CUPE / OMECC SUBMISSION TO MOHLTC ON PUBLIC HEALTH MODERNIZATION

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CUPE·SCFP Canadian Union of Public Employees
Syndicat canadien de la fonction publique

INTRODUCTION

Our submission regarding this proposed restructuring is sent to you while we are all coping with the COVID-19 pandemic in Ontario. In light of all this entails for public health workers, our first position on the proposed restructuring is that you should not be proceeding with any overhaul to the administration or funding model for public health.

The pandemic highlights all the breaking points in the system: public health workers and paramedics operating without the personal protective equipment (PPE) we need, mass diagnoses of our public health members that then create staff shortages, skyrocketing call volume, and job-related illness and injury.

Through it all, CUPE members continue to report to work and deliver this vital public service. The idea that this restructuring is proceeding apace behind the scenes when no one has the ability to fully evaluate options makes no sense to us. All the consultations were cancelled (appropriately) in light of the pandemic. We ask that you hit pause on this entire process while the whole province is working together to stop the pandemic, and that we then come together at some time in the future to re-evaluate how to consult properly, and whether or not this proposed restructuring should even be taking place.

The need for the province to send increased funding to public health units to help us cope with the pandemic is in itself telling: it indicates that the cuts you introduced to the funding model in January 2020 do not equip us to deliver services properly. These cuts should be reversed. The COVID-19 crisis has made it clearer than ever that the services delivered by public health units must be properly and consistently funded. There will be time for collective post-mortems when the global pandemic recedes, and we'd wager that no one will suggest that cuts to funding will help anyone prepare for, prevent, or cope with a future pandemic.

We hope you will consider our submission, largely prepared in advance of the COVID outbreak, in light of our overarching view that the entire restructuring process should be completely halted until the global pandemic has receded, and until we have had a chance to collectively make plans for how best to meaningfully consult going forward.

The Ministry of Health is conducting a consultation on public health modernization in the midst of a global public health crisis. This crisis underscores the importance of robust preventive public health interventions to mitigate risk. The COVID-19 pandemic is a stark reminder of the importance of strong health systems, and, in particular, strong public health systems.

Even prior to the pandemic, the Ontario health system was under duress. Numerous reports have highlighted the dire lack of resources in health care, depicting a system that cannot keep up with the rising volume and changing nature of health needs of Ontarians. Overcrowded hospitals, overflowing emergency services, hallway health care, and reduced services in rural and smaller urban areas are testing the limits of the system. The lack of capacity in Ontario's health care and hospital systems raise real questions about the ability of Ontario to weather a pandemic and put even more responsibility on public health.

Over the last 20 years, public health funding has been in decline, cutting services to the bone and putting Ontarians at risk. At this critical time, it is imperative that the Ontario Government reverse the cuts and reinvest in the services that communities need. This is not a time for cutting more corners, searching for fictitious efficiencies, or further reducing the overstretched resources in public health.

The Canadian Union for Public Employees (CUPE) in Ontario and the Ontario Municipal Employees Coordinating Committee (OMECC) are committed to ensuring quality and adequate public health services for communities across the province. CUPE is the largest union in both Ontario and Canada by a considerable margin. We represent working people in almost every city, town, village and unorganized territory. We are also the largest municipal workers and health care workers union in Ontario.

CUPE represents over 5,000 workers in the public health sector in 25 of the 34 public health units in Ontario. Our members understand the entire range of public health roles, challenges and opportunities. We represent Public Health Inspectors (PHI), Dental Hygienists, Health Promoters, Registered Practical Nurses (RPN), Registered Nurses (RN), Tobacco Enforcement Officers, Nutritionists, Epidemiologists and Administrative Assistants. CUPE members are also active in our communities, and we are key advocates for stronger and healthier communities on the public health and other issues. Through our work as front-line service providers, and through our community engagement, CUPE members are keenly aware that public health services, and health care services more generally, are not keeping up with the growing population and changing demographics in Ontario. There is an urgent need for more and better investments in the public health sector in order to ensure vibrant communities and to safeguard against public health risks.

Given that CUPE represents a majority of unionized employees in the Public Health sector in Ontario, we have a keen interest in the consultation process that the Ministry of Health (MOH) has launched on public health modernization. This submission is presented on behalf of the public health front-line workers that are affiliated to CUPE.

The submission was put together through the work of a public health sub-committee and inputs were solicited from representatives of all the public health units where CUPE has members.

While we welcome the stated objective of the consultation process, and in particular the expressed desire to start with a “blank slate” and do a “reset” of the troubling and unhelpful policy announcements related to public health that the current provincial government floated in 2019.We are concerned that the consultation discussion paper and questions omit some key aspects without which no serious discussion of the modernization of public health can take place. This submission therefore emphasizes those missing pieces, which we consider essential to the discussion.

First and foremost, it is clear that in order to improve public health in the province, increased investments are urgently needed. These investments have to cover both infrastructure and human resources. At present, public health resources are stretched beyond any acceptable level. More than any misalignment, duplication, or inconsistency in the system, the lack of sufficient resources to fully deliver on the public health standards as mandated by law, are the core challenge that needs tackling.

Instead of increasing resources, the province has recently downgraded its contribution to municipal budgets for the delivery of public health and other services (from 75% to 70% and in some cases from 100% to 70%). Though the discussion paper does refer to insufficient capacity as a first area of concern, it focuses solely on the varied capacity among public health units and not on the generalized issue of lack of sufficient resources across the board. Municipal budgets are constrained and more of the burden for funding critical public health services is being downloaded onto them. It has been established again and again that there is not much fat in municipal budgets, that they already overdeliver and outperform other levels of government. Making cuts, instead of increasing budgets, for public health services makes limited sense.

Second, the discussion paper misses another important mark by not discussing the need for greater public education on the benefits of public health. The case for public health, and the critical role it plays in avoiding or greatly diminishing downstream health costs, is not understood well by the public and by decision makers. For every dollar spent on public health there are considerable savings for the health system and for society overall. Public health interventions, and in particular preventive interventions, are highly cost-effective and have a positive impact, not only on the health system, but also more broadly within society, including on the economy. A study in the UK that analyzed different public health interventions concluded that the median rate of return for public health investments is 14.3 to 1 while the median cost-benefit ratio is 8.3.[1]

[1] https://jech.bmj.com/content/71/8/827

The preventive nature of public health services is a crucial component of a healthy and resilient community. In order for proper resources to be allocated to public health, education on the merits and benefits of public health is essential.

Third, the governance structure and accountabilities for the delivery of public health services are not considered as key elements of the system in the discussion paper. We strongly believe that the decisions on public services must remain as close to communities as possible. There are some advantages that can be derived from coordination across Public Health Units, specific health programs and priorities need to be tailored to the particular needs of the communities across the province. And communities vary significantly – in size, in resources, in demographics, in population, etc. Decisions about public health must remain close to the ground, and therefore any discussions about amalgamating or merging public health units must consider first any adverse effects on the governance and accountability mechanisms to the communities. Democratic control and public accountability are a major strength of municipal government, including in the area of public health. Weakening that role will not be beneficial to local communities.

Fourth, the question of modernizing the public health standards themselves is not given the attention it needs in the MOHLTC discussion paper. This is the aspect of public health that would most benefit from a “modernization” process. The current standards are outdated and do not address some of the current thinking, evidence or emerging challenges. This needs to be addressed in priority to ensure that our communities continue to be safe and resilient. Recent developments with COVID-19 indicate the importance of this point. Ontario, like many jurisdictions, has been caught unprepared for this pandemic – insufficient ventilators, “expired” and destroyed N95 masks, insufficient protective equipment, etc.

Finally, the question of privatization is not openly addressed in the discussion paper, even though there is ample evidence that stakeholders in the municipal and public health sectors are actively contemplating how to divert the delivery of public services to private actors. We want to be clear that CUPE and OMECC will oppose any and all attempts to privatize the funding or delivery of municipal services, including contracting out elements of these services to profit or not-for-profit companies. Public services must be funded and delivered by public sources. Anything else is privatization and will end up being costlier, less efficient, and less accountable, to the citizens that receive and require the services.

In order to address these and other critical issues in public health moving forward, CUPE and OMECC believe that mechanisms should be put in place by the MOH that include front-line workers to craft solutions, and find new and better ways of delivering public health services in communities. Front-line workers are the ones who live in the communities in question and, through their contact with residents and the exercise of their professional duties, intimately understand what works, what does not work and what is needed.

This submission expands on each of these key issues which are critical in our perspective to address the growing problems of hallway health care and ensuring quality health care for Ontarians.

CUPE'S DIAGNOSIS OF KEY CHALLENGES AND OPPORTUNITIES IN PUBLIC HEALTH

As introduced above, CUPE members working in the public health sector concur that the main challenge faced by the sector is one of grossly inadequate funding. They report that there is probably no public health unit in Ontario today that has the resources required to fully meet the standards. So, the chronic under resourcing of the sector is felt across urban and rural, small and large, and irrespective of the governance model in place. It is presenting a serious accountability issue for the different levels of government beholden to the statutory obligations as spelled out by the Ontario Health Promotion and Protection Act.

The crunch is felt most severely at the staffing level. Public health units are constantly adding more responsibilities on the staff without additional resources. Gapping, job cuts, and replacement of senior professionals by less experienced ones, has resulted in a system with excessive sick leave, long-term disability and overtime. This has negative impact on the well-being of the staff, creating a health and safety risk. The sector consequently has a high number of grievances and arbitration cases at any given time.

Public health workers are stretched beyond thin. And an absence of proper retirement and succession planning is resulting in a brain drain, as some of the more experiences public health workers retire. Wages in public health are lower than in other comparable sectors, requiring an urgent modernization of salaries and benefits for the sector. Need to put the right people to do the work needed.

Programs are often cut or downloaded to the municipal level. Some services are being privatized or provided by other partners of the health system, often at a cost (for example vaccines, breastfeeding, parenting).

At the Public Health Leadership Forum organized by OMECC in January of 2020, participants from public health units from across the province were invited to reflect on the issues and solutions for public health in Ontario.

The three issues that emerged most consistently were:

a) The severe underfunding of the public health system in Ontario which is stretched to the limit. Re-investment is urgently needed – not further cuts, amalgamations or privatization;

b) There are no one size fits all solutions and it is not helpful to try to paint everything with the same brush. It is therefore of utmost importance that public health remains responsive and connected to local communities; and

c) Front-line workers are the best positioned to identify solutions for emerging public health challenges and to advocate on behalf of the marginalized population groups that are an important group of users of public health services. Public health workers must be at the center of any consultations and modernization efforts moving forward.

More specifically, on the key issues limiting the delivery of quality public health services, public health workers identified the following:

- Decreasing front-line staff including, elimination of front-line positions in branch offices.
- Gapping positions (cutting phone line coverage, not replacing positions when maternity leaves and retirements happen).
- Increased workload has psychological impacts, and health and safety concerns.
- Not enough staffing to meet community needs.
- Lack of adequate funding.
- Outsourcing programs and service delivery.
- Inadequate funding to address the social determinants of health for the most vulnerable.
- Local delivery of culturally sensitive programming, and specifically to local immigrant populations that often do not have OHIP coverage, is not adequately funded.

- Upheaval and uncertainty are creating chaos between members and locals.
- Lack of or limited marketing of public health programs — including social-media marketing.

The solutions that were put forward for these key challenges include the following:

- Increase front-line staff complement.
- Fill job vacancies.
- Develop a strategy for staff retention.
- Management heavy – needs outside the box solution.
- Increase and stabilize funding.
- Stop adding layers of management.
- Engage front-line staff in modernization committee discussions.
- Providing proper funding to educate public on value of PHU services and availability.
- Need to deliver services locally based on municipal priorities.
- No privatization – keep services public. Warn against impact of privatization of PH services and quality of health services. Impact on the health of public will be negative.
- Utilize, where appropriate, centralized campaigns instead of every health unit designing separate literature with the exact same message.

REACTION TO DISCUSSION PAPER CHALLENGES AND QUESTIONS

Some of the challenges identified in the discussion paper are correct, but the solutions proposed are not. Mergers and amalgamations will not effectively address any of the issues highlighted. There is ample experience in Ontario, with the municipal mergers and others, to show that mergers and amalgamations result in weaker governance and accountability to the communities, greater costs and poorer quality services.

The last PC government of the 1990s also engaged in restructuring on a scale comparable to the scale made possible by this legislation. PC government privatized home care, shut or merged scores of hospitals, moved chronic care hospital services to less well publicly funded (and often privatized) long-term care facilities, and cut hospital funding by hundreds of millions of dollars. Their goal was to move services out of hospitals and into home and "community" care.

The Auditor General revealed however, that the mergers and hospital restructuring actually cost the province $3.2 billion dollars. Despite hopes that these mergers would help them cut spending, the Harris government quietly recognised reality, starting in

1998. By 2000, they silently completed a U-turn on hospital funding, increasing funding 12.6% in one year.

Between 1998 and 2003 (when the PC government was defeated), funding increased on average 7.5% per year. The Health Services Restructuring Commission completed its work and shut down in March 2000. So, arguably, the fruits of its work might be expected to have been gained in the five following years (including the first full year of Liberal governance). But funding increases averaged 8.7% for the 2000-2004 period. This, needless to say, is not strong evidence that the mergers, closures and restructuring did anything to reduce costs.

Provincial Hospital Funding Annual Percentage Increase (or Decrease):

1995	**-1.5**
1996	1.9
1997	-4.8
1998	5.2
1999	6.1
2000	12.6
2001	3.1
2002	8.4
2003	9.7
2004	9.6

Source: CIHI National Health Expenditure Trends, Table D.4.6.1

Another round of restructuring began in 2007 with the creation of fourteen Local Health Integration Networks (LHINs) to fund, oversee and restructure hospital, long-term care, and other health care services. Again, the hope was to cut hospital capacity and solve the ensuing problems through home and community care. This time, however, the cuts expanded to include tight restrictions on long-term care, further compounding the dramatic increase in the acuity of home care patients and leading to the removal of some patients from publicly funded home care. The ultimate result is the lack of capacity that is now widely acknowledged.

More recently, Community Care Access Centres were merged with LHINs in the last few years. However, since the new government was established a year and a half ago, the LHINs themselves are being dismantled, Ontario Health is being established with their own teams being established. Each successive round of restructuring was sold as

the saviour of health care, even when independent sources suggest otherwise. So, scepticism is well deserved when the suggestion of still more restructuring is mooted.

Mergers and amalgamations also open the door for privatization which further increases costs, reduces accountability of elected leaders, and reduces quality of services. And very importantly, mergers and amalgamations can have severe impacts on unionized staff, affecting the benefits, conditions and forcing unionized workers to merge unions and negotiate harmonization of conditions. This has proven to be a very destabilizing and stressful process for staff in previous mergers, which will negatively impact the focus and delivery of quality public health services for Ontarians. The mergers that CUPE has been involved with in public health have consumed significant time and resources.

Case study of Southwestern Public Health: Mergers put workers and public services at risk!

On November 10, 2017, the Elgin St. Thomas Board of Health and Oxford County Board of Health announced the merger of their public health units. The new amalgamated unit—Southwestern Public Health—operationalized in May 2018 to serve approximately 204,000 people in Oxford County, Elgin County and the City of St. Thomas.

The Boards promoted the merger as an opportunity to increase efficiency of health programs and services by pooling resources. But CUPE members in Southwestern Public Health have reported the opposite effect: job losses, understaffing, confusion for the public, and cuts in programs and services for small rural communities.

As one CUPE member explains, "*It felt like more of a takeover than an amicable merger. We experienced a huge turnover of staff in the entity we merged with and our new contract was not favourable. I do not recommend any more mergers or amalgamations—smaller communities will be underserved. The intention of this merger was to maintain the rural voice, and I don't think that has been maintained."*

The experience of Southwestern Public Health proves that mergers and amalgamations have severe impacts on public health workers and the delivery of quality public health services for Ontarians.

The challenges identified in the discussion paper for this consultation can be solved with greater investments in public health and in the health system more broadly, by strengthening rather than weakening local decision-making, by promoting local partnerships and collaboration, by better aligning staff responsibilities, and by promoting and funding a social equity. Some adjustments are needed, as detailed below, but not major changes as suggested in the discussion paper.

We concur fully that there is insufficient capacity in public health at this time, and that this puts everyone at risk. But this is not because public health workers are not doing their job or are doing it wrong. On the contrary, they are going beyond the call of duty at the peril of their own health and security. Capacity deficits need to be addressed with greater investments in the sector – more professional staff, more technical and other resources, and less management. The system has become increasingly top heavy, with more management and coordination roles being created at the expense of front-line jobs. This is not serving the public well and needs to stop. The austerity mindset that has reigned in government has also led to managers to demand more from less resources. The constant threat of cuts can lead to great inefficiencies, as some workers might be forced to do jobs they are overqualified for in order not to lose their jobs. In addition, enhancing program teams has the added benefit of enhancing surge capacity, for dealing with public health crisis like the one we are currently experiencing with the coronavirus, opioid crisis, or other challenge.

On the issue of misalignment of health, social and other services, again we agree that this is a problem in the sector, but the solution is far from being amalgamation or mergers. Partnerships at the local level needs to be supported to address this issue. Multi-sectoral teams need to work better together, and that is best done at the local level, where different teams can actually be housed in the same buildings and work side by side in their communities. Another important element to address this are funding models and agreements. At present, the only sector required as per its funding agreements to collaborate with other sectors is public health. And it does try, but this is made difficult by the reality that the other sectors do not have this same requirement.

On duplication of effort, we agree there are some areas where some degree of centralization could be beneficial and avoid waste. The most obvious is for health promotion programs of general interest, such as smoking, coronavirus, measles. Centralized campaign materials would avoid duplication and enhance efficiency across the system. Otherwise, instead of centralizing through mergers and amalgamations, public health units should be encouraged and supported to share resources and services, with neighbouring units. Cost sharing in this fashion, as a win-win solution, could result in lack of duplication and increased efficiency.

Where we have a different understanding than what the discussion paper suggests is on inconsistent priority setting. We believe that different priority setting is a direct result of the fact that different communities will have different priorities based on their particular circumstances: size, urban or rural, north or south, age of the population, cultural composition, etc. There is no cookie-cutter for public health priorities, and in allowing local municipalities to make decisions and set priorities based on a keen understanding of their population's circumstances and needs. This is a good thing.

CONCLUSIONS

The capacity of public health has to be expanded. The main way to do that is through increasing resources. Mergers and amalgamations are not a panacea and may well make the situation worse. Privatization is also a non-solution. We do need better public education on the role and value of public health. We do need to foster cooperation between different public health units. Finally, as the COVID-19 pandemic shows, we do need to update and raise our public health standards.

On the lack of participation of front-line workers and unions in the consultation process, we want to underscore that, despite Mr. Jim Pine's initial comments on the importance of consulting front-line workers in priority during this process, we have seen that in reality it has been very challenging for our members to become involved in this process. Compare the hours spent with management, at any given visit, and the limited time provided workers, if any. The initial commitment to meet with front-line workers organized by CUPE and other unions, which was then limited to only a few sessions and webinars instead.

Though some municipalities have taken it upon themselves to reach out to front-line workers and include them in their process of presenting submissions for the consultation, meaningful engagement has been the exception and not the rule. There is often mistrust between management and workers. CUPE members feel that in general management is going to focus its response to the consultation process equating efficiencies to cuts, thinking quantitatively and not qualitatively. Front-line workers are the best equipped to focus on what works best, on what communities really need, on what is missing. They are also, as expressed above, the ones that are in daily contact with marginalized and vulnerable populations that depend on public health services for their wellbeing and survival. These end users are voiceless in a process like this one, unless their interests can be voiced by front-line workers.

Also, important to repeat that the apparent mistrust of unions in this context is detrimental to the process. Unions will of course defend the wellbeing of their members, but a union like CUPE is at its core an advocate for the public good. CUPE represents the largest number of front-line workers in the public health service, and as such is an important and legitimate actor in this process.

Finally, we would like to reiterate our concern with the announcement that no formal report will be tabled as a result of this public consultation. We anticipate that by the end of the process, thousands of managers, workers, counsellors, and private citizens will have been mobilized to participate in the consultation process and share their views.

Hundreds of formal submissions, including this one, will have been received. We expect, as a matter of fundamental accountability and good governance, that a formal and public report will be produced that will report both what was heard through this process and what recommended to government.