more Francophones and French Designated Areas (Figure 1), legally obligating more resources be devoted to translation and to ensuring provision of French-language services. Public Health must also engage with Francophone communities and organizations who are numerous across the large Northern geography.

**Map highlighting the French Designated Areas in Ontario**

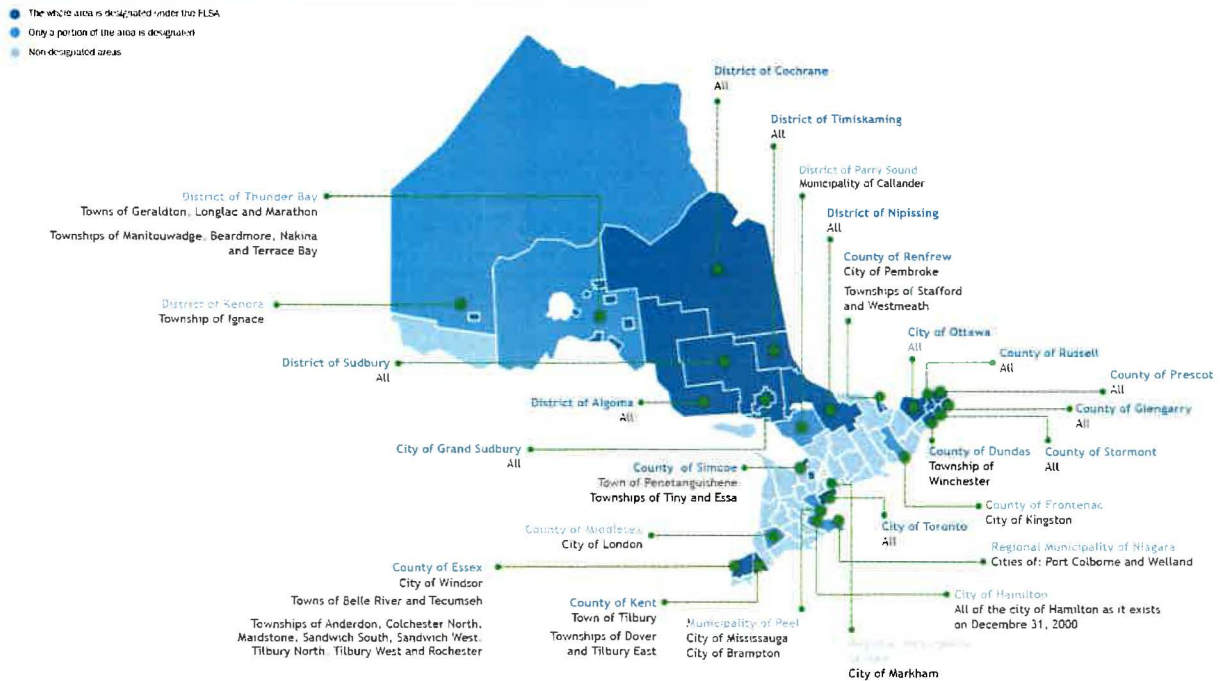


Figure 1. Designated French Language Areas in Ontario. [8]

The implication of this breadth and diversity of our populations and our partners is that it multiplies our workload: we have more municipal, Indigenous, and other partners with whom to engage; and we must meet people where they are with respect to language, Indigenous status, and social determinants of health, and invest in mitigating these. These are challenges not experienced as acutely in other parts of the province.

In addition, when attempting to work upstream, the complex patchwork of partners, many of whom are not well-funded, pose challenges to building coherent coalitions to advance advocacy or policy change for improvement of upstream health determinants.

### 3. Health Care Gaps

Northern Ontario is unfortunately lacking in health and dental care capacity. According to Ontario's Health Care Experience Survey for December 2019 (most recent results available) [9], 6.7% of Ontarians lacked a primary care provider, but that increased to 11.7% of residents of the North West LHIN and 11.8% of the North East LHIN. The Northern Sub-region reached as high as 29.0% of residents lacking a primary care provider.

In part, this is a function of primary care providers delivering acute care in much of Northern Ontario. In the North, family physicians routinely cover emergency departments, handle most obstetrics, are the primary surgical assists, and support long-term care, often working at multiple sites in a week.

It often falls to local public health to fill the gaps in primary care. For example, looking at the Fall 2023/24 COVID-19 vaccination program, pharmacies did not have the capacity to provide vaccinations in the North to the extent they did in the rest of the province (44.7% of vaccinations delivered by pharmacies in the North compared to 73.9% of vaccinations province-wide). Northern Public health units filled that gap, delivering 43.2% of COVID-19 vaccinations as compared to 15.7% Ontario-wide. Indeed, the six public health units with the lowest pharmacy delivery were all in Northern Ontario, and all 7 Northern Ontario PHUs were in the bottom 10 PHUs for pharmacy share of COVID-19 vaccinations. Despite the lack of pharmacy participation, Northern local public health agencies achieved above average vaccination coverage (17.9% to provincial average of 15.8%) through our efforts.

Table 1 Fall 2023/24 COVID-19 Vaccination Delivery [10][11]

Public Health Unit	Proportion of Vaccines Delivered by Pharmacy	Proportion of Vaccines Delivered by Primary Care	Proportion of Vaccines Delivered by Public Health	Coverage Achieved
<b>Ontario</b>	73.9%	4.4%	15.7%	15.8%
<b>Northern PHUs</b>	44.7%	5.4%	43.2%	17.9%
<b>Porcupine</b>	21.2%	2.2%	66.0%	13.3%
<b>Northwestern</b>	16.2%	3.4%	71.8%	17.0%
<b>Timiskaming</b>	24.0%	12.3%	57.9%	17.2%
<b>Algoma</b>	65.4%	10.0%	18.6%	19.6%
<b>Thunder Bay District</b>	39.7%	8.5%	44.2%	19.9%
<b>North Bay Parry Sound</b>	48.8%	2.0%	43.8%	19.2%
<b>Sudbury &amp; Districts</b>	54.8%	2.6%	36.9%	17.1%

Similar gaps in in primary health care capacity impact other program areas such as child health programming, sexual health programming, infectious disease programming, and rabies post-exposure prophylaxis.

Gaps in primary care can also increase rapidly with the closure of a single clinic or provider group. For example, in 2024, Sault Ste Marie experienced a dramatic announcement that 10,000 patients (8% of the entire health unit’s population) would be de-rostered from their primary healthcare provider due to one provider group having difficulty recruiting primary care providers to replace retirements. [12]

There is also a lack of specialists in the North. Ontario’s Health Care Experience Survey [9] shows that 65.2% of Ontarians must wait longer than 30 days for specialist care. However, that increases to 72.3% of residents in the North West LHIN and 73.8% of those in the North East LHIN. These specialist care gaps create particular challenges for public health follow-up. For example, in the follow-up and care of tuberculosis clients or syphilis infections, both of which have increased in incidence since the pandemic, most Northern communities do not have infectious disease specialists to oversee care, and primary care providers lack experience with these diseases. It falls on public health, who has some expertise from following all cases of these infections, to guide the health care system in care of such clients. This is not the norm in the rest of Ontario where greater clinical expertise exists.



## 4. Municipal Capacity

Just as local public health agencies struggle with the lack of economies of scale when delivering services to rural and remote populations, it should be observed that municipalities experience these same challenges with their services. Adding in the relatively lower economic opportunities in the North, Northern municipalities therefore have property tax bases that are very stretched. This makes it comparatively difficult for them to contribute to cost-shared funding of local public health. This should be considered in the obligation placed on municipalities in a new funding approach.

We believe all of the above make it more costly to deliver local public health in Northern Ontario, and that needs to be taken into account in the new funding approach.

We also wish to make a couple of comments on measures and metrics which may seem sensible to apply in the funding approach, but which have weaknesses when used for Northern geographies.

## Caution on Applying Measures in Northern Ontario

### 1. Census Undercounting of Indigenous Populations

It is known that many Indigenous people do not complete the Canadian Census, and so the Census's counts for Indigenous population are significant undercounts throughout Northern Ontario. [12]

For example, the Health Counts Kenora project (Our Health Counts - WNHAC) used a respondent driven sampling approach and demonstrated that 76.9% of Indigenous people in the City of Kenora did not complete the 2016 census [7]. Using a conservative approach, "the Canadian Census undercounts Indigenous adults and children living in Kenora by at least 2.6 to 4.0 times." The 2016 Canadian Census reports that 3,155 Indigenous people lived in the City of Kenora; the 2021 Census reported 3,595. Both Thunder Bay and Timmins have also conducted similar counts and found significant undercounts.

As a population known to experience disproportionate health inequities, it is important that any new funding approach factor in the undercount of Indigenous peoples in the Census, and that this undercount is of a population that deserves disproportionate public health resources invested to address their health inequities.

In particular, as a new funding approach attempts to account better for population growth over time, it needs to be addressed that Northern Ontario is seeing significant growth in populations not well captured by the Census, such as Indigenous, anabaptist, and newcomer populations.

## 2. Inapplicability of ON-Marg in low population areas

The Ontario Marginalization Index is based on analysis at the Census dissemination area. Unfortunately, for much of Northern Ontario, there isn't sufficient population to have data for dissemination areas. For example, in Northwestern health unit, of 229 constituent dissemination areas, 101 (44%) have no data. Therefore, these areas are ignored in ON-Marg calculations. These areas that are excluded from ON-Marg calculations have many First Nation communities with low socioeconomic status and high deprivation, and so their exclusion has the impact of skewing ON-Marg metrics for Northern Ontario to appear less marginalized than is the reality.

Where dissemination areas do have data, that data is not always reliable. For example, on First Nations communities, the Low Income Measure input to ON-Marg has a flag of caution on interpretation, which means that the material deprivation dimension of ON-Marg should similarly be used in caution when looking at First Nations communities. The Northern public health units share land with 107 of the 134 First Nation communities in Ontario.

We appreciate that designing a funding approach for a diverse and complex group of local public health agencies is no easy task.

At its core, our fundamental message is that if a funding approach is to truly advance health outcomes and health equity across the province, health equity must be foundational in its design, and not be simply a variable included amongst many others. Metrics like per capita funding are attractive for their simplicity and ease of understanding. But that clarity in fact masks the complexities of serving Ontarians who are not uniform statistical units, but who live within diverse social contexts defined by countless inequities. We seek a funding approach that delivers not *equal* per capital funding, but *equitable* per capital funding.

We thank you for the consideration of the issues raised in this letter as you undertake the challenge of developing an *equitable* funding approach.

We would be very pleased to meet in the near future to discuss our perspectives further, and how we can support your team as the funding review proceeds.

And we look forward to there being an opportunity to review a funding proposal in the coming months before a final version is submitted for government approval.

Sincerely,



[Lianne Catton \(Aug 21, 2024 09:39 EDT\)](#)

Lianne Catton  
Medical Officer of Health & CEO, Porcupine  
Health Unit



[Glenn Corneil \(Aug 19, 2024 08:59 EDT\)](#)

Glenn Corneil  
Acting Medical Officer of Health & CEO,  
Timiskaming Health Unit



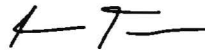
Janet DeMille  
Medical Officer of Health & CEO, Thunder  
Bay District Health Unit



M. Mustafa Hirji  
Acting Medical Officer of Health & CEO,  
Public Health Sudbury & Districts



Kit Ngan Young Hoon  
Medical Officer of Health, Northwestern  
Health Unit



[John Tuinema \(Aug 16, 2024 19:11 EDT\)](#)

John Tuinema  
Acting Medical Officer of Health & CEO,  
Algoma Public Health



[Carol Zimbalatti \(Aug 17, 2024 16:33 EDT\)](#)

Carol Zimbalatti  
Medical Officer of Health & EO, North Bay  
Parry Sound District Health Unit

CC:

Liz Walker, Executive Lead, Office of the Chief Medical Officer of Health  
Colleen Kiel, Director , Public Health Strategic Policy, Planning and Communications  
Branch  
Brent Feeney, Director , Accountability and Liaison Branch  
Fiona Kouyoumdjian, Associate Chief Medical Officer of Health  
Wajid Ahmed, Associate Chief Medical Officer of Health



## References

- [1] Innovation, Science and Economic Development Canada, "Evaluation of the Northern Ontario Development Program (canada.ca).," January 2022. [Online]. Available: <https://fednor.canada.ca/en/evaluation-northern-ontario-development-program>. [Accessed 28 July 2024].
- [2] Blue Sky Economic Growth Corporation, "Northern Ontario Broadband Report 2023 - Connected North," May 2023. [Online]. Available: <https://connectednorth.ca/northern-ontario-broadband-report-2023/>. [Accessed 26 July 2024].
- [3] Ministry of Indigenous Relations and Reconciliation, "Indigenous peoples in Ontario | In the Spirit of Reconciliation: Ministry of Indigenous Relations and Reconciliation's first 10 years | ontario.ca," 29 March 2018. [Online]. Available: <https://www.ontario.ca/document/spirit-reconciliation-ministry-indigenous-relations-and-reconciliation-first-10-years>. [Accessed 2 May 2022].
- [4] Ministry of Finance, "2019 Ontario Economic Outlook and Fiscal Review | Economic Data Tables," 6 November 2019. [Online]. Available: <https://budget.ontario.ca/2019/fallstatement/ecotables.html#t2>. [Accessed 26 July 2024].
- [5] Public Health Ontario, "Potentially Avoidable Mortality Health Equity Snapshot," [Online]. Available: <https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Avoidable-Mortality-Health-Inequities>. [Accessed 29 July 2024].
- [6] Statistics Canada, *2021 Census*..
- [7] M. H. D. L. Kit Young Hoon, *Considerations for the funding formula for local health units*, Northwestern Health Unit Briefing Note, July 5, 2024.
- [8] Government Services in French. Ministry of Francophone Affairs, "Map highlighting the French Designated Areas in Ontario," 31 May 2024. [Online]. Available: [https://files.ontario.ca/ofa\\_designated\\_areas\\_map\\_en.pdf](https://files.ontario.ca/ofa_designated_areas_map_en.pdf). [Accessed 25 July 2024].
- [9] Ontario Health, "Health Care Experience Survey—Full Report," 31 December 2019. [Online]. Available: Ministry of Health Visual Analytics Hub. [Accessed 7 August 2024].
- [10] Ministry of Health, *COVID-19 Vaccination Program: Weekly Report*, 2024.
- [11] Ministry of Health, *COVID-19 Vaccination Program: Weekly Report*, 2024.
- [12] "Community Update Regarding Primary Care. Group Health Centre.," 25 January 2024. [Online]. Available: <https://ghc.on.ca/featured/community-update-regarding-primary-care-2/>. [Accessed 9 August 2024].
- [13] "Indigenous people in Toronto badly undercounted by census, but experts hopeful for change | CBC News," 30 September 2022.
- [14] Funding Review Working Group, "Public Health Funding Model for Mandatory Program: The Final



Report of the Funding Review Working Group," Ministry of Health, 2013.

[15] Statistics Canada, "Price Trends: 2014 to Today," [Online]. Available: <https://www150.statcan.gc.ca/n1/pub/71-607-x/2018016/cpilg-ipcgl-eng.htm>. [Accessed 14 August 2024].