Office of the County Warden
789 Broadway Street, Box 3000
Wyoming, ON N0N 1T0

Telephone: 519-845-0801
Toll-free: 1-866-324-6912
Fax: 519-845-3160

July 14, 2016

Linda Stewart, Executive Director
Association of Local Public Health Agencies
2 Charlton Street, Suite 1306
Toronto, ON M5B 1J3

Dear Ms. Stewart:

Re: Grey Bruce Health Unit Brief in Response to Patients First Discussion Paper

At its meeting of June 1, 2016, the County of Lambton Board of Health passed a motion supporting a letter from Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit dated March 7, 2016 endorsing the *Grey Bruce Health Unit Brief in Response to the Patients First Discussion Paper*. The paper specifically addresses Section 4 in the *Patients First* proposal titled "Stronger Links Between Public Health and Other Health Services".

The County of Lambton Board of Health supports many of the key points, as public health's role is different from the health care focus on the sickness care system. Our role remains "upstream" aimed at prevention of disease and injury, promoting and protecting health and advocating for healthy public policy.

Similar to Grey Bruce Health Unit, we have established extensive connections and partnerships with community agencies, health care, primary care and a wide range of health professionals, lower-tier municipalities, First Nations communities and educational institutions. Through these networks, public health is well positioned to help populations or communities to take steps to improve their own health and well-being.

In addition to Grey Bruce Health Unit's response to *Patients First*, our Board also acknowledges the leadership and advocacy provided through alPHa and many Ontario Boards of Health on this important public health issue.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Bob Bailey, M.P.P., Sarnia-Lambton
Monte McNaughton, M.P.P., Lambton-Kent-Middlesex
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

March 7, 2016

Association of Local Public Health Agencies
Suite 1306
2 Carlton Street
TORONTO, ON M5B 1J3

Dear Ontario Boards of Health:

Re: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

On February 26, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached 'Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document'. The following motion was passed:

Motion No: 2016-19

Moved by: David Shearman Seconded by: Laurie Laporte

"That the Grey Bruce Board of Health does endorse the Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document."

Carried.

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey

Encl.

Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

February 2016

For More Information:
Drew Ferguson
Public/Media Relations Coordinator
Grey Bruce Health Unit
101 17th Street East Owen Sound ON N4K 0A5
519-376-9420 ext. 1269
d.ferguson@publichealthgreybruce.on.ca

Grey Bruce Health Unit Brief in Response to Patients First Discussion Document

This brief specifically addresses Section Four of the *Patients First* discussion document, titled *Stronger Links Between Public Health and Other Health Services.*

This brief is comprised of two components. The first looks at the population health approach taken by Public Health and issues that arise. The second section provides a Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

THE ISSUE

The initial statement ***Public health has historically been relatively disconnected from the rest of the health care system*** is at the core of this discussion.

The focus of the LHIN-based health care is on individual patient care, service provision and costs. In essence, it is sickness care.

Public Health has a different role than the sickness care system. Our focus is "upstream" through prevention of disease and illness, staying well.

Public Health's population health approach aims to improve the health of the entire population. It considers the things that influence our health both inside and outside the health care system. It recognizes that at every stage of life, our health is affected by complex interwoven fabric of factors referred to as 'determinants of health'. These include Housing; Income; Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetics; Health Services; Gender; and Culture. These factors do not exist in isolation. Rather, the combined influence of these factors determines our health.

This is profoundly different from the health care system's view of population health. The health care system's approach to population health is to provide interventions to specific, identifiable groups whose needs are greatest and it is taken that, by extension, this will improve overall population health.

A Public Health-based, population health strategy addresses the factors contributing to dis-ease in the population as a whole. That goes beyond behaviour and lifestyle approaches. Working at the population health level does not translate well to the individual. Using alcohol misuse as an example, greater societal gain is achieved from a small change within the larger population than by addressing the problem on an individual basis. Referred to as the 'prevention paradox'; preventive measures, through strategies such as policy development, that address health equity or social determinants of health, that bring benefit at the population level, offers little to the individual. Public Health is virtually invisible to the public. In the population health model, success is marked by a non-event.

Public Health is the ounce of prevention. In terms of health funding, Public Health is small potatoes accounting for about 1.4 per cent of the province's over-all health budget. When limited funding for population health initiatives is balanced again individual care, the scale invariable tips to individual care. Referred to as the, "tyranny of the acute", when limited resources are in play, the demands of sick person will always take precedent over the need to better the health of the larger population. The public have a preoccupation with acute and medical care, as that affects them directly.

In identifying the current situation, Section Four states that ***Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.***

Given that reality, it would be unrealistic to expect a relatively small Public Health sector to have much influence on the larger and more powerful set of illness care-oriented priorities. As seen in other jurisdictions, the larger culture of illness care will steer Public Health to a more clinical orientation and away from population health. As a result, the already scarce Public Health resources are diverted to acute, primary and long-term care issues (e.g., emergency room diversion strategies).

The role with respect to the regulatory functions performed by Public Health is not addressed in the *Patients First* discussion. These roles do not align well with health care and speak to the "disconnect from the rest of the health care system" as. Areas including safe drinking water, beach water testing, food premise inspections, personal service setting inspections (aesthetic/tattoo etc.), tobacco by-law enforcement, environmental hazards, and emergency preparedness are all significant components of the Public Heath portfolio. The transfer and monitoring of accountability and performance in these regulatory areas is a substantial undertaking for LHINs. Additionally, it would seem redundant to require 14 independent LHINs to provide universal regulatory and performance oversight in these non-healthcare areas.

Further to this discussion of accountability and performance, it should be noted that population health does not lend itself easily to quick measurements as compared to acute care. It is easy to count ER visits, but as we have seen with the shift towards tobacco de-normalization, results are often incremental and can take decades.

The LHINs are defined by health-care referral patterns where the patient goes. Owen Sound patients go to London, Blue Mountains patients go to Collingwood and Barrie, Dundalk patients go to Shelburne and Orangeville. Public Health is defined by municipal boundaries. The two do not align. The current proposal puts the Grey Bruce Health Unit in three LHINs; the majority in the South West LHIN, Southgate in the Waterloo Wellington LHIN and Town of Blue Mountains the North Simcoe Muskoka LHIN. The implications of these over-lapping alignments require clarification.

QUESTIONS FOR DISCUSSION

The following provides the Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

How can public health be better integrated with the rest of the health system?

Should it be? As described, the healthcare system is sickness care, the system comes into play once you become ill; Public Health is all about maintain and extending wellness. That question could well be reversed to ask how the rest of the health system can better integrate with Public Health. This would have the health care system acknowledge and adopt a population health approach as fundamental to all significant health issues. By necessity, this is a long-term approach re-directing the focus towards health and not just health care.

What connections does public health in your community already have?

Grey Bruce Health Unit has filaments that thread throughout our community. The list is extensive; these connections can be characterized as being with:

- upper and lower tier municipal partnerships and working groups. We perform regulatory roles but also focus on planning and policy for healthy communities
- health care, primary care/health care and a wide range of health professionals, providing materials, knowledge and resources
- community and community groups supporting capacity in the community around specific issues
- school boards, from frontline services such as dental screening and immunization, to issue specific initiatives such as youth mental health, to broader healthy school initiatives
- post-secondary institutions
- First Nations communities
- Plains Communities, also known as Amish and Mennonite communities
- federal and provincial ministries
- agriculture and veterinary, producer and consumer groups, industry, and
- the community at large.

What additional connections would be valuable?

Many of the areas of public health involvement, including the provision of clinical services, reflect ongoing or historic gaps on a population-wide basis. This has been particularly true for the more vulnerable populations. One of the emerging roles for the Grey Bruce Health Unit is to

identify capacity within a community and seek out the resources and links that can help empower populations or communities to take steps to improve their own health and wellbeing. These types of partnerships may provide examples of collaborative models between primary care and Public Health.

As noted, health inequities and the broader social determinants of health are often outside the immediate scope of healthcare services. In this regard, LHINs not only need to work with Public Health but they should also develop formal relationships with the municipal, social services, housing, education, and voluntary sectors to support service integration. As the Ottawa Charter for Health Promotion suggests, health services should be expanded to include building healthy public policy, creating supportive environments, strengthening community action and supporting development of personal skills.

What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Ministry plan would ***create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.***

A direct role by the Medical Officers of Health in informing or influencing decisions would provide a public health link to healthcare systems. Offering the potential to bring a population health view to health issues and the planning of healthcare services. This can only be achieved with the Medical Officer of Health's routine participation in the executive management team and at the Board level. Experience from other jurisdiction has shown that success requires a strong and interested health sector leadership combined with strong public health leadership and epidemiological capacity. Public health's involvement in providing a population health perspective can only be achieved by design and cannot be left to the discretion of individual LHINs or their Boards.

Without a formal or direct influence on budgets, programs and staffing, it might fall to the Medical Officers of Health to be the lone voice for Public Health. The challenge being to mitigate adverse impacts on Public Health including loss of funding, fragmentation of capacity, diversion of staff through re-orientation to clinical issues, and barriers to engagement with community and municipal partners.