CUPE Public Health Survey April 2023

1590 Responses

1014 Full responses

576 Incomplete Responses

Introduction

The effect of the COVID-19 pandemic on CUPE public health workers has been profound. Delegates to the 2020 Ontario Municipal Coordinating Committee (OMECC) Conference reported excessive workloads, greater than usual health and safety hazards, difficult redeployments, heightened stress, decreased mental health and declining workplace morale. As a women-dominated workforce, delegates also described the stress of disproportionate responsibilities for child and elder care, helping children to adapt to online learning, working multiple jobs as sole income earners, and feeling their work was devalued compared to other health care professionals.

Members had faced intense challenges prior to the pandemic: chronic underfunding, lower wages compared to other health care jobs, chronic problems with recruitment and retention, and the on-going threat of privatization and forced mergers and amalgamations. The pandemic brought short-term funding into the sector and halted provincial merger and amalgamation discussions. Yet it was clear to delegates in 2022 that these changes were temporary, and that it was necessary to prepare for the bargaining and policy challenges that were to come after COVID.

To prepare, OMECC committed to conducting a sector wide survey with objectives of:

- Identifying the key challenges facing public health members – both personal and sector wide;
- Providing recommended sector-wide actions for CUPE to meet the challenges ahead.

In January 2023, OMECC provided support to conduct a sector wide survey. Between January and April 2023, a public health inspector and local union president worked closely with the municipal researcher, communications representative, and others on the Municipal Sector Team to design and promote the online survey, analyze results, and prepare the report for presentation at the OMECC conference on April 11, 2023. This report is presented to the 2023 OMECC Conference Public Health Caucus for discussion and feedback.

Survey Design

The survey was designed by the OMECC survey project coordinator and the CUPE municipal researcher, with input from the municipal sector team.

The first section provides demographic information including location of work and job classification, current work status, gender, marital status, and membership in equity-seeking groups.

The second section of the survey focuses on respondents' economic and mental well-being, job satisfaction and morale, with specific emphasis placed on their experience of the COVID-19 pandemic. The first two questions about the impact of wages falling behind inflation on workers' families and the multiple consequences of income precarity were based on the Ontario School Board Council of Unions (OSBCU) 2019 survey of their members. Other questions were formulated using the CUPE/OMECC 2020 Submission to Ministry of Health and Long-Term Care on Public Health Modernization[i], as well as various literature concerning health workers' response to COVID-19.

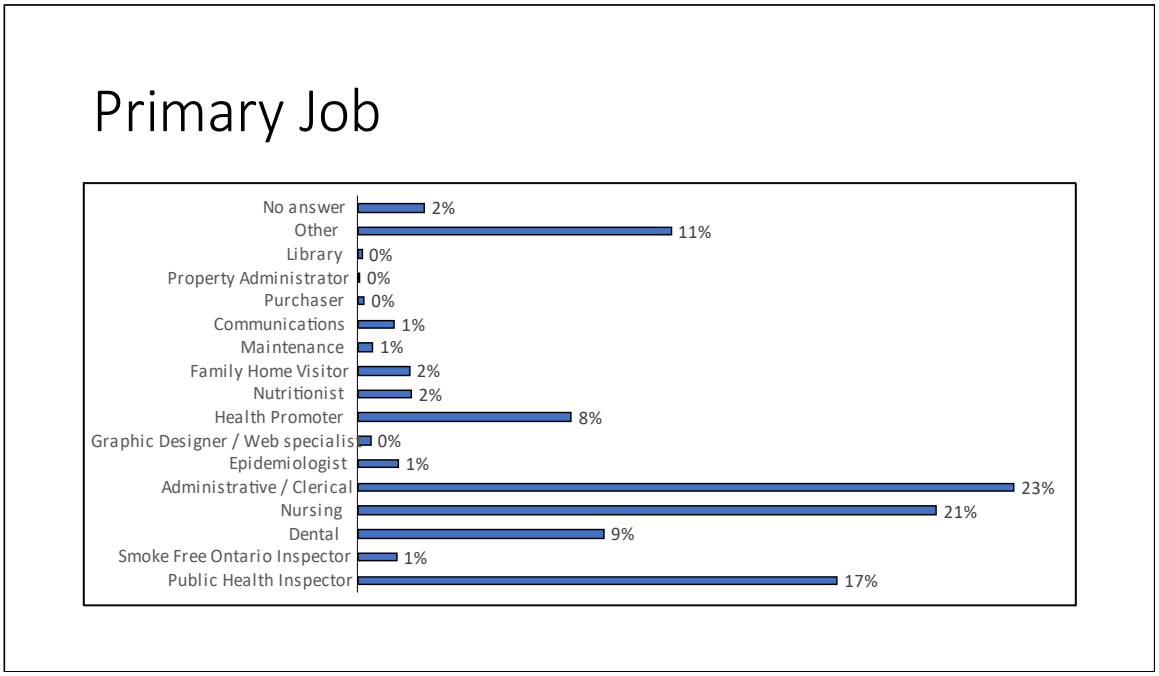
The final section of the survey focuses on key challenges in the sector, asking respondents to rate the importance of each of these challenges as well as to rank them in order of priority. Lastly, respondents rank the key priorities for union action.

Response Rate

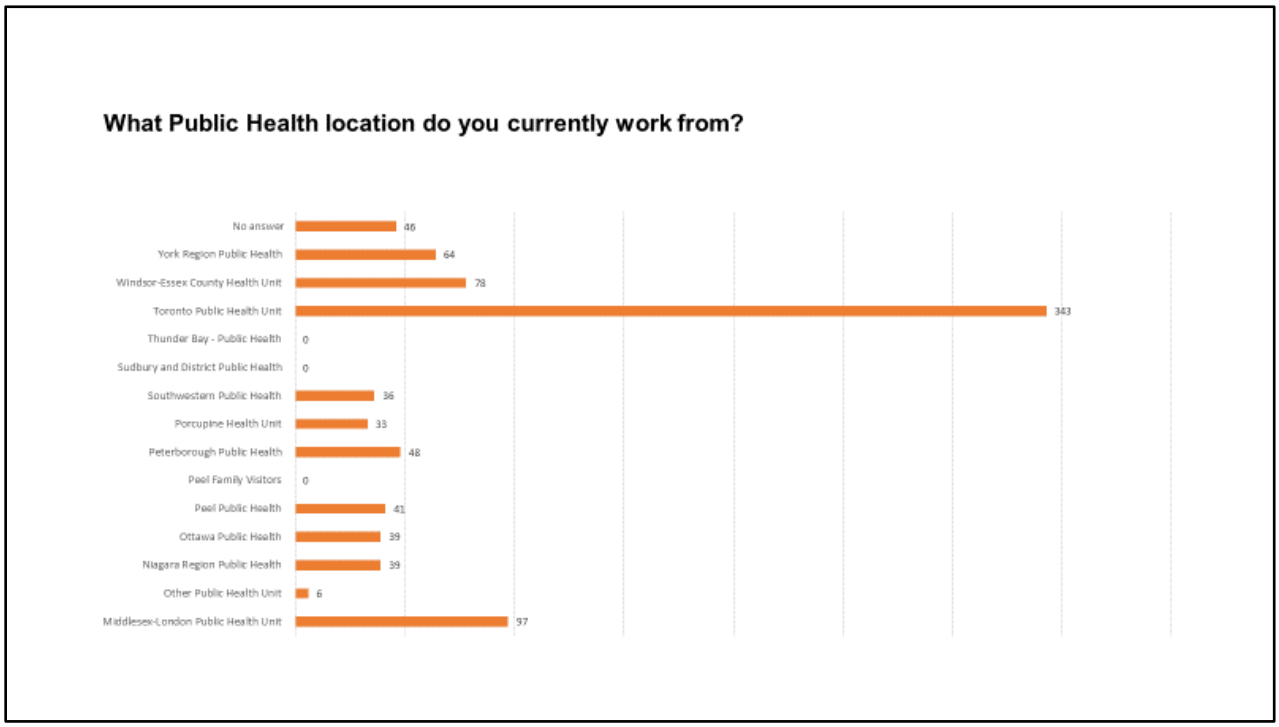
The survey was hosted by CUPE National on Lime Survey using an open link, and sent to local union presidents and national staff representatives. There were 1,590 total responses, 1,014 complete responses, and 526 partial responses.

SECTION ONE: DEMOGRAPHICS

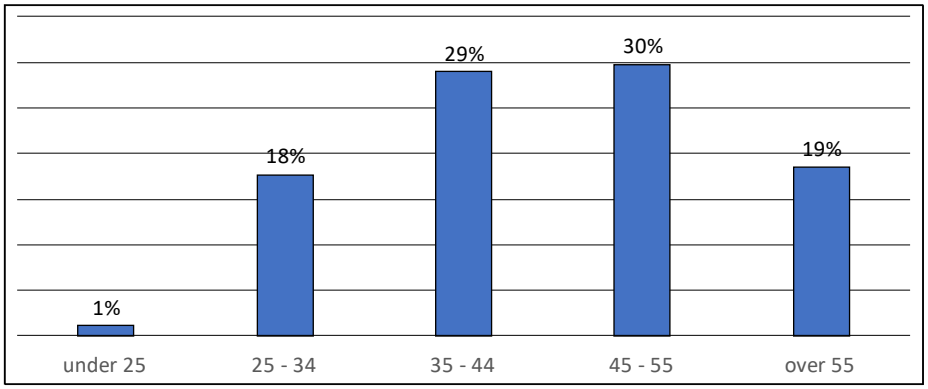
In any effort to be inclusive, jobs were grouped in broad classifications.



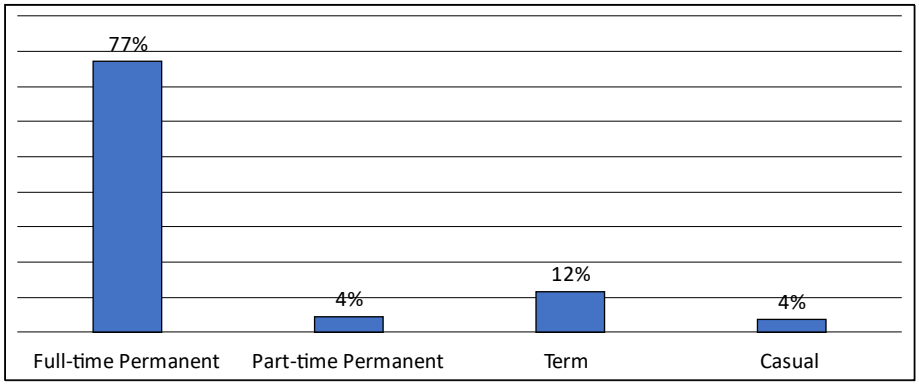
The health unit rather than local union number was chosen as it was felt some members might not know the latter.



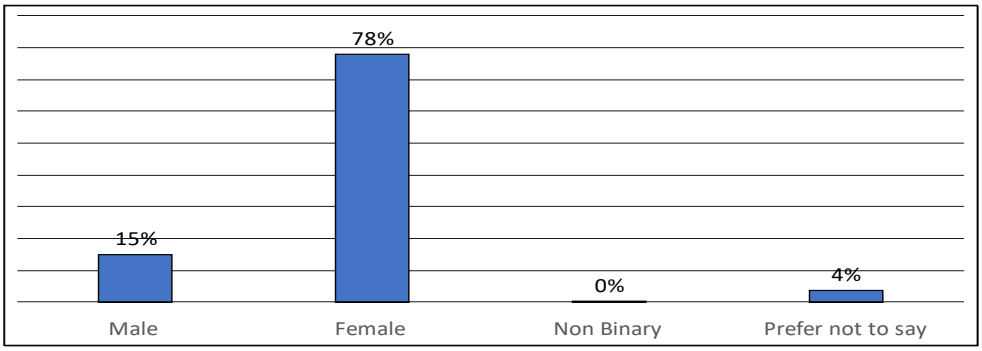
Age



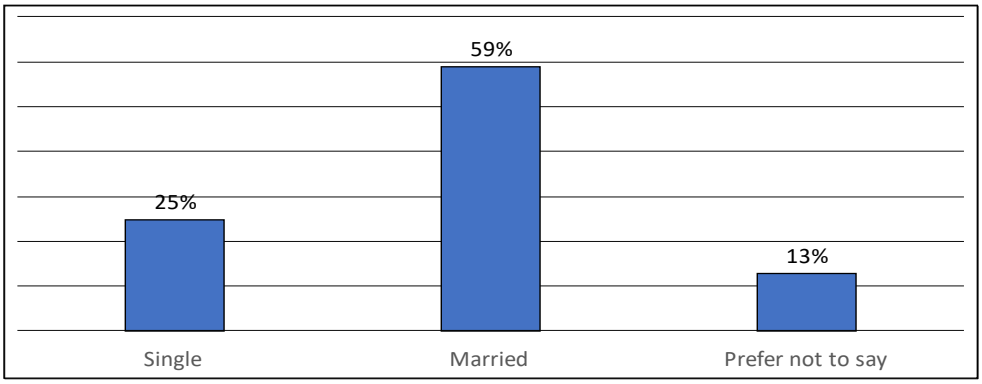
Current work status



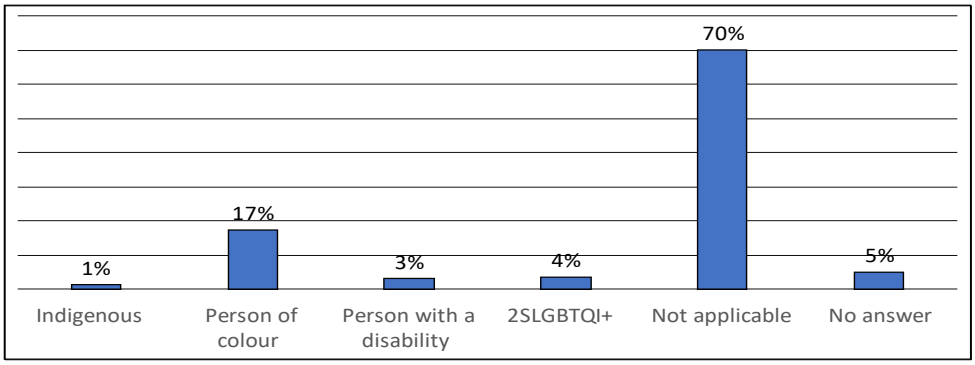
Gender



Marital Status



Member of Equity seeking groups



SECTION TWO: ECONOMIC AND MENTAL WELL-BEING, JOB SATISFACTION AND MORALE

Wages, Income and Household Finances

The 2019 OSBCU survey questions provided a valuable template to gain insight into the economic insecurity facing public health workers. Over one-third reported being unable to afford new essentials, while two-thirds felt stress or anxiety about being able to afford everything they needed. Twenty-two per cent reported taking an extra job and 75% worried an unexpected event would cause economic hardship. Almost 80% reported some or great difficulty meeting their family's financial needs. Members are acutely aware of the impact of inflation, with one survey respondent commenting, *"*We have lost at least 20% wages over the last 10 years due to not matching with inflation." Another remarked, *"*Wage levels and increases are not keeping pace with inflation and fighting for adequate wage increases should be CUPE's focus. The current state of wages in public health contributes [to] both the feminization and revitalization of poverty since public health is heavily populated by women and increasingly by people (women) of colour."

In 2020, both CUPE and the Association of Municipalities of Ontario (AMO)[ii] identified underfunding as a major issue in the sector. It is also a leading contributor to CUPE's ongoing fight to negotiate better wages and benefits, improve working conditions and fight for higher staffing levels, create reasonable workloads, better health and safety conditions, protect against contracting out, privatization and forced amalgamations and mergers, and more. Currently, the provincial government funds only 70% of public health care budgets, leaving cash-strapped municipalities to pay the remainder. Bill 23, the recent legislation exempting developers from fees when building "affordable" housing will further strain municipal budgets.

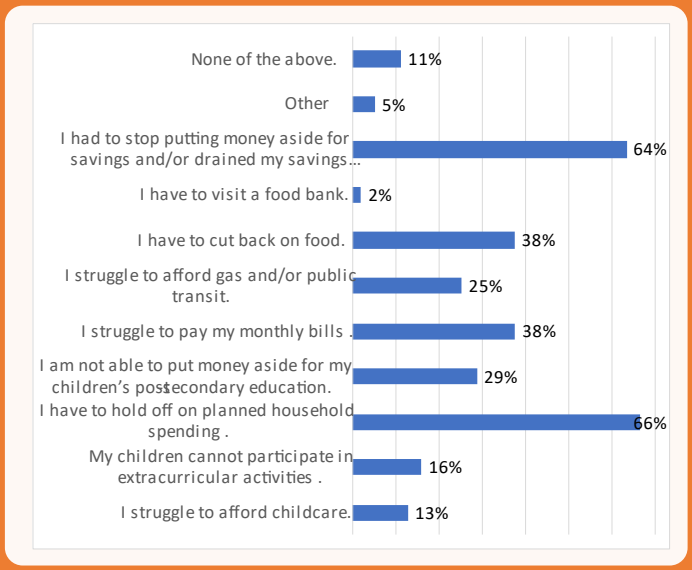
Citing a survey of its 34 member agencies the Association of Public Health Agencies (APHA)[iii] states that the current $47 million funding envelope is wholly "insufficient to meet the provincially mandated standards… in the coming years**, including collective agreements**, substantially increased inflationary pressures, the additional demands of the COVID-19 response, and the backlog of programs and services that has built up over nearly three full calendar years." To meet Ontario Public Health Standards would require an increase of 11.8% or $132 million – merely 0.2% of the Ministry of Health and Long-Term Care overall budget.

In its recent pre-budget submission APHA called on the provincial government to revert to the oringal funding formula:

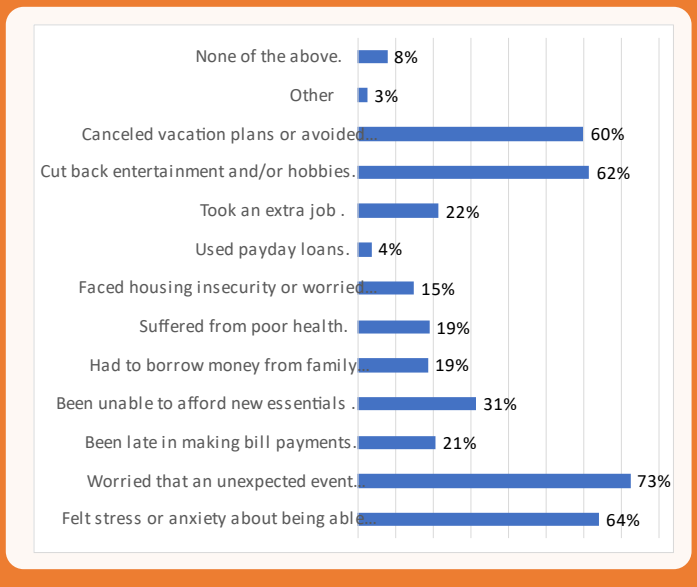
"Changing the funding formula for public health will result in no net savings for the Ontario taxpayer but cause a disproportionate hardship for Ontario's municipalities. The

provincial government has already recognized this by providing mitigation funding to offset this burden, so we reiterate our call to immediately revert to the 75- 25% provincial-municipal public health cost-sharing formula, along with a pledge to continue 100% funding for programs that have been traditionally underwritten by the province."

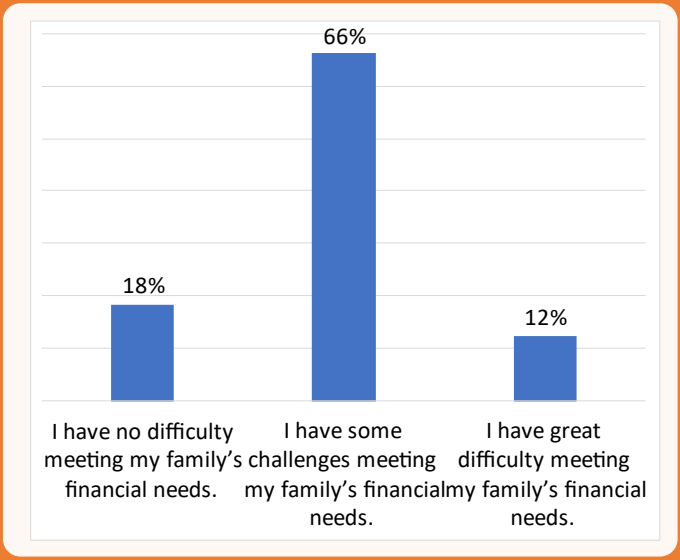
Wages have not kept up with inflation. What has this meant for you and your family?



Because of my income I have:

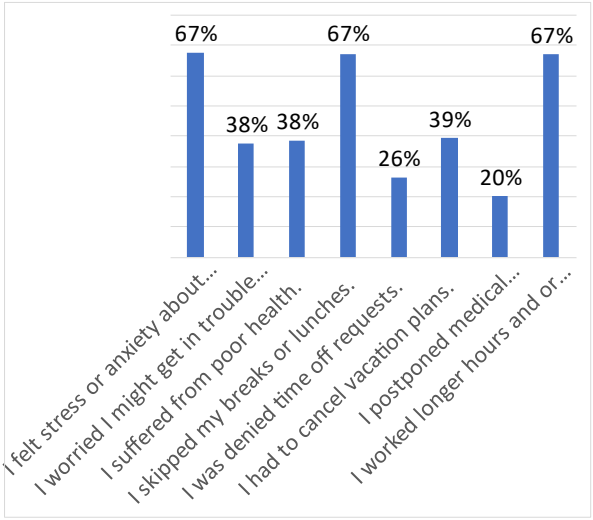


What statement best describes your household financial situation:



Experiences During COVID

During COVID because of my workload:



Workload

In January 2020 OMECC held a Public Health Leadership Forum where key issues were identified including workload. A major factor contributing to workload was the growing inability of employers to recruit and retain staff, leading to job gapping. Workload increases also resulted from new, less experienced staff replacing those who had quit or retired. Excessive workload also led to sick time and long-term disability.

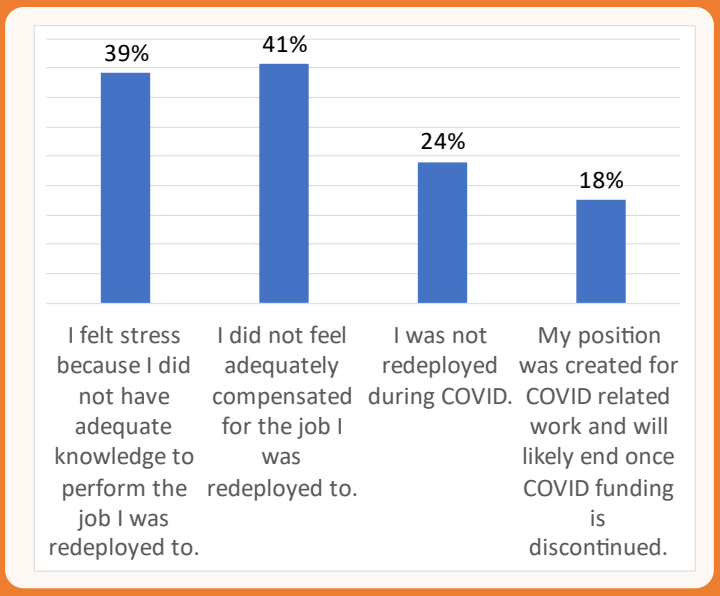
However, the survey asked respondents to specifically address workload during COVID-19. It was clear from information reported to the union that workload had increased dramatically during the pandemic due to added responsibilities such as redeployments, vaccine clinics, and other emergency measures. Members worked longer daily hours and weekends. Redeployments also added to workloads as members struggled to learn on the job, often with little or training or support from managers.

Over 65% of respondents reported feeling stress about inability to complete work, skipped breaks or lunch, and working longer hours or working on weekends. Almost 40% suffered from poor health, had to cancel vacation plans, or worried that they would "get in trouble" for not completing work. Twenty-six per cent were denied time-off requests.

Speaking of workload, one member noted, "Working in Communications during the pandemic felt like a 24hr operation. And often, it was. The workload was so heavy that I couldn't take important appointments towards the end of my pregnancy. In a time were

focusing on my own mental and physical health, and the health of my unborn child – I couldn't. I missed so many bedtimes and morning routines with my two young children at home because I would be staying late and coming into work early. The emergent response needed all hands-on deck but there weren't enough hands. My mental health was forever changed from working in public health during the COVID-19 pandemic."

During COVID because of my redeployment



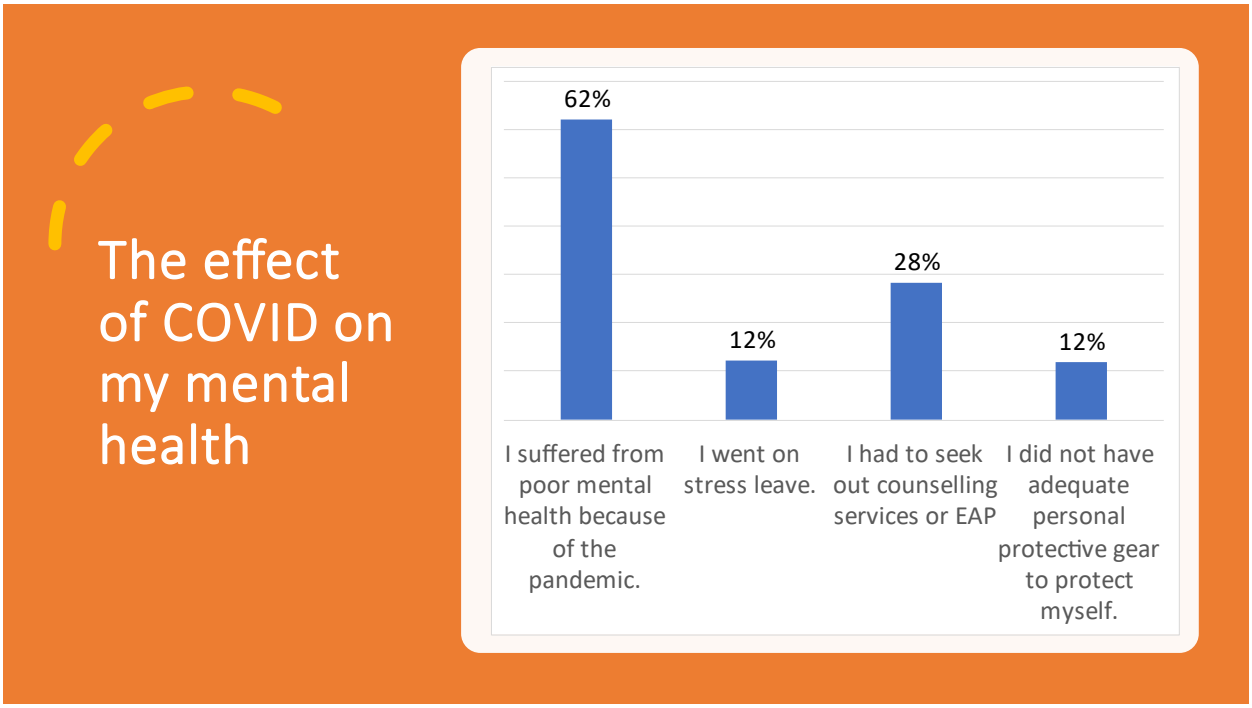
Redeployment

Members were redeployed to other jobs during COVID. Forty per cent of respondents who were redeployed did not feel they had adequate knowledge to perform the job they were sent to, and did not feel they were adequately compensated for their new position.

One member complained that they had little notice, stating, "I found out at 4:30pm that I was being redeployed to IMS-COVID for the following morning at 8:30am to another office which was in an area that I was not familiar with. This redeployment upset my entire life for 16 months, I was working long hours, including weekends, and was denied much needed time-off for medical appointments and even had to work on statutory holidays."

Another noted working two jobs: "Being redeployed and having to keep up with my regular job was so stressful. We were asked to answer the phones for the COVID call centre. The public we spoke with were afraid and angry. The calls left us drained with nothing left to give."

This member said, “I have been back in my home job as a Tobacco Enforcement Officer for 14 months now, but the 20 months I was redeployed to work for the City's COVID Response Team is something that will haunt me for the rest of my life. The four different jobs I was assigned during those months exposed me to situations I was not ever trained to deal with. I have since been diagnosed with a Moral Injury by a psychiatrist. This type of diagnosis is often seen in soldiers after war.”



Mental Health Effects

A disturbing number of respondents – 62% – reported that they suffered from poor mental health during COVID. Almost 30% sought counselling services or EAP, and 12% went on stress leave.

A major COVID study of 20,000 US health care workers showed 38% reported anxiety/depression, 43% suffered work overload, and 49% had experienced burnout, with higher stress scores were observed in women and racialized workers. These feelings were compounded by lack of employer support, with 50% of survey respondents reporting they did not feel valued by their organization.

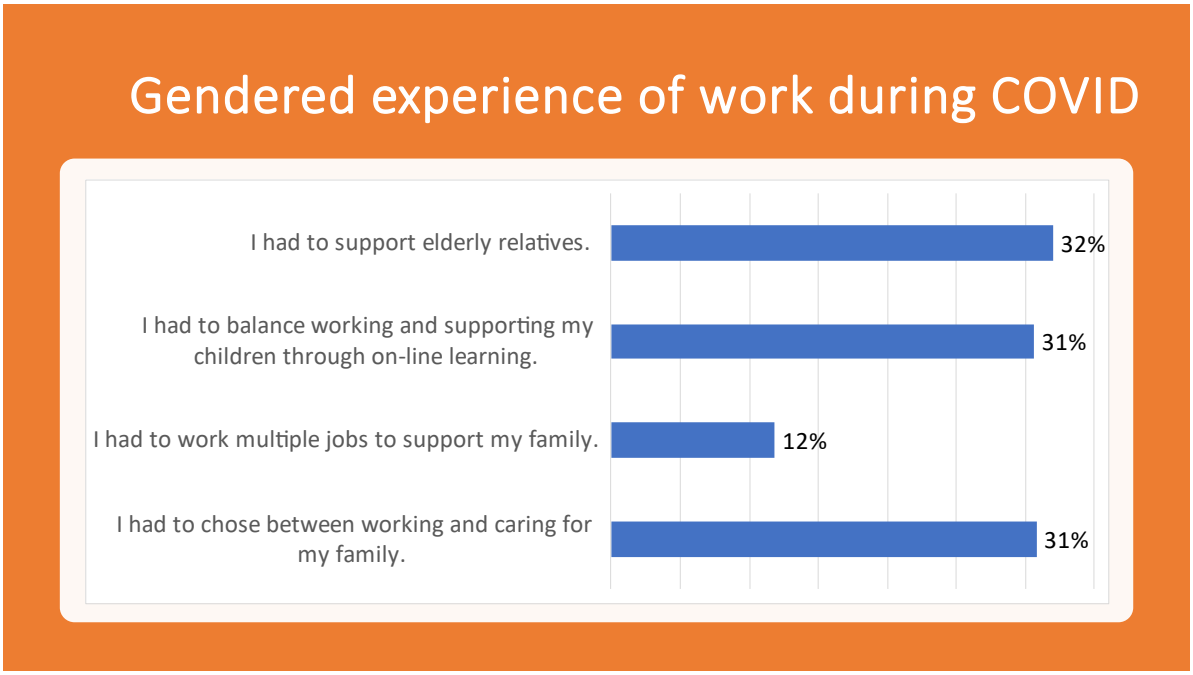
Public Health Canada[iv] also found that the COVID-19 pandemic has negatively impacted the mental health of the health care and public health workforce. The Public Health Physicians[v] of Canada has stressed the importance of acknowledging and

addressing the significant burnout among public health and health care teams after the experience of COVID.

Members' comments reflect their acute feelings of worry, stress and trauma.

One member said, "It was a very traumatizing time. I had never struggled with mental health in the past, but during this pandemic, due to work stress, I had several mental health breakdowns, required therapy, medication, and eventually took time away from work. Being redeployed with little training, working all weekends for over 6 months straight, altering my work hours completely to include evenings, while simultaneously juggling childcare of a toddler (daycares were closed, and when they reopened, I was not comfortable sending my 2-year-old for a long time thereafter), and being pregnant with our second. Being scared for my life, as I was pregnant before vaccines were available, and pregnant women were becoming extremely sick with COVID. I had parents on chemotherapy who were immuno-compromised. I try not to think too much about that time because it was truly horrendous. I did not feel supported in anyway by the government, nursing bodies like the CNO or my workplace. I feel like I have nothing left to give the nursing profession anymore, and it gives me nothing in return."

Another remarked, "I was moved to do COVID-response work. It was incredibly stressful, and I had family matters on top of that. The stress almost killed me, and I was sobbing in between client phone calls. I went off sick for a short period of time to get better. Management was supportive. But, still, it was so insulting to get emails from HR and wellness to tell us over and over again to use EAP and to eat well and de-stress instead of doing other things to support our wellness like flex time, and the ability to earn lieu time so that we can take time off to take care of ourselves instead of always dipping into vacation time that I need to not burn out in the first place."



Gendered experience of work

Public health is a profession dominated by women. In this survey question, members responded to questions about gendered responsibilities like child and elder care, and balancing work and family life. Approximately one-third of respondents reported supporting elderly relatives, choosing between working and caring for family, working multiple jobs to support their families, and balancing their jobs with supporting their children's online learning.

Studies have shown COVID has had a destructive impact among health care workers, particularly among women, who already tend to be hypervigilant toward work responsibilities, self-doubt and have difficulty balancing exceptional work and life demands.[vi]

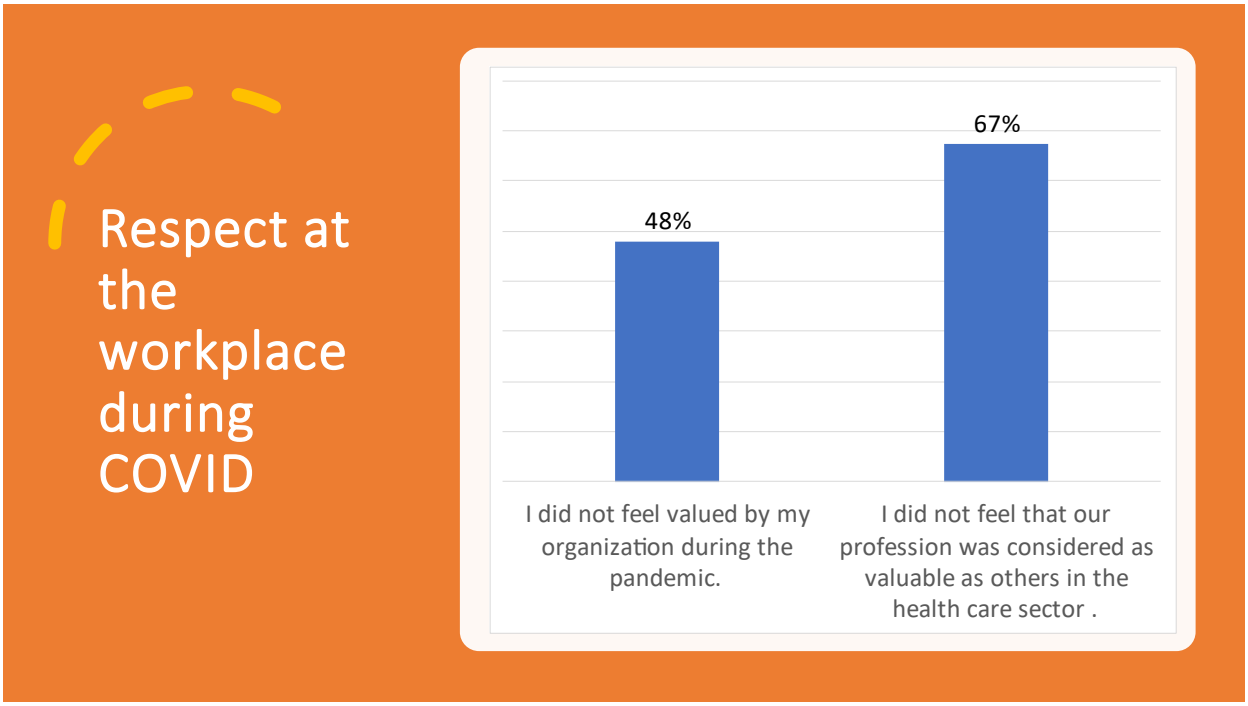
And while burnout is not a new phenomenon in health care, COVID has increased the prevalence of mental health issues such as anxiety and depression, particularly among women who are more likely to feel devalued by their organizations and struggle to balance the "dual shift" of high workloads on the job and at home.[vii]

The following comments capture these dual obligations and their effects in a striking way:

"The pandemic was such a stressful time not only for me but for my family, my friends and my colleagues. I remember many days crying at my desk in my basement feeling so lost and alone and being shifted from one role to another within a day with no training or idea on how to do my job correctly. I feel that the pandemic has given me post

traumatic stress and I missed my kids lives. I was glued to my desk, calling patients to make sure they were ok when I didn't even have time to check on my own kids and what they were doing with schooling. My kids suffered and I see it so much more now as they need counselling for stress, depression and anxiety. My life will never be the same. I am sad when I think about the pandemic, and I hope that we never have to go through that again."

"*As a single parent trying to navigate a global pandemic with two small children, while working from home on 12-hour COVID shifts and home-schooling was extremely difficult not only physically, but emotionally and mentally on everyone in the household. My children suffered [from lack of] proper parental guidance and were often left to fend for themselves because I was too busy working."*



Respect in the Workplace

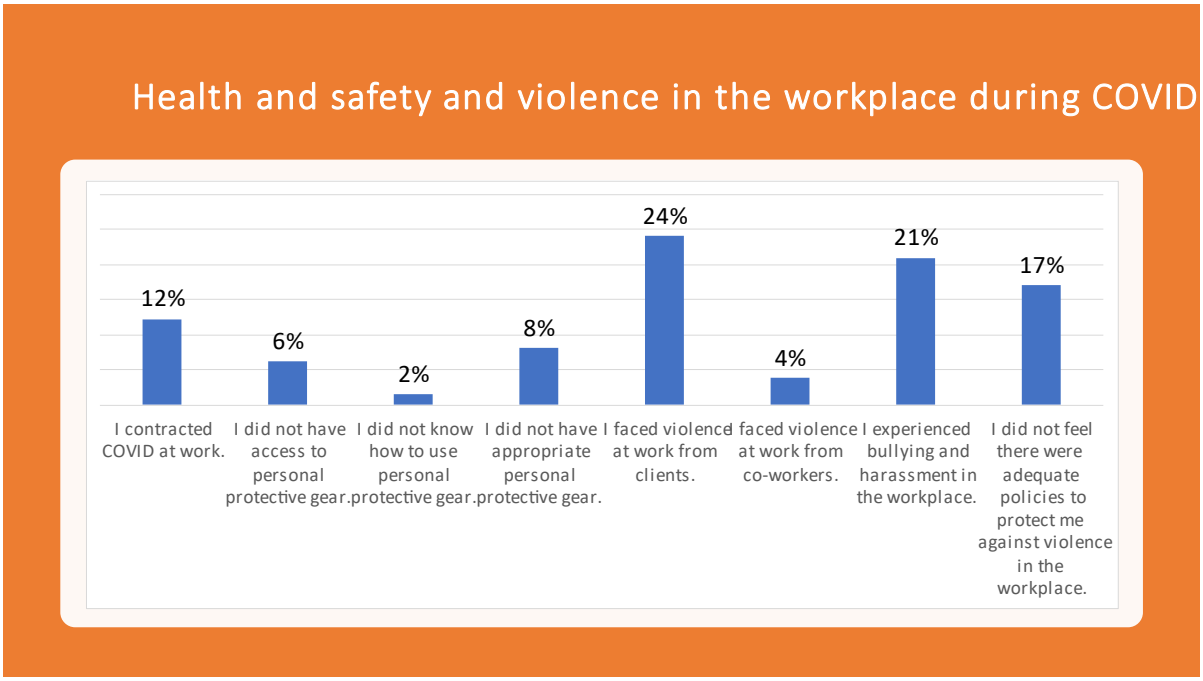
Almost one-half respondents did not feel valued by their organizations during the pandemic, and over 65% did not feel their profession was as valuable as others in the health care sector. Members' comments reflect these data, with respondents stating that they did not feel supported by the employer or the province.

"I faced a lot of verbal threats from the public because of my re-deployed role as a Communicable Disease Investigator in which one of my job is to get the client to confirm people they contact during the period of transmission. Threats from client happens from

time to time. Sometimes I felt when I try to get support from the management, they did not care about my mental wellness and still ask me to continue work with the threatening client. It put me in a very bad situation. So, my mental wellness took a toll and I end up need to get counselling to deal with the aftermath of all these traumas I got from the work during the pandemic."

"The lack of acknowledgement and care to staff working in a high stress environment over several years, as well as times of working remotely with no support has made my job satisfaction extremely low, and has made my level of stress extremely high. I have suffered many emotional and physical health issues because of my work environment during the pandemic. Having the province and my employer recognize the contributions of public health, offering more support to us as human beings who are exhausted and mentally and physically stressed, and compensating us fairly and competitively for the work that we do, would help improve my job satisfaction and my life. If no consideration is given to making our working conditions better, or compensating us fairly, I will be seeking alternative employment."

"As a community outreach worker and union steward the collapse of morale in the workplace, multiplied the intensity and volume of support my coworkers needed from me. There was no support for the supporters."



Health and Safety during COVID

Health and safety were important concerns during COVID. Twelve per cent of respondents contracted the disease at work. Members reported concerns about access to and the proper use of personal protective equipment. Violence and harassment from

both clients and co-workers were also significant concerns, as well as the lack of policies to protect members in the workplace.

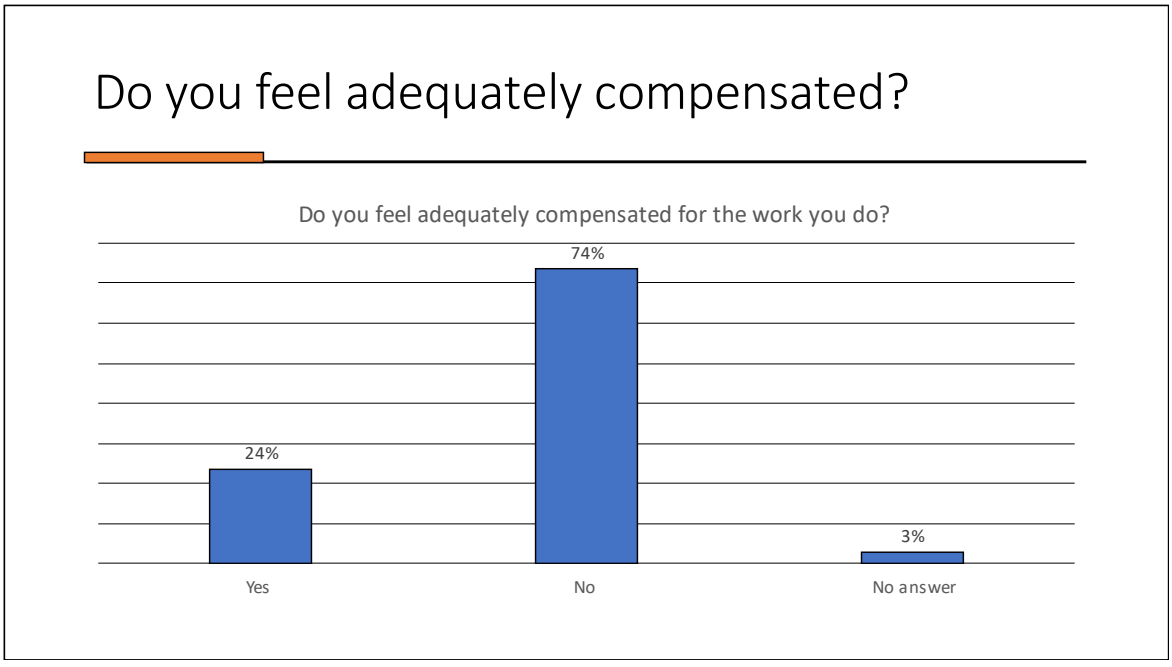
Members' comments reflected the importance of addressing health and safety issues:

"[The employer needs to raise] awareness of violence in the workplace."

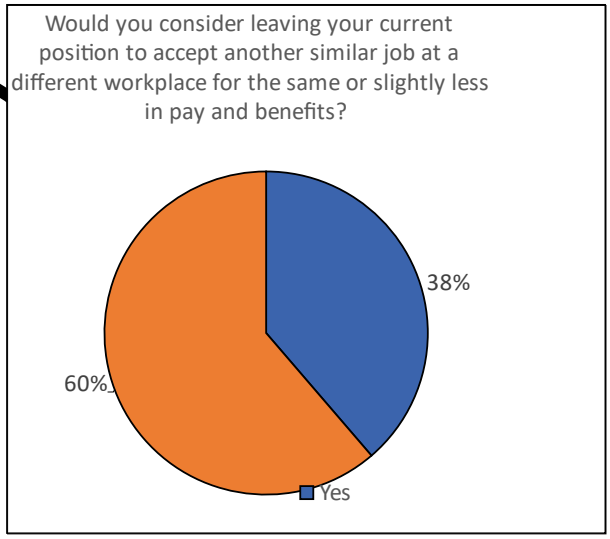
"Raising awareness that injured workers are not just physically hurt. It changes your entire life."

"I experienced violence in the field pre-vaccination and threats of being spit or coughed on, threats to follow my vehicle, and had little support and reaction from my employer. Post-pandemic we still lack clarity in our roles as [public health inspectors] struggling to balance program planning, health promotion, and inspection priorities. I am continuing to seek opportunities outside of local public health as I struggle with the trauma I experienced during the pandemic."

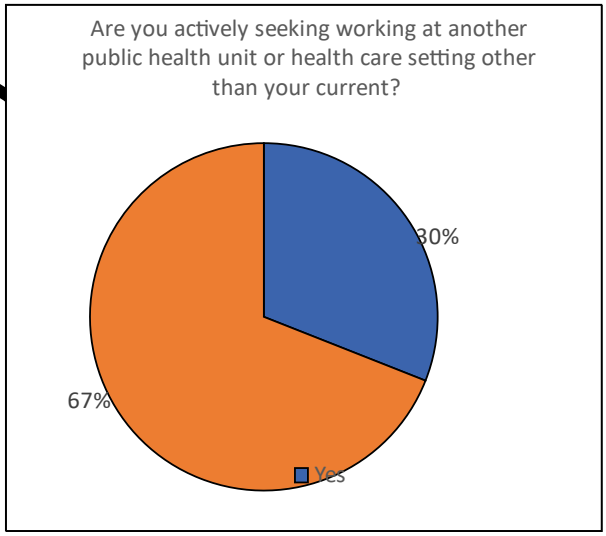
"[We need] actual managerial support for workers when faced with workplace violence, especially by patients/clients. Currently the attitude is 'it's our fault' and patients/clients are now aware they can use threats and bullying tactics to get what they want, as the leadership rolls over to accommodate them."



Would you consider leaving your current position?



Are you actively seeking work elsewhere?



Compensation, Job Satisfaction and feelings of value at work

Almost 75% or three-quarters of respondents do not feel adequately compensated for work they perform. Thirty-eight per cent would consider leaving their current position for another similar job at a different workplace for the same pay and benefits or slightly less. Thirty per cent are actively seeking work in another public health unit or health care setting. Sixty-seven do not feel valued at work.

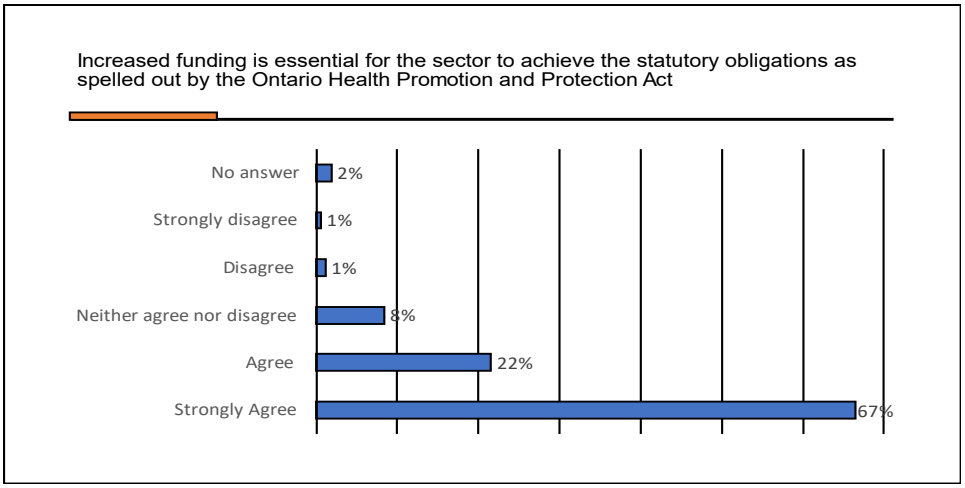
These responses reflect a high level of dissatisfaction with compensation and feelings of devaluation by employers.

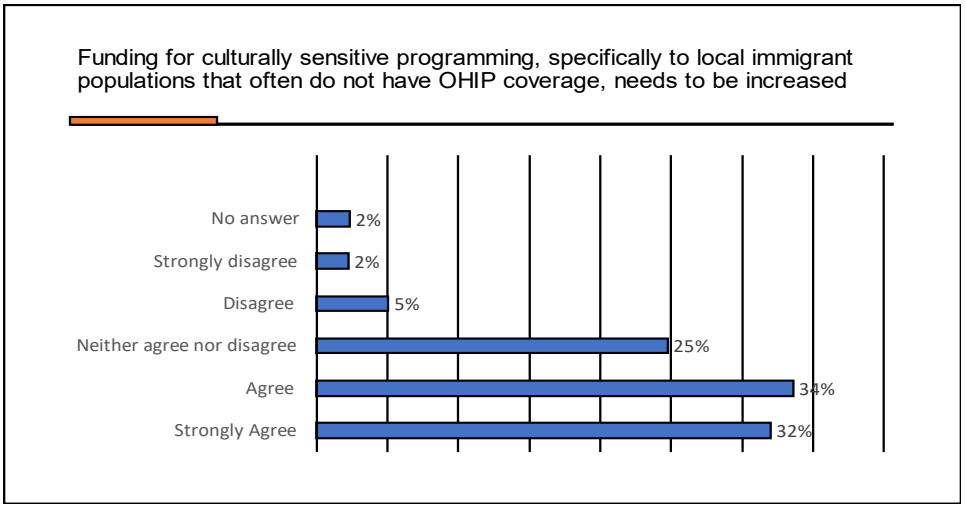
Summary of Section Two Findings

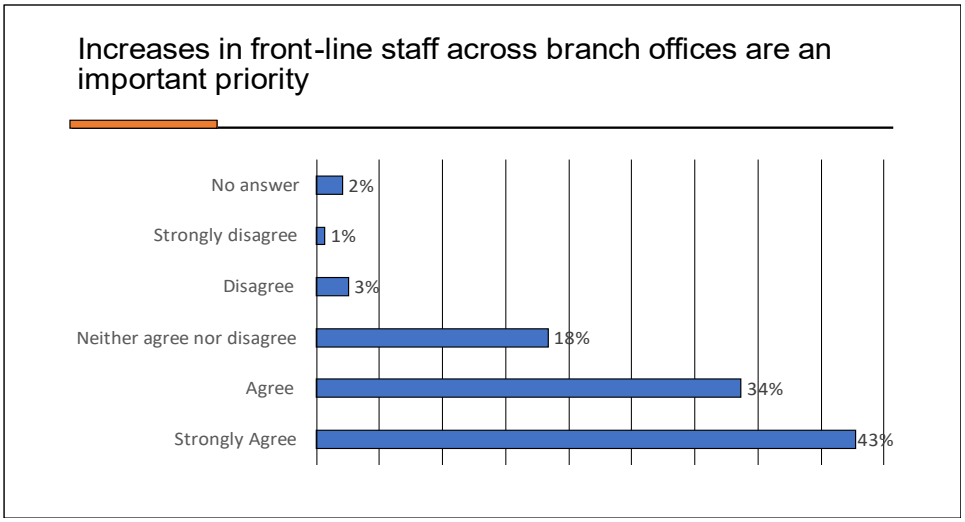
The impact of the COVID-19 pandemic on CUPE public health workers has been profound. Almost 62% of survey respondents report poor mental health due to the pandemic. Excessive workloads, redeployment, exposure to infection, violence, and health and safety concerns, and gendered responsibilites, created an intensely stressful workplace environment. In addition to these impacts, members report high levels of job dissatisfation and feelings of devaluation. While these issues predated COVID, the pandemic highlighted the need for the union to continue advocating for fair wage and working conditions.

SECTION THREE: KEY CHALLENGES AND PRIORITIES

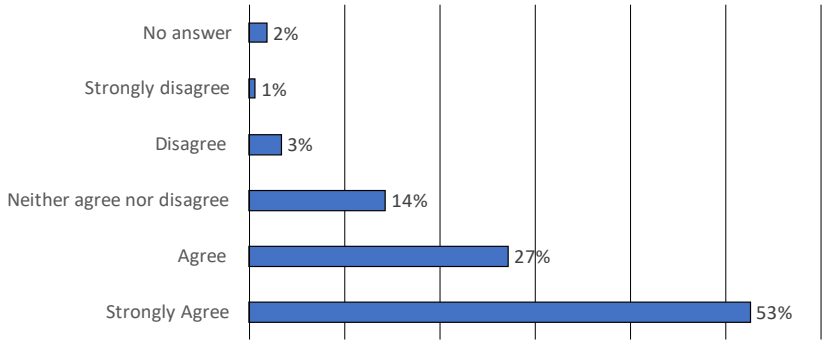
Increased funding, staffing, recruitment and retention, and wages



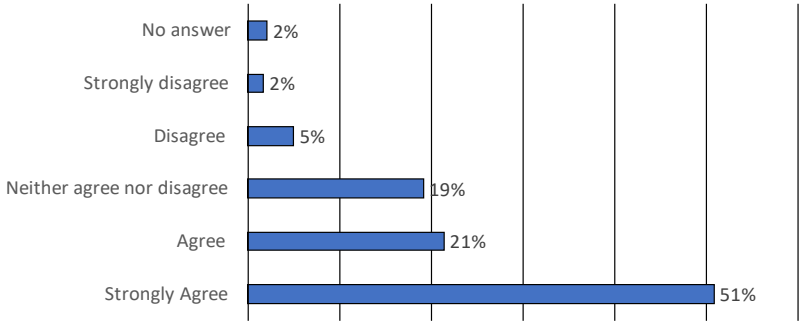




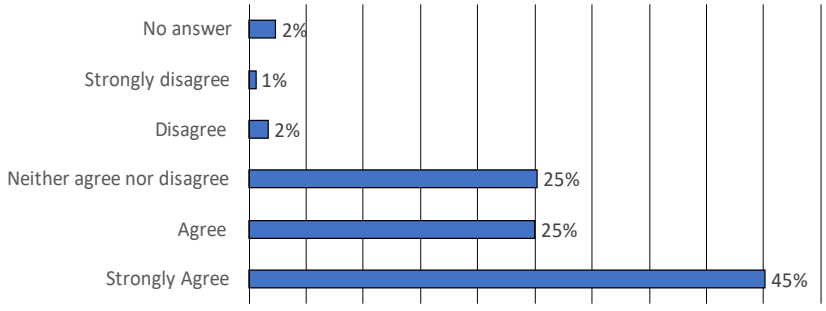
Staff recruitment and retention is a major problem for the sector



Wages are not competitive with the private sector



Wages are not comparable between health units in the province



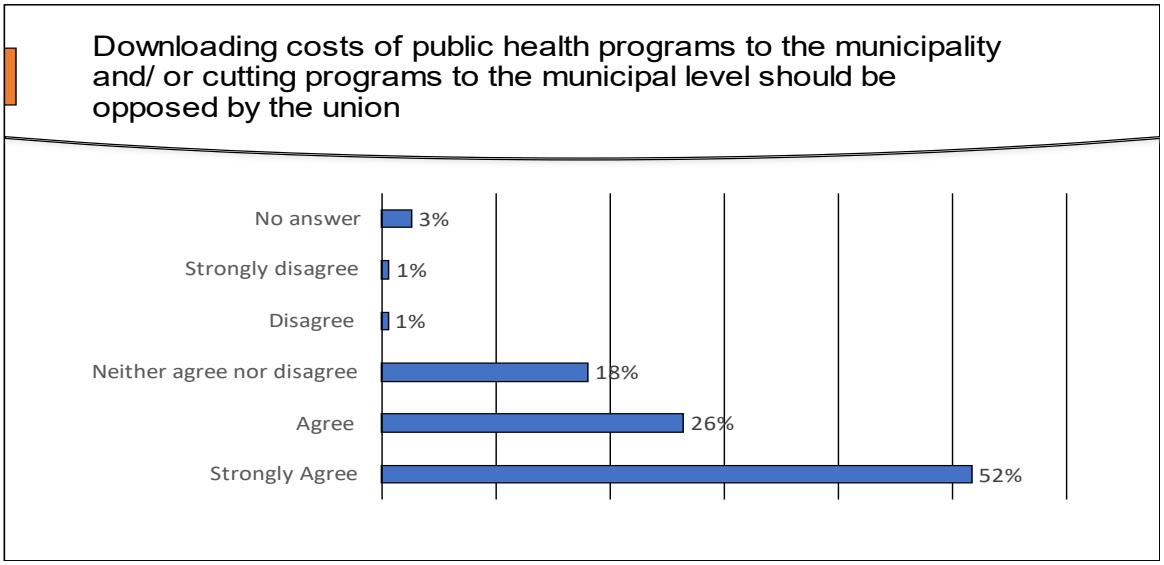
Funding is the dominant factor linking these six key issues. Sixty-six per cent of members do not feel there is sufficient funding to deliver the statutory requirements of the Health Promotion of Protection Act, or to deliver culturally sensitive programming. Funding is also a determining factor in establishing wage rates to improve recruitment and retention, boost competitiveness with private sector employers, and increase front-line staffing levels. Increased funding levels are also a crucial factor in addressing excessive workloads, poor mental health, low job satisfaction, and low workplace morale.

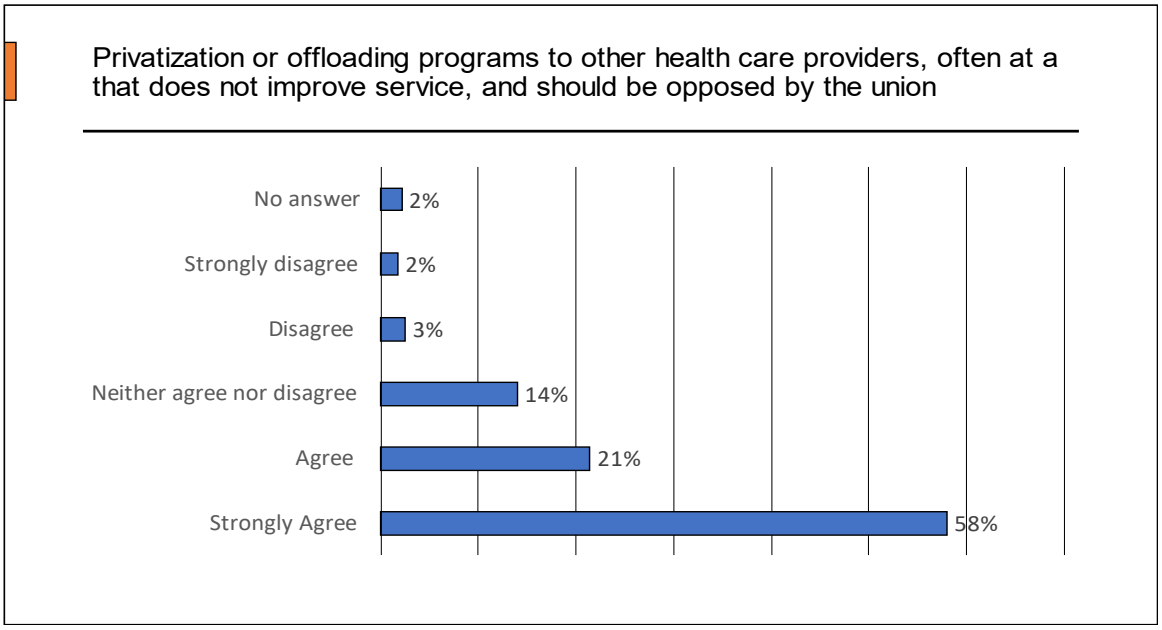
COVID further highlighted the systemic problem of chronic underfunding in the sector. Ontario is the only province in Canada that mandates municipalities to pay for a portion of public health care costs, while continuing to reduce its share of overall percentage of funding (from 75% to 70%) and withdraw support for fully funded programs. However, according to the Association of Municipalities of Ontario (AMO) in 2018, municipalities paid on average 38% public health costs, well above the mandatory 25%. Municipalities have limited resources to absorb these costs with resulting pressure to privatize programs and services or contract them out to other health care partners. CUPE and AMO have consistently called on the province for stable base funding to pay for public health, rather than property taxes which are an inappropriate use of revenue for a human service.

COVID has placed added financial strains on the system in the form of a backlog of mandated services. According to the Association of Local Public Health Agencies (APHA), mandated programs and services were significantly curtailed for almost two years, with an average of 74% of 2020 Local Public Health Agency (LPHA) resources and 78% of 2021 LPHA resources diverted to the COVID-19 response.

Both APHA and the Association of Municipalities of Ontario (AMO) have called on the province to continue funding for ongoing COVID responses, to clear backlogs of mandated services, and to increase base funding. Currently, the provincial government commitment to public health funding is $47 million to end of 2023, but it is not clear whether this amount will fully support the delivery of mandated services as well COVID related costs at the local level.

Downloading, Offloading and Privatization





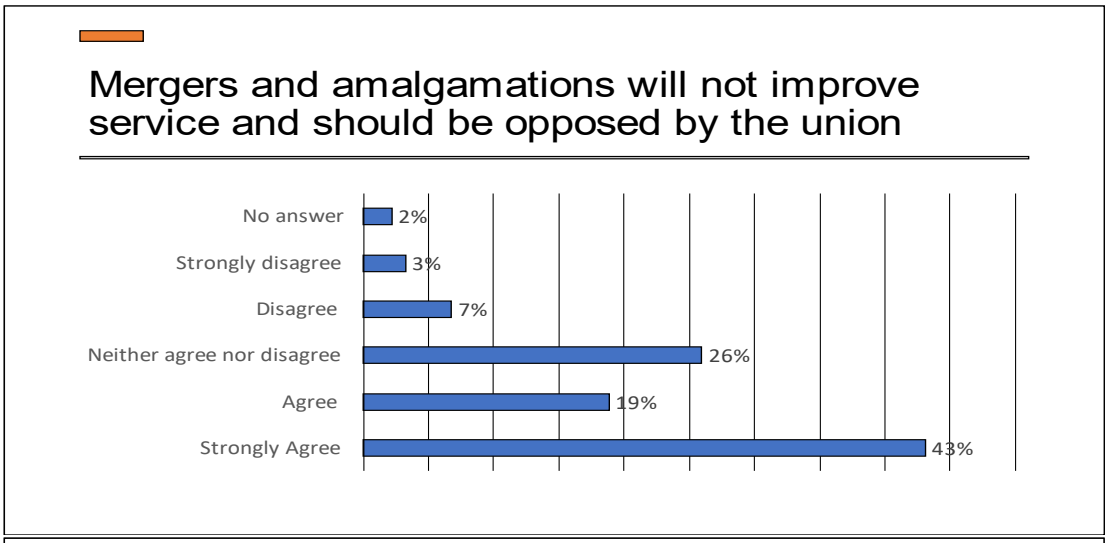
The downloading of costs to municipalities and the privatization and offloading of programs are related to the provincial-municipal funding model in Ontario public health. Eight per cent of survey respondents strongly agree or agree that downloading, privatization, and offloading programs to other health care providers does not improve service and should be opposed by the union.

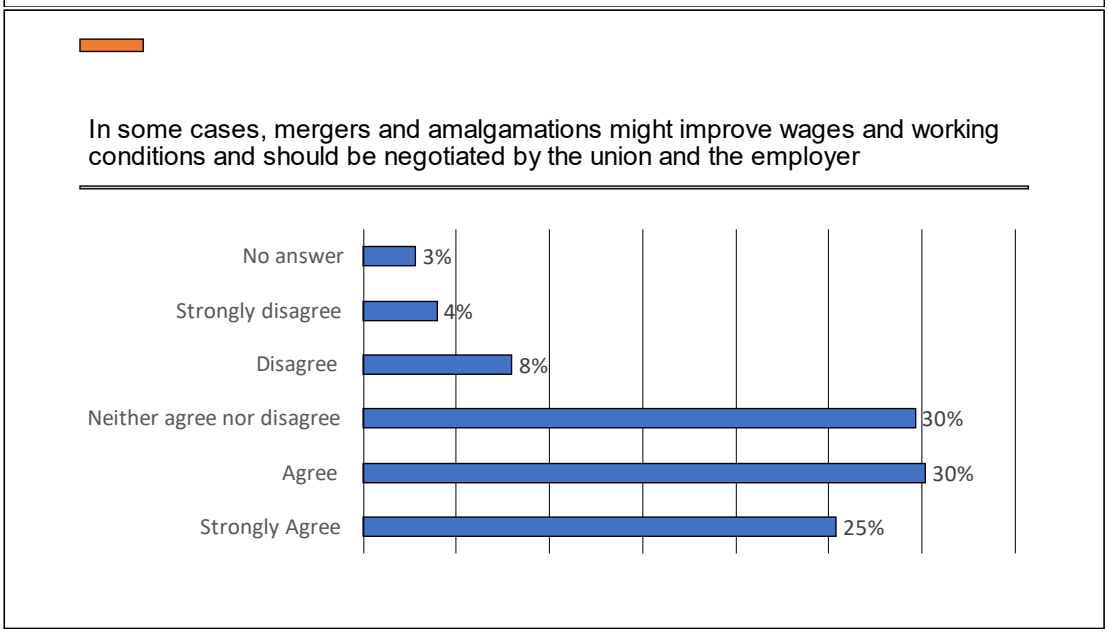
As previously noted, the mandated contribution of municipal funding is unique to Ontario. Prior to 2020, the provincial government paid for 75% of public health costs and fully funded programs such as oral health. Starting in 2020 the model became 70-30, with added costs downloaded to municipalities. While temporary funding was

provided to mitigate these funding changes and COVID responses, the restructuring has created instability and a systemic underfunding problem for public health units.

Moreover, all thirty-four public health units must meet the statutory obligations set out by the Ontario Health Promotion and Protection Act regardless of the amount of funding provided to them. With insufficient municipal funding to make up the shortfall, health units reduce costs by laying off front line staff, gapping positions, outsourcing programs and service delivery to other health care partners, or using reserve funds. Privatization or offloading services to other health care providers also become options for cash strapped municipalities.

Mergers and Amalgamations





In 2019, the Conservative government announced its intention to merge Ontario's 34 local public health agencies into ten regional entities to save $200 million dollars, improve capacity and reduce duplication. During a series of consultations in 2020, CUPE, AMO, and others raised serious concerns about involuntary mergers and amalgamations, arguing that the proposed restructuring would not achieve the projected savings. In fact, AMO argued, the costs associated with severance, successor rights, and other disruptions involving 7,000 public health staff covered by seventy-three separate collective agreements across the province would be costly, complex and disruptive to the public, staff, and the entire system.

AMO pointed out the lessons learned from the mergers and amalgamations of municipalities in the 1990s were instructive. (Even the right-wing Fraser Institute[viii] stated by 2015: "We find very little evidence of tax savings or cost reductions [in municipal amalgamations]. In most of our cases, the tax burden on individual households increased. In some cases…property taxes increased more than 50% … between 2000 and 2012.") AMO warned that restructuring could make public health too distant from the communities it served, and weaken important connections between municipal planning that affect health promotion and protection. "There are," cautioned AMO, "hidden costs to amalgamation," and put forward a series of alternatives to the provinces' restructuring.

Another key factor in opposing mergers and amalgamations is the importance of local control. As CUPE noted in 2020, public health governance structure and accountabilities are crucial elements of the system. Decisions about public services should remain as close to communities as possible which varies significantly in size, resources, demographics, and population. Democratic control and public accountability are a major strength of municipal government and public health is part of that.

As advocates of local control maintain, though broader health care is a provincial responsibility the social determinants of health occur at the local level and can be improved through municipal policies and practices such as land use planning, housing, transportation. More could be addressed in a progressive and well funded system.[ix] Other advantages include the ability to define area specific problems more quickly, build relationships of trust with local stakeholder groups, and find innovative solutions to health care problems much more rapidly than is possible within more centralized and bureaucratic systems. The consolidation of public health into a larger provincial acute care system, it is argued, would undermine these local capacities in such a targeted and effective manner.

> *By its very nature, public health is a collaborative and outward-looking enterprise, seeking to make connections within and between social and political actors. At best, it consolidates networks of communication and*

> *collaboration for effective policymaking. An effective system of public health is not facilitated by governance reforms seeking to centralize and rationalize all functions. The centralization of governance functions tends to consolidate public health units away from the local level, where they can be most effective.*[x]

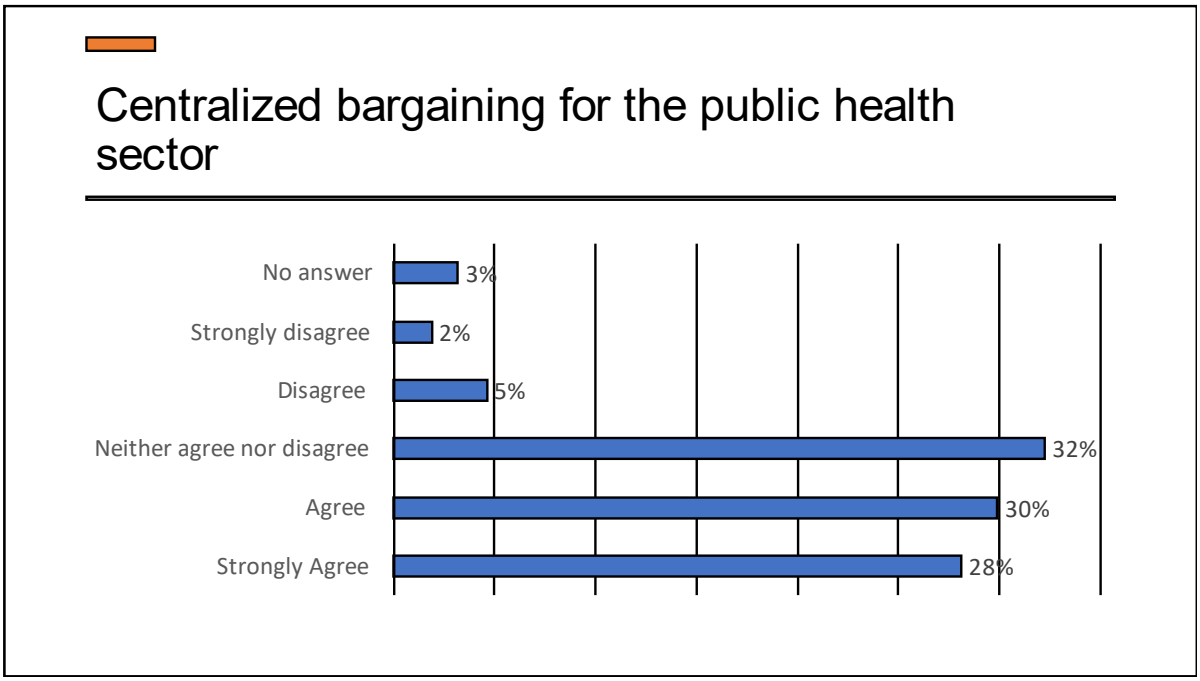
Cost-saving is the major argument put forward for mergers and amalgamations. However, investment in public health has a high rate of return. As AMO pointed out 2020, escalating health care costs are driven by preventable conditions, noting that many of the challenges facing public health could be met by addressing the recommendation made by the Auditor General 2017 Report on Chronic Disease Prevention and citing examples of investment in health care returns in the US and globally[xi]. CUPE also made this argue in 2020 and it remains foundational to our view of public health as well as broader investment in public services.

Not all survey respondents opposed mergers and amalgamations. Fifty-five percent of survey respondents felt that mergers and amalgamations might be desirable. CUPE has successfully negotiated terms and conditions of collective agreements during mergers and amalgamations and are aware there are circumstances in the sector where consolidating programs and services could improve services as well as wages and working conditions for members. In all cases, the union would need be fully involved in all aspects of the process the ensure the members' rights were protected.

One member commented, *"*Amalgamation can be done in many different ways. I don't oppose amalgamation, but it must be done carefully and with top priority given to the needs of the communities served. Amalgamation is easier with centralized bargaining though."

Another member said, "I feel that an amalgamation/merger of health units would be an immense improvement to public health. It would help streamline services and make our services more accessible to all members of the public. It would create fair, equitable wages for employees. No more pay inequities! If the employer truly saw the hard work that we've done before, during, and after the pandemic, then they really need to shift gears and wake up to modernization of public health. People should expect the same level of service no matter which health unit location they find themselves stumble into around Ontario."

Though survey respondents have differing views of mergers and amalgamations, it is clear from the responses that members feel the union has a strong role to play.



Almost 60% of survey respondents agree or strongly agree the union should pursue centralized bargaining. Public health does not have a centralized bargaining system and currently CUPE negotiates collective agreement in a decentralized manner, one local public health agency at a time. However, this does not preclude the possibility of the sector acting in a coordinated way. Negotiating common language and common expiration dates for collective agreements, and engaging in campaigns to influence provincial polices, and other legislative reforms are all ways that the sector can coordinate their activities in a centralized way. Building our power in the workplace is the most important way to influence the direction of the sector. CUPE has resources and tools, such as strategic planning guidelines and organizing for power training that help locals get started.

Priority Challenges

- Wages are not competitive with the private sector and are affecting recruitment and retention
- Increased funding is essential for the sector to meet its statutory obligations as spelled out by the Ontario Health Promotion and Protection Act
- Wages are not comparable between health units in the province

Ranked priorities

1. Collective bargaining to raise our wages and improve our working conditions
2. Educating the public on the importance of public health care workers
3. Political action to increase funding and oppose privatization, mergers and amalgamations
4. Raising the profile of public health workers in CUPE

This survey merely provides a snapshot of the challenges facing the public health sector. Bill 23, the *More Homes Built Faster Act,* will reduce municipal budgets by exempting developers from paying crucial fees, and giving "Strong Mayors" undemocratic authority to pursue provincial priorities that can be set at any time by regulation. Currently this priority is housing, but could be changed at any time without consultation to municipal wage suppression, or mergers and amalgamations. Public Health restructuring, started in 2019 and put on hold by COVID, could be reinitiated at the provincial level at any time. With a Conservative majority government, the sector will need a clear strategy to face potential threats and build power. Survey respondents have identified key priorities going forward.

[i] 2020, CUPE / OMECC Submission to MOHLTC on Public Health Modernization

[ii] 2020, Association of Municipalities of Ontario, Response to the Ministry of Health's Discussion Paper: Public Health Modernization 2020

[iii] alPHa_Submission_Pre_Budget_2023_140223.pdf

[iv] PHO-covid-19-public-health-workforce-recovery.pdf

[v] PHPC_Public Health Lessons Learned from the COVID-19 Pandemic.pdf

[vi] Kris Vanhaecht, Deborah Seys, Luk Bruyneel, Bianca Cox, Gorik Kaesemans, Margot Cloet, Kris Van Den Broeck, Olivia Cools, Andy De Witte, Koen Lowet, Johan Hellings, Johan Bilsen, Gilbert Lemmens, Stephan Claes, COVID-19 is having a destructive impact on health-care workers' mental well-being, *International Journal for Quality in Health Care*, Volume 33, Issue 1, 2021, mzaa158, https://doi.org/10.1093/intqhc/mzaa158

[vii] Prasad, Kriti, Colleen McLoughlin, Martin Stillman, Sara Poplau, Elizabeth Goelz, Sam Taylor, Nancy Nankivil et al. "Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study." *EClinicalMedicine* 35 (2021): 100879. https://www.sciencedirect.com/science/article/pii/S2589537021001590

[viii] https://www.fraserinstitute.org/sites/default/files/de-amalgamation-in-canada.pdf

[ix] Municipal_Role_Public_Health_171122.pdf

[x] Municipal_Role_Public_Health_171122.pdf

[xi] In California, $1 invested in public health resulted in $67 to $88 of benefits to society (Academy Health, 2018). Prevention approaches reduce 50% to 75% of cardiovascular disease deaths in high-income countries, and 78% globally (World Health Organization). $10 invested in public health can decrease 7.4% of infectious disease deaths (Academy Health, 2018).