Long Term Care Covid-19 Commission Mtg.

Cuts to Public Health Funding
on Thursday, December 17, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 17th day of December, 2020, 1:00 p.m. to 2:30 p.m.

BEFORE:
The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:
MINISTRY OF HEALTH & PUBLIC HEALTH ONTARIO:
Cathy Campos, Chief Financial Officer, Public Health Ontario
Elizabeth Walker, Director, Office of the Chief Medical Officer of Health, Ministry of Health
Brent Feeney, Manager, Funding and Oversight, Office of the Chief Medical Officer of Health, Ministry of Health
Colleen Gieger, President and Chief Executive Officer (Acting), Chief, Strategy, Stakeholder Relations, Research, Information and Knowledge (SSR & RIK) Public Health Ontario
Alwin Kong, Chief Legal Officer and Corporate Secretary, Ministry of the Attorney General
Sunil Mathai, Counsel, Ministry of the Attorney General
Amy Leamen, Counsel, Ministry of Health and Ministry of Long-Term Care
Roopa Mann, Counsel, Ministry of the Attorney

General

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

The following is a list of documents undertaken to be produced or other items to be followed up

INDEX OF UNDERTAKINGS

The documents to be produced are noted by U/T and appear on the following pages: 19:8, 22:14, 75:15, 75:20

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, I don't know if everybody knows everybody, but Commissioner Angela Coke and Commissioner Dr. Jack Kitts are the other two Commissioners.

We are here, and I am sure Mr. Mathai has explained to you the way we have generally carried on, so I think you can just start whenever you are ready to start.

ELIZABETH WALKER: Thank you. So I am happy just to launch right in, unless anybody would like to make any comments before I do?

Okay, thank you very much.

So I will just introduce myself and Brent who is here, and then perhaps ask PHO colleagues to introduce themselves as well to you.

My name is Liz Walker. I am the Director of the Accountability and Liaison Branch here in the Office of the Chief Medical Officer of Health.

I would very much like to thank you for offering the opportunity this afternoon to meet with you and provide you with a briefing and answer

questions you may have.

Unfortunately, Dr. Williams is not able to join us today. I am sure you can imagine his schedule these days, but he has asked us to present on his behalf and answer some questions.

So I will just turn this over to Brent, so you can see him and he can introduce himself.

BRENT FEENEY: Good afternoon, everybody. Yes, so it is Brent Feeney. I am the Manager within the Funding and Oversight Unit. Our unit is responsible for providing oversight and managing and administering the funding provided to Ontario's Public Health Units and Public Health Ontario.

I have been in the Ontario Government since I believe 2001 and the majority of which has been in the public health file.

So definitely interesting times and looking forward to having our discussion this afternoon.

ELIZABETH WALKER: Thanks very much, Brent.

So PHO colleagues, should I turn it to you to introduce yourselves?

COLLEEN GEIGER: Thank you, Liz.

I am Colleen Geiger. I have met the three Commissioners once before early in your journey as you were getting an introductory presentation about Public Health Ontario.

I am, as you know, the Acting President and Chief Executive Officer, and I am joined today by my colleague Cathy Campos, who is our Chief Financial Officer and who will be speaking to the financial slides in the PHO part of today's presentation.

So I will turn it over to Cathy to just say a couple of words. Thank you.

CATHY CAMPOS: Thanks, Colleen.

Good afternoon, everyone. My name is Cathy Campos and I act in the capacity of Chief Financial Officer at Public Health Ontario. I am working very closely with Colleen and the executive team, and I also work closely with Liz and Brent.

ELIZABETH WALKER: All right, so thank you very much.

I will take myself off video while I am running through the slides because you will either see the top of my head or me doing this for most of the slides, so if you are comfortable with that, I'll take myself off video while I am running

through.

But please don't hesitate to ask questions as we go, or if you wish to wait until the end and I will put myself back on video and am happy to engage in a dialogue with you, if you are comfortable with that.

COMMISSIONER FRANK MARROCCO (CHAIR): I think we are.

ELIZABETH WALKER: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Nobody is objecting. So I think we are, so away we go.

ELIZABETH WALKER: We'll proceed, okay.

So thanks very much to Amy for running through and operating the slides for us.

I understand that there is also some documentation that you have, including an information note and agreements and some sample funding letters that have been shared with you in advance of this afternoon's briefing as well.

COMMISSIONER FRANK MARROCCO (CHAIR): I know that we received some documents I think yesterday, if that is what you are referring to?

ELIZABETH WALKER: Yes, I think so.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ELIZABETH WALKER: I will defer to our lawyers around the timing, but yes.

SUNIL MATHAI: Yes, sorry, just to interact, Commissioner Marrocco, some documents were sent to you yesterday, including two business cases, that address some of the proposals that are going to be discussed today, but prior to that, documents were also provided on these topics as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

ELIZABETH WALKER: Perfect, thank you.

So just in terms of the executive summary, we did receive some questions from you that we understood you have with respect to things like public health modernization and our public health units and Public Health Ontario.

So we thought we would do an overview presentation first, and then we are going to get into a little bit more detail around the 2019 Ontario budget decisions and financial considerations.

We have attempted to answer the

questions that you had in the presentation, but as I said, happy to take further clarification or questions as we go or at the end, whichever you would like.

So if I can ask to flip over to slide 4, we can perhaps start with the public health mandate in Ontario.

And as you probably know, the focus of public health is on the whole population rather than just individuals, and its work is embedded in the daily lives of people in Ontario, "where they live, work and play" is a phrase we often use.

The work of public health is broad, and it contributes to improving and protecting the health of Ontarians through public health programs and initiatives, the kinds of things that you see on the slide, like childhood immunizations, infectious diseases, safe water, education and inspections related to food handling.

Over the years public health interventions have made the food that we eat safer. They have protected us from infectious diseases and environmental threats. They have created healthier environments, and have helped us learn and support informed voices about risks related to things like

tobacco and alcohol, for example.

Public health also impacts communities around things like healthier environments, responding to public health emergencies, and also social conditions that affect or certainly could improve health. So we call those social determinants of health or just general determinants of health.

And through the health units in looking at those different determinants and reducing the health risks to the population, we contribute to reducing the need for other health care services.

COMMISSIONER FRANK MARROCCO (CHAIR):

Sorry, Ms. Walker, when you said the "health units", did you mean the local units that have a Local Medical Officer of Health, or did you mean a different kind of unit?

ELIZABETH WALKER: So I do mean the public health units that have the Medical Officer of Health.

The next slide actually will get into -- and maybe we could just go there, and I can go straight into the sort of explanation of the structure in Ontario.

So you'll probably hear us refer

interchangeably to boards of health and public health units, and I will explain the difference across those as we go.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ELIZABETH WALKER: So with respect to that model, it is unique in Ontario. Ontario's model is unique across the country, and it reflects the diversity of our population and it also involves shared authority and accountability at the provincial and municipal levels, which is unique.

And really the value of that kind of a model, it allows us to balance provincial consistency, where it is important to have a consistent approach across the province, as well as local autonomy and the ability of the health units to reflect the public health needs of their local communities right down to neighbourhood levels.

It also supports and really strengthens the bridge between the health and the non-health sectors. So I referred earlier to the determinants of health. It is a relationship with the social services sector and the education sector that is strong at a municipal level.

COMMISSIONER FRANK MARROCCO (CHAIR):

And that is distinct from the Chief Medical Officer of Health?

ELIZABETH WALKER: It is. So what --

COMMISSIONER FRANK MARROCCO (CHAIR): What is the difference between the two of them?

ELIZABETH WALKER: So I'll explain.

What you see here is what we call the three legs of the stool.

So at the provincial level, we have the Chief Medical Officer of Health who is part of the Ministry of Health and reports in to our Deputy Minister of Health.

And then at the local level, we have 34 boards of health that employ 34 Medical Officers of Health and serve an area, a geographic area that we call the public health unit.

So as I said, sometimes we use those terms interchangeably, but the Medical Officers of Health at a local level report to the boards of health.

The Chief Medical Officer of Health at the provincial level is separate and distinct from that, but obviously there is a very close working relationship across them.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

COMMISSIONER JACK KITTS: Can I just ask, does the shared accountability model change during a pandemic, or is it just like this shared accountability right through?

ELIZABETH WALKER: So in terms of the structure, it is the same, but you will start to see some nuances. Like there will be potentially more section 22 orders from the Local Medical Officers of Health, for example, and our funding relationship will shift to enhanced provincial resources.

So there is nuances, but the structure itself remains the same.

COMMISSIONER JACK KITTS: Okay, and just during the pandemic, does the Local Medical Officer of Health have the full authority in their area, or do they have to work closely with the Public Health Officer?

ELIZABETH WALKER: So at the local level, the Medical Officers of Health, they have the authorities under the HPPA, and those are the same during a pandemic or in regular times. If they feel that there is a risk to health, they have

options available to them, so that that remains the same.

COMMISSIONER JACK KITTS: Okay, thank you.

ELIZABETH WALKER: You are welcome.

So I'll just very briefly then touch on sort of at a high level those three legs of the stool.

The provincial, which is the Ministry of Health and the Chief Medical Officer of Health, as I mentioned, provides policy direction, guidance and oversight.

At the local level, we have the boards of health who are responsible for delivering those programs within those geographic boundaries that I mentioned.

And then we also have the third leg of our stool, which is Public Health Ontario which provides scientific and technical advice to the health units, to the Ministry, to ourselves, to the CMOH, to other ministries across government, and also operates Ontario's Public Health Laboratories, which we'll touch on a little bit later in the deck as well.

COMMISSIONER FRANK MARROCCO (CHAIR):

I am sorry to stick on this, but I am just a bit confused. I thought that the Chief Medical Officer of Health was supposed to provide advice to the government. Does Public Health Ontario report to the Chief Medical Officer of Health?

ELIZABETH WALKER: So there is an MOU and there are various sort of instruments and documents in place where the Board Chair of Public Health Ontario reports in to the Minister of Health. The Chief Medical Officer of Health sits on the Strategic Planning Committee of the Board and is an observer to the overall Board of Health.

And then there is what we sort of call the administrative accountabilities and responsibilities that happen between government and a Crown agency that would come through Dr. Williams as well.

Is that helpful?

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

ELIZABETH WALKER: Okay. So perhaps if we can go to the next slide, so what we wanted to do was just spend a few minutes providing a little bit more detail with respect to the public health

unit leg of the three-legged stool and give you a little bit more information on some of the comments that I have just made.

So there are currently 34 public health units or boards of health in Ontario. They are established under the Health Protection and Promotion Act, and they deliver health promotion, health protection and disease prevention public health programs.

So I mentioned previously the boards of health. So each health unit is governed by a board of health, and that board is accountable for ensuring the provision of public health programs and services required by the HPPA and Ontario's Public Health Standards, which I'll refer to in just a moment.

So most of our boards of health in Ontario, and there is 22 of the 34, have an autonomous governance structure meaning that they are independent corporations separate from any municipal organization.

And other boards in Ontario have varying degrees of connection with their local municipal organizations, so some of them, the regional council acts as the board of health, for

example.

So those boards of health and their geographic boundaries are aligned with municipal boundaries. All of those boards include municipal members, and the majority of the boards, so the autonomous ones, also have provincial appointees as members of their boards as well.

COMMISSIONER FRANK MARROCCO (CHAIR):

So the regional government can act as the board of health, the local board?

ELIZABETH WALKER: Yes, it can.

COMMISSIONER FRANK MARROCCO (CHAIR):

And can it also own long-term care homes?

ELIZABETH WALKER: I am not sure --

COMMISSIONER FRANK MARROCCO (CHAIR):

Or operate them?

ELIZABETH WALKER: Yes, I am not sure about that. I would have to take that back. I am not as familiar with the long-term care structure.

COMMISSIONER FRANK MARROCCO (CHAIR):

Because if that is correct, it would sort of be a conflict. If the Local Medical Officer of Health found something wrong with the way in which the long-term care facility was being

run or not run, if the board of health to whom he would report that, he or she would report that to is the same person operating the home. That is why I asked.

But I understood your answer. You are not clear, so you are not certain of what the answer is, so I understand that.

U/T ELIZABETH WALKER: And I appreciate you offering the context of which you are asking your question, so we'll certainly take that back, absolutely.

So with respect to all of those boards of health, as I mentioned previously, they must appoint a full-time Medical Officer of Health for each of those public health units. That MOH reports directly to the board of health on public health issues and is responsible to the board for the management of public health programs and services.

So although the MOH is an employee of the local board of health, his or her appointment must also be approved by our Minister of Health as well, and that is included in the legislative requirements.

So I mentioned a moment ago the Ontario

public health standards. Those standards have been developed by the province in collaboration with many others, but they do identify the minimum expectation for Public Health programs and services to be delivered by those 34 health units.

The standards are published by the Minister of Health under the authority of the Health Protection and Promotion Act under section 7.

So it is the responsibility of the boards of health to be accountable for ensuring the provision of those standards in that local public health unit catchment area, including the protocols and guidelines that are referenced as part of those standards.

And protocols and guidelines to varying degrees set some of those guidelines and expectations around what needs to be done consistently across the province and also provides some guidance as to where local priority-setting and considerations would come in based on local community health assessments that are done by the health units.

COMMISSIONER FRANK MARROCCO (CHAIR):

Is that any different in a pandemic or

does that structure remain the same?

ELIZABETH WALKER: Sorry, you mean in terms of the --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, defining the work and strengthening accountability. I am just wondering if the decision, the policy-making decision-making changes at all when you have something like we are dealing with.

ELIZABETH WALKER: Yes, it does. So every board of health is also required to have pandemic plans or continuity of operations plans in place that would address exactly that kind of situation.

So if they are dealing with a health emergency in their area or a particular response that is part of those emergency plans, they would plan out ahead of time what are the kinds of supports and services that they would need to consider varying or what are those local priorities.

And it would depend health unit by health unit and emergency by emergency or public health event by public health event, but that would be part of what a board of health would be

accountable for ensuring their health unit has in place.

COMMISSIONER FRANK MARROCCO (CHAIR):

So they are all expected to have a pandemic plan, so it is foreseeable in the mind of the Ministry of Health that it may be necessary at some point to resort to a pandemic plan because there is a pandemic.

ELIZABETH WALKER: Exactly, yes, that is exactly right.

COMMISSIONER FRANK MARROCCO (CHAIR):

How long has that been the case, Ms. Walker, do you know?

U/T ELIZABETH WALKER: I actually don't know. I am looking at Brent. I am not sure we know. We would have to go back. I would have to have a look. I know it has been a requirement of the standards, but we would have to go back and have a look at when that became part of the standards or the transfer payment agreements it may have been with as well, so we can look back at that as well.

COMMISSIONER FRANK MARROCCO (CHAIR):

That is fine, thank you.

ELIZABETH WALKER: Okay, so just

carrying on, the standards also, just to finish off on that very quickly, the standards also include a public health accountability framework and organizational requirements, transparency and demonstrating impact and public health indicator and transparency frameworks, which are part of that.

So for slide 8 then, for funding and accountability, part of the accountability of each of those boards of health that I had mentioned includes setting priorities, where it is within their authority to do so, and also establishing the budget for each of their public health units to deliver on those standards, including how they will be operationalized in each of those communities. And it is the board of health that is responsible for establishing and approving the budget that it needs effectively to meet those legislated requirements.

Under the legislation, it is actually the municipalities who are required to pay for that budget of the boards of health and the health units, and then the Minister of Health may make discretionary grants for the purposes of the services underneath the Health Protection and

Promotion Act, but it is actually not legally obligated to do so, and that is outlined in the Act as well.

However, historically, the Minister of Health has provided funding to boards of health for the purpose of delivering programs such as the standards, and this has varied over time.

So there is an appendix to the deck that shows you some of the variation over the last few years.

We call it the cost-shared portion, but in addition to that, there is some provincial programs that are funded at 100 percent. They are not cost-shared with the municipalities.

I should also note that there are areas in the province that are called unorganized territories where they don't have an organized municipal track, and in those instances the province pays that percentage as well.

The provincial funding for public health units is usually based on a calendar year, which equates to the municipal fiscal year, and provincial funding decisions are made on the Ministry's review of budget submissions received from the boards of health and subject to the

Minister's approval.

I want to also mention --

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I just ask you to clarify for me, the local board establishes its budget.

ELIZABETH WALKER: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

So it sets its own budget, and then the municipality has to pay it?

ELIZABETH WALKER: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

If the municipality doesn't approve the budget, they are obliged to pay it, to fund it?

ELIZABETH WALKER: That is correct.

You know, I will just ask, and maybe I can just turn this over, and again, apologies for the movement, but maybe Brent could just add a little bit to that.

BRENT FEENEY: Yeah, hi, everybody.

So yeah, it is the local board of health that approves and sets the budget, and it is the municipalities that are legally required to pay it.

But I do think it is important to note that, you know, the majority of members on that

board of health are municipal members. There is a regulation under the Health Protection and Promotion Act that sets the number of municipal members per board of health, and each municipality within that health unit has representatives on the board.

So the municipalities in essence have a say in terms of the board of health budget that it approves. They are mostly represented on the board of health.

COMMISSIONER FRANK MARROCCO (CHAIR):

Where the region is also the board of health, then the budget would be set by the region?

BRENT FEENEY: You got it.

COMMISSIONER FRANK MARROCCO (CHAIR):

So that then would be a little different.

BRENT FEENEY: Yes, in an autonomous board of health, that autonomous board of health approves the budget, and then under legislation it has to actually provide a notice to the municipalities in their area, which would include the amount that municipality has to pay and the timeline.

Within a regional board of health, it

is the regional government that approves its own budget of what it pays.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay, thank you. And just lastly, let me just ask you one other thing. These situations where the region is also the board of health, are they historical or is there some -- what is the rationale for that, if you know?

BRENT FEENEY: I don't know specifically the rationale, but it is definitely historical.

As far as I know, under the Health Protection and Promotion Act, there are basically three types of boards and they have been in the Health Protection and Promotion Act for a number of years. I can actually look back and find out exactly when it was.

So you have got your autonomous boards of health that have been established under the HPPA; you have your regional boards of health; and we also have single-tier boards of health as well.

So we do have some single-tier councils in the province that also act as the boards of health, so City of Toronto and City of Hamilton. That has been the structure for public health, you

know, at least as far as I know, back to the late '90s. I would have to see if there was a different structure prior to then, but that has been the structure in public health as long as I have been around at least, for over 20 years.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ELIZABETH WALKER: Okay. So just one more thing to note with respect to again what we sort of call the cost-shared portion of the funding of the health units is that if the board of health's approved budget actually exceeds the Ministry's approved funding level, then it is the responsibility of the obligated municipalities to pay for that difference in cost.

So one example of where that occurs is that starting back in 2006 and in order to manage within approved allocations within the Ministry, the Ministry of Health began implementing caps on growth funding, so at this time the municipalities began to provide funding over and above their 25 percent share, for example.

So in 2019 the Ministry was aware that there was about two-thirds of the provincial municipalities that do actually provide more than

their 25 percent share, and some up to as much as 40 percent, in order to cover the costs of those health units.

So I just wanted to make it clear that it is not necessarily a strict 75 or has been a strict 75/25 percent reimbursement. It is actually a capped allocation model.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ELIZABETH WALKER: So with respect to our funding, the funding is governed by the public health funding and accountability agreement, which is an evergreen agreement that came into effect and it started on January 1st, 2014.

And that accountability agreement requires public health units to achieve specific and measurable results. They have to have governance and administrative structures in place. They have to provide periodic reports on financial status and relevant financial and program results achieved to us, and they also permit the recovery of provincial funds or the discontinuance of ongoing funds in the event of public health unit non-performance or non-compliance.

COMMISSIONER ANGELA COKE: Could I just

ask a question. You had mentioned before that some of the programs are 100 percent provincially funded. Are those sort of one-time special initiatives, or is that an ongoing stream of funding for certain programs?

ELIZABETH WALKER: It can be both. So I am trying to think, so the Ontario Seniors Dental Program, for example, is a hundred percent funded, and that is an ongoing amount. In other instances, some of the one-time time-limited is also a hundred percent provincially fund.

COMMISSIONER ANGELA COKE: Okay.

ELIZABETH WALKER: So if we move to the next slide, we can start talking just a little bit about public health modernization.

And as you are probably aware, there was several reports over the last twenty years and we have included or cited some of them here who have identified challenges in how the public health structure or public health sector is structured; for example, the misalignment of health, social and other services, duplication of effort, inconsistent priority setting, the variation in capacity across health units.

So as part of the 2019 Ontario budget,

which was released in April of that year, government committed to modernize the public health sector in order to address some of these issues and balance fiscal responsibility as well.

So as part of that budget, government committed to do a few things.

It committed to adjust the provincial/municipal cost-sharing of public health funding.

It also committed to establishing ten regional public health entities that would be governed by ten regional boards of health that had a common, consistent, single governance model, so to take away the variability that you have heard us talk about between the autonomous and regional boards, for example.

The third was to modernize Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reduce the number of laboratories, and also protect what matters most by ensuring public health agencies focus efforts on things like providing better and more efficient frontline care and looking at removing back office inefficiencies through digitizing and streamlining

some of those processes.

COMMISSIONER FRANK MARROCCO (CHAIR):

But can I just ask you, Ms. Walker, these ten regional public health entities, how does that fit with the 34 units, the 34 health units?

ELIZABETH WALKER: So part of the discussion and the proposal at the time that has now been put on hold, and I can explain some of why it has been put on hold in a moment, but those ten regional entities were developed based on the current -- or a consideration of current health unit boundaries and also looking at some of the Ontario Health region or other boundaries or regional office structures across the province to look at some consistency of alignment to enable the better working relationship between the health units and their partners, where we were looking at some of those collaborative efforts.

COMMISSIONER FRANK MARROCCO (CHAIR):

It is just that it is the same province, and you have 34 local health units and then somehow intermingled with that there is 10 regional public health units.

And I was just wondering how all of these units -- there would obviously be overlap,

but I just wondered how they fit together, or maybe they don't.

ELIZABETH WALKER: I see, yes, so the 34 boards would actually have been collapsed and ten new regional public health entities and boards would have taken their place.

So for example, in the north we would have looked at bringing together a number of the public health units that are currently existing in the north and bring them into one regional entity, and the same with the southwest and the east.

So it would actually be a bringing together of the existing health units in certain areas to create greater capacity and try and balance out, for example, where there are smaller health units, smaller catchment areas, a lack of capacity and size of health unit and numbers of staff, for example, and create more consistency across the province.

So it would actually replace the existing structure.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ELIZABETH WALKER: They wouldn't be running in parallel.

COMMISSIONER ANGELA COKE: So I am assuming, though, they map to some municipal boundaries, because that is obviously who you are cost-sharing this with, so it is ten reconfigured but matching somehow municipal boundaries so that people know exactly which part of that they would be paying for?

ELIZABETH WALKER: That is correct.

So again, I sort of want to just note that this was put on hold. It was subject to -- we were having consultations with respect to what those proposed boundaries would be looking like, and that was put on hold for a few reasons, not the least of which was the pandemic.

But the boundaries of the regional health entities were considered based on -- and I am trying not to use the amalgamation idea because that feels like it is taking over, whereas it was really a coming together of the capacities that exist. But for example, the health unit boundaries, I gave the north as an example, so those existing seven, I think it was, health units and their boundaries would come together to create the one entity that would still have those municipal boundaries.

There was a slight variation in a couple of the areas in what was proposed to ensure alignment with the Ontario Health regional boundaries and others, the MCCSS regional boundaries, for example, so there was a slight variation, but they were, again, on those municipal boundaries.

So you are correct, it would have been clear as to which municipality belonged to which health unit still or regional entity.

COMMISSIONER ANGELA COKE: So with this consolidation, I am asking is the expectation that that you would have less FTEs in this new model?

ELIZABETH WALKER: So again, that was part of the consultation. There would certainly be opportunities for efficiencies, so where, for example, some of the back office functions wouldn't necessarily need to be duplicated as those health units joined together.

There may also have been opportunities to review some of those budgets and increase some of those frontline services.

So there wasn't particular decisions made on that.

COMMISSIONER ANGELA COKE: No, I was

thinking more just in terms of the skills and capacity. You know, you have a certain number of resources now of FTEs with whatever skills and capacity you need, and I am trying to understand how that capacity and skills would be maintained in this new structure or not.

ELIZABETH WALKER: So again, that would have been part or was part of the consultations that were underway. The intent was to build on and strengthen the public health system in response to some of those recommendations. So that would have been absolutely part of the considerations in the deliberations that would have come out of those consultations.

So I'll continue on just with some of the points on this slide to say that in August of 2019 and in response to some of the concerns that were raised by municipalities with respect to what was committed to in the budget, the government announced that it would actually modify some of the financial impacts that were originally stated and, as I mentioned, would also then launch consultations with municipalities that would inform the design and implementation of that local public health modernization, including the discussion that

we have just had with respect to the number of regional health entities and what that would look like and the related timing and financial considerations of that.

So one more slide and then I am going to turn it over after this one to Brent to get a little bit more into some of the details, but just to finish off on the consultations, so in October of that same year our Minister announced that a gentleman by the name of Mr. Jim Pine would be the government's advisor on public health modernization, and then the following month, in November, the government launched the consultations which included the release of a public health discussion paper.

And following that release, the Ministry has received over 500 submissions from organizations and individuals providing their feedback and advice in response to the discussion paper and the questions that were included within it.

Also, we had met with over 300 participants in over eight regional in-person consultations, but then unfortunately back in March those in-person consultations and any further

decisions with respect to public health modernization were put on hold as we needed to enable and support the public health sector to respond to the pandemic.

So consultations and modernization of the public health sector continues to be a priority for the government and for the Ministry. And once the pandemic is managed - I won't say over, although I would love to - but certainly when it is managed and contained and those key risks are mitigated and it is feasible operationally both for the field and for the Ministry, we will be moving forward and consider the changes that need to be made and have been proposed and will continue on with those consultations looking to modernize and strengthen public health services.

So on the next slide, I am actually going to turn it over now to Brent to take you through some of the next set of slides.

BRENT FEENEY: Thanks, Liz.

So as was mentioned, so the 2019 Ontario budget announced changes to public health units that supported the government's commitment to achieving fiscal balance and to better coordinate access at the local level and to also increase the

role for municipalities.

Notably with respect to public health units and funding, there were a few ways in which the government was looking to accomplish this, one of which was, as Liz had walked through, was the establishment of the ten regional public health entities effective as of April 1st.

And I think what is important to note on that piece is that as public health units and boards of health are established under legislation, any changes to the structure of public health units and governance would require legislative changes, so I think that is an important piece to note, that any changes to structure or governance would require changes to legislation.

Another piece that was recommended and announced through the Ontario budget was the government had proposed that it would adjust the provincial/municipal cost-sharing of funding from the current, from what was the 75 percent provincial/25 percent municipal cost share and it would change to a -- it would change to a different set of cost-sharing for different entities over a three-year period. And the final ratios would have been set based on the population size of the new

regional entity to recognize the variation across Ontario.

So basically, what the proposal at the time was is that we would be shifting provincial costs as part of a 75/25 arrangement and we would be shifting costs from the province over to municipalities.

So there wasn't an intent to reduce the budget of the health unit, but to just shift the responsibility between the province and municipality of costs.

So I am not going to go in too much detail of what those cost-sharing arrangements were, but just quickly, the plan at the time was effective April 1st, 2019, the provincial/municipal cost-sharing arrangement were to be changed to a 60 percent provincial/40 percent municipal for the City of Toronto and a 70 percent provincial/30 percent municipal for all other public health units.

In that first year, the Ministry had planned to give one-time mitigation funding to cap the municipal increases at 10 percent as a result of the change in the cost-sharing.

In year two, which would have been

effective as of April 1st, 2020, the provincial/municipal cost-sharing arrangements were going to be maintained at a 60/40 for Toronto and a 70/30 for all other proposed regional entities, but the one-time mitigation funding was to be removed so there would be no cap on increases for municipalities.

And an end state effective April 1st, 2021, the province had planned to move to a 50 percent provincial/50 percent municipal for the proposed Toronto regional public health entity, 60 percent provincial/40 percent municipal for those six regional public health entities that had populations of over 1 million, and then for the three smaller regional public health entities with populations under a million, it would remain at a 70/30.

So these actions, and what I mean by "actions" is the establishing of the ten regional public health entities and the adjusting of the provincial/municipal cost-sharing arrangements, these actions would lead to an annual provincial savings target of approximately 200 million dollars, and that 200 million dollars was to be achieved by '21/'22, and that was announced as part

of the 2019 Ontario budget.

But as Liz had mentioned, you know, following the release of the 2019 budget, the public health and municipal sectors did react strongly to the planned change and the cost-sharing arrangements, including the inability of municipalities to build in or absorb the increased costs especially in the first year.

So in response to these concerns, on May 27th, 2019, the government committed to maintain the current cost sharing arrangement for 2019, so a 75 percent provincial/25 percent municipal, to provide municipalities with more time to find efficiencies.

So in May, the government announced that we were going to maintain 2019 cost-sharing at a 75/25 arrangement, no changes to funding for 2019 in terms of the cost share programs.

Further, in August 2019, as part of the Annual Conference of the Association of Municipalities of Ontario, the Minister of Health announced a revised public health modernization plan than what was proposed originally as part of the 2019 Ontario budget.

This plan included, you know, the

government's commitment to consult more broadly on public health modernization to begin in the fall, as Liz had walked through earlier. And so with that commitment to consult further on the structure, that meant that the existing structure and total number of health units, which at the time was about 34 health units, would be maintained pending the outcome of the public health modernization consultation.

The Minister also announced that the cost-sharing arrangement would be changed, and effective January 1st, 2020, a consistent 70 percent provincial/30 percent municipal cost-sharing ratio would be applied to all public health units. So the original three-year phased approach was no longer being applied. The government committed to a 70/30 cost-sharing ratio to be applied to all health units, and that would be effective as of January 1st, 2020.

And then finally, the Minister had announced mitigation strategies and that one-time funding would be provided to public health units for 2020 to ensure that no municipality would experience an increase greater than 10 percent as a result of the cost-sharing change moving from a

75/25 ratio to a 70/30.

Through the public mental health modernization consultation process, which again began in the fall of 2019, municipalities continued to raise concerns regarding their inability to fund increased public health costs once the one-time mitigation funding was to be removed in 2021, effective January 1st, 2021.

In response to these concerns, on March 17th, 2020, the government announced that it was extending the one-time mitigation funding for public health units for an additional calendar year, so it would be extended into 2021 to ensure that the municipal adjustments would remain capped at 10 percent and recognizing the considerable time and necessary resources that were required for health units to respond effectively to COVID-19.

And as Liz mentioned earlier, at that time in mid-March the public health modernization consultations were also put on hold to allow public health, the public health sector to respond to COVID-19.

And then further, in August of 2020, on August 17th, 2020, the Minister of Health announced that the Ministry would be increasing the one-time

mitigation funding for public Health Units to fully offset the increased costs of municipalities from going from a 25 percent to a 30 percent in both '20 and '21 so that municipalities are not impacted at all by the cost-sharing change during this critical time.

So I know that is a lot of info, and as you can see on this slide, given the changes that have taken place since the original announcement through the 2019 Ontario budget, the original provincial savings targets, as you can see on this slide, are not being realized at all.

So what was originally proposed as a 200 million dollar provincial savings target to be achieved by '21/'22, as you can see below that table, we are now no longer looking to achieve any provincial savings as a result of public health modernization at this time.

COMMISSIONER FRANK MARROCCO (CHAIR):

So in essence, everything remained the same; is that right?

BRENT FEENEY: Not entirely true. Everything remained the same in terms of the cost-shared funding amount but --

COMMISSIONER FRANK MARROCCO (CHAIR):

I'm sorry, that is what I was referring to, that the financial arrangement did not -- whatever was intended -- I am just trying to make sure that I have it clear in my own head. Whatever was intended for a variety of reasons did not change?

BRENT FEENEY: You are correct. The only thing I would clarify is the cost share did go ahead, so we did go to a 70 percent provincial and 30 percent municipal effective as of January 1st, but what the government has committed for two years is that we would fully offset the municipal increases as a result of that cost-sharing change.

So there is no impact to the public health unit or the municipalities as a result of these changes.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right, okay. Commissioner Coke?

COMMISSIONER ANGELA COKE: Yes, I understand what you are saying in terms of no change at this time, but was the anticipation -- you are downloading this cost to the municipalities. Were the other modernization initiatives going to enable them to have the savings to respond to that? Was that the thinking?

BRENT FEENEY: Yes, partly that was part of the thinking of any savings, any potential back office savings that would have resulted from us moving to ten regional entities would be also applied to any municipal costs.

COMMISSIONER ANGELA COKE: I see. Okay, thank you.

BRENT FEENEY: Okay, so before we get into Public Health Ontario, I just wanted to walk through some COVID-19 provincial support that has been provided to the public health units.

So we definitely acknowledge the extraordinary and continuing efforts of the public health sector, including public health units, to monitor, detect and contain COVID-19 in the province.

Ontario's public health system has demonstrated a remarkable responsiveness to COVID-19 as the outbreak has evolved locally and globally.

For the '20/'21 fiscal year, the Ministry has increased public health sector investments to ensure there is sufficient capacity in the province to manage and respond to COVID-19 and ensure that other critical public health

programs and services in Ontario are not compromised due to the COVID-19 pandemic.

So back in March, around the same time that the government had put a pause on the consultations for modernization, the government's Ontario Action Plan Responding to COVID-19 included up to 100 million dollars in additional funding - and this was at 100 percent provincial funding, so not to be cost-shared with municipalities - 100 percent in additional funding for the public health sector, including public health units, to ensure that they have the capacity required to monitor, test and do appropriate case and contact management in their local area.

In addition, as part of Ontario's Plan for the Safe Re-Opening of Schools in September, the Ministry approved up to 62.5 million in additional funding for public health units to hire up to 625 additional school-focussed nurses for the '20/'21 school year.

In addition, as part of the province's COVID-19 fall preparedness plan, that plan also included additional funding to add case and contact management staff to support the public health sector to identify and follow up with new COVID-19

cases and outbreaks to avoid further spread.

And the government also approved additional funding through what was called the Temporary Pandemic Pay Initiative to help frontline staff, including public health unit nurses who worked and are experiencing severe challenges and are at heightened risk during the COVID-19 outbreak.

And then finally, there has been a lot of support for the local municipalities, and in partnership with the federal government, the province also provided up to 4 billion dollars in one-time assistance to Ontario's municipalities as part of the Safe Restart Agreement.

So the Ministry --

COMMISSIONER FRANK MARROCCO (CHAIR):

So -- and sorry to interrupt.

BRENT FEENEY: No problem.

COMMISSIONER FRANK MARROCCO (CHAIR):

So in terms of testing and contact tracing, that is 1.5 billion dollars?

BRENT FEENEY: So for the public --

COMMISSIONER FRANK MARROCCO (CHAIR):

And sorry, let me be clear, 1.5 billion dollars was made available for that purpose?

BRENT FEENEY: So these are investments that were specifically for public health units and part Public Health Ontario. There are a lot of other additional investments as well.

There was a 1.4 billion dollar approval, which I believe we reference later on, that was approved through the government's fall preparedness plan to support laboratory testing.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BRENT FEENEY: So if we can move on now to Public Health Ontario, and very similar to public health units, we'll provide a bit of an overview of Public Health Ontario, including funding and accountability.

We'll walk through some of the impacts, some of the commitments that were made through the budget that had an impact on Public Health Ontario and go through some of the COVID initiatives as well.

So following major public health events such as Walkerton in 2000 and SARS in 2003, numerous external reports, Naylor, for one, the Walker Report and the Campbell Report, recommended the creation of a public health agency for Ontario.

The 2004 government report titled "Operation Health Protection" then committed to establish an arm's length public health agency by 2006/07.

The Ontario Agency for Health Protection and Promotion Act was passed in 2007 to establish a board-governed agency, known as the Ontario Agency for Health Protection and Promotion, which operates as what you likely know them as is Public Health Ontario.

In accordance with this Act, Public Health Ontario's legislative mandate includes providing scientific and technical advice and support to the health and public health systems in the areas of infection prevention and control, communicable diseases, environmental health and chronic disease prevention.

The agency also carries out and supports activities such as public health research, surveillance, epidemiology, planning and evaluation, and operates and provides public health laboratory services in public health laboratory centres across Ontario.

In 2011, the Ministry of Health's public health science and epidemiological functions

were transferred to Public Health Ontario, creating a key dependency for Ontario's Chief Medical Officer of Health to perform his or her legislative duties.

I had mentioned the public health --

COMMISSIONER FRANK MARROCCO (CHAIR):

I'm sorry, what do you mean by a "key dependency" for the Chief Medical Officer of Health? What does that mean?

BRENT FEENEY: Well, I will give this a go. So what it means is that the Chief Medical Officer of Health has a separate arm's length agency that it can rely on for advice and support in areas of science and epidemiological functions.

COMMISSIONER FRANK MARROCCO (CHAIR):

So "dependency" means that the Chief Medical Officer of Health can rely on that agency, not that the Chief Medical Officer of Health is dependent on that agency?

BRENT FEENEY: Sorry, I'll just give it to Liz here.

ELIZABETH WALKER: Sorry, we are trying to minimize the vertigo here.

BRENT FEENEY: Yes.

ELIZABETH WALKER: So one example is

surveillance. So there was surveillance capacity that is required by the Chief Medical Officer of Health to undertake his legislative duties under the HPPA, and as part of the 2011 changes, that capacity was moved over to Public Health Ontario.

So rather than having that capacity within the division, it is now within Public Health Ontario, so it is a function that the CMOH relies on, and that is where we are talking about key dependency. So for him to be able to make decisions, to make recommendations to government and to Cabinet, as you reflected earlier, Judge, those are the kinds of key dependencies that are now under Public Health Ontario that the Chief Medical Officer of Health would rely on.

COMMISSIONER FRANK MARROCCO (CHAIR):

But he can't command them because they belong to Public Health Ontario and that is an independent agency managed by a board. Have I got that right?

ELIZABETH WALKER: That's right. That is where --

COMMISSIONER FRANK MARROCCO (CHAIR):

So he is dependent?

ELIZABETH WALKER: Yes, that is right.

COMMISSIONER FRANK MARROCCO (CHAIR): That is the dependency. They have to agree with what he wants to do, or she, but Dr. Williams is a he. They have to agree?

ELIZABETH WALKER: So there is a number of different I don't know if "labours" is quite the right word, but there is certainly a number of structures in place where that happens, so the annual business planning process between Public Health Ontario needs to submit to the Ministry for approval, the legislated objects that require the agency to undertake those specific functions. I am trying to think of a couple of others, and Colleen and Cathy may be able to refer to some of those as well.

BRENT FEENEY: It is actually on the next slide, I think.

ELIZABETH WALKER: Oh, is it on the next slide as well?

BRENT FEENEY: Yeah.

ELIZABETH WALKER: The CMOH is also able to issue directives to the agency, so there certainly are options there that support that key dependency role so that it enables that to happen as an independent Crown agency.

So I'll pass it back to Brent.

BRENT FEENEY: So as a Crown agency, Public Health Ontario receives ongoing transfer payment funding from the office of the Chief Medical Officer of Health, Public Health of the Ministry of Health for its base operations/legislative mandate.

Funding is provided by the province on a global basis, meaning that Public Health Ontario has the flexibility and ability to allocate the funding that the province provides to meet their legislative mandate activities.

The Ministry, as Liz was referencing, we do have several accountability mechanisms in place with Public Health Ontario to ensure the prudent use of funds and to ensure that they are meeting their legislative mandate activities.

The reporting requirements of Public Health Ontario are defined and outlined by the Ontario Agency for Health Protection and Promotion Act. There is a Memorandum of Understanding that is in place between Public Health Ontario and the Ministry that ensures that Ministry deliverables are met and value for money is achieved.

There is one important piece to note

about the Memorandum of Understanding that I wanted to flag in the context of the current COVID-19 pandemic.

The existing MOU that is in place between the Ministry and Public Health Ontario includes a requirement that should Public Health Ontario not be able to find an offset for unplanned emergency outbreak costs, the Ministry of Health and Public Health Ontario shall work together to take any necessary steps to meet this financial requirement.

And I will provide a bit more detail on the COVID-19 supports in a few slides.

We also, as we do with public health units and as actually the Government of Ontario has with any transfer payment agency, we do have an evergreen transfer payment agreement in place that has been signed between Public Health Ontario and the Ministry of Health. When we say "evergreen", we mean that it is ongoing, that there is no end date. And that also builds on the requirements and provides for enhanced reporting mechanisms.

And then there are a number of directives that the province issues and requires that provincial agencies abide and comply with, one

of which is the agencies and appointments directive, and that sets out the rules and accountability framework for provincial agencies, as well as the remuneration guidance for government appointments.

So moving on to the next slide, because I know there was a question about whether PHO in our view has met their deliverables. Have they, you know, met their legislative mandate since the creation post-SARS.

So the government definitely values the important service that Public Health Ontario provides to Ontarians. Public Health Ontario's mandate and work continues to directly support government priorities through its focus on improving public health promotion and prevention within the health care system.

It does this by providing scientific and technical advice to Ontario's Chief Medical Officer of Health and by performing public health laboratory testing services for the provincial health system. The role of public health labs is fundamental to the work of the health system overall.

An internal audit of Public Health

Ontario was conducted by the Ontario Internal Audit Division in 2015, and that found that there are processes in place to ensure public resources are allocated and used with regard to value for money, and Public Health Ontario is meeting the objectives of the approved annual business plan.

There was also a mandate review of Public Health Ontario conducted in July 2016 that confirmed that, given Public Health Ontario's specialized expertise in providing scientific and technical advice with a public health focus, that their functions are best performed by the agency rather than by a Ministry, another agency or entity.

The mandate review also noted that further opportunities exist to align its services with the Ministry of Health and the broader health sector.

We also wanted to note that public health laboratory volumes, and I know Public Health Ontario is going to speak a bit further about this later, their laboratory volumes and related costs have increased significantly over the last few years, which are becoming a challenge for Public Health Ontario to manage within its own budget.

Over the past two years, the Ministry has been working closely with Public Health Ontario to identify operational efficiencies, to mitigate these increased costs, including the development of a Public Health Laboratory Modernization Plan which was announced as part of the 2019 budget, which I'll go into right now.

So if we go to the next slide, so the 2019 Ontario budget also announced that the government would streamline Public Health Ontario to align with the new public health system.

Part of this streamlining included modernizing Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reducing the number of laboratories.

As a result, provincial savings targets for Public Health Ontario were to be graduated, starting in 2019/20 associated with the modernization of Ontario's public health labs system, approximately 3.7 million in 2019/20 and 1.3 million in '20/'21.

So 3.7 million in 2019/20 were proposed savings, and 5 million dollars in '20/'21 associated with the lab modernization plan.

However, very similar to the public health unit piece, it is important to note, however, that the public health laboratory plan approved as part of the 2019 Ontario budget has not been implemented, nor has any of the original provincial savings targets approved been realized.

So there have been no changes to the laboratory system as it is currently structured today.

COMMISSIONER FRANK MARROCCO (CHAIR):

So do I understand basically there has been no change, neither financial nor physical, basically been no change because of the pandemic?

BRENT FEENEY: That is correct, although I will clarify --

COMMISSIONER FRANK MARROCCO (CHAIR):

Excuse me, that there was increased funding, as you have -- when I say "no change", I recognize there was increased pandemic funding, but these kinds of changes that were envisioned in the budget never happened?

BRENT FEENEY: Correct, although, and I will go through right now that there were some funding adjustments that were made to Public Health Ontario that I think is important to walk through,

which I can do right now.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure, go ahead.

BRENT FEENEY: So as I was mentioning, so the laboratory plan was put on hold for a few reasons.

One, there was a recent laboratory services optimization study conducted by the Ministry of Government and Consumer Services which also looked at government-run laboratories. The public health modernization consultations which are also looking at the mandate and role of Public Health Ontario in a modernized system are currently on hold. And of course, the COVID laboratory activities currently underway and the increased capacity required from all Public Health Ontario-run laboratories.

So as you can see on this slide, the table at the top shows a summary of the funding allocations that were approved for Public Health Ontario.

Although Public Health Ontario's base funding allocation was adjusted in 2019/20 to reflect the provincial savings targets pertaining to public health laboratory modernization, overall

provincial funding has remained at the same levels over the past few years, approximately 155 million, not including the COVID investments being made, which I will go through in a few minutes.

In '19/'20 and '20/'21, one-time laboratory transition funding was provided by the Ministry to Public Health Ontario while implementation of the public health modernization plan is on hold.

So Public Health Ontario's base funding allocation was adjusted to reflect the laboratory savings. However, because the laboratory plan is on hold and is up for further discussion through modernization, we have offset those adjustments through providing one-time transition funding.

Another key component that we wanted to raise as part of the April 2019 -- if you can just go back one slide, sorry.

So one of the key components of the April 2019 Ontario budget was a commitment to combine a number of existing provincial health agencies and the Local Health Integration Networks into one new agency, Ontario Health, to streamline health care oversight and reduce administration.

There was initial consideration of

including Public Health Ontario as one of the agencies to be moved into Ontario Health. As a result, there was an adjustment of approximately 9.5 million for 2019/20 related to efficiency savings.

So as you can see, if you look at the base funding, their base funding from '19/'20 -- or sorry, my apologies, from '18/'19 to '19/'20 was adjusted by 13.2 million, so that included the 9.5 million for the agency, the Ontario Health Agency, and then the 3.7 million for the laboratory modernization savings.

However, the movement of Public Health Ontario into Ontario Health was put on hold pending outcomes of public health modernization consultations, and the base funding was restored in 2021. This was also mitigated by one-time funding in 2019/20.

And if we could go to the next slide, so with respect to COVID-19, Public Health Ontario has played an extraordinary role in the pandemic response, including and not limited to COVID laboratory testing and scientific support, COVID data collection, monitoring, analysis and reporting, COVID case and contact management,

including resource support for the public health units, and providing scientific and technical advice and guidance to the public health units and other parts of the health care system, as well as other sectors.

COMMISSIONER FRANK MARROCCO (CHAIR):

So do I have it right that with respect to contact tracing, that remained the responsibility of the local health unit, but it was funded this way?

BRENT FEENEY: No, so the funding -- so to clarify, Public Health Ontario and public health units are separate agencies.

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes.

BRENT FEENEY: So the local public health units, the funding that we provide to the local public health units to support their local work with case and contact management, we provide funding directly to the public health units to support that work, as well as any other work that they undertake with respect to COVID-19.

ELIZABETH WALKER: I think the additional piece that you may be referring to -- and sorry, here goes the camera again. So there

has been surge capacity that has been developed in partnership with Public Health Ontario to enable some of those additional contact traces that have been brought on board to be able to move across the province virtually.

So if Peel, for example, required additional support as their cases spiked, there was surge capacity at Public Health Ontario to enable that.

And then if it was Ottawa's turn and their cases spiked, there was surge capacity at Public Health Ontario to enable that.

So there was a bit of a layered response, and the funding followed that layered response.

COMMISSIONER FRANK MARROCCO (CHAIR):

So the initial response, the initial responsibility for funding contact tracing would have been locally, apart I guess from these units where the regional municipality or the municipality is the unit, but forgetting that for a minute, where you had a local health unit, it had its budget for contact tracing and you provided additional funding because, of course, the contact tracing required would dramatically increase

because of the pandemic?

BRENT FEENEY: You are absolutely right. Like for a local public health unit, regardless of the governance structure, a local public health unit as part of the Ontario public health standards is required to comply and deliver infectious diseases control programming. A major part of that work, especially with respect to outbreak management, is case and contact management. It is a major component of the role and legislative responsibility of the local public health unit.

Normally, if there is a local outbreak, a local public health unit would fund those costs within its existing budget, within its existing funding, but COVID-19 has required a level of response that goes way beyond that.

And the same can be said with Public Health Ontario with their lab testing. The costs for lab testing and the costs for the local response case and contact went way over and above their approved budgets, and that is why the province had announced additional funding so that any pressures that the public health units incur and any pressures that Public Health Ontario incurs

we would offset at 100 percent through these different initiatives that I have identified through the slides.

COMMISSIONER FRANK MARROCCO (CHAIR):

So if you had a long-term care home, it is in a local health unit, and if you wanted to contact trace all of the cases that arose and were connected with that unit, the local health unit would pay for it but the additional costs caused by the fact that this all arises from COVID-19 would have been funded by the province.

BRENT FEENEY: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

So in your view, was there ample funding to permit that kind of contact tracing to go on?

ELIZABETH WALKER: So I think that -- sorry, and I'll turn the camera over again.

I think that is hard to answer just because the scale of the response is like nothing we have envisioned before.

So in a normal year, let me go back to that, in a normal year if there was an outbreak at a long-term care home of flu, for example -- or no, that is not -- of a reportable disease that

required contact tracing, it would be within the capacity of the health units. If it went above that, extraordinary costs would be covered to bring in additional expertise to enable that. I think in some of the health units, the capacity for scaling up, for finding some of those resources has been quite significant.

So it is sort of hard to say health unit by health unit.

COMMISSIONER FRANK MARROCCO (CHAIR):

But when you say find those resources, I thought you were saying earlier that the additional funding or your colleague was saying earlier that the additional funding required because of the pandemic was provided to the local health units because the local health unit's budget wouldn't sustain that.

And so therefore I was trying to understand whether in the province's view there was sufficient funding provided to the local health units to permit them to do the contact tracing that they had to do?

ELIZABETH WALKER: So funding is absolutely a fundamental part of that. The other, and if I use a colloquial expression, is the warm

body to fill the position.

So the pandemic has put an enormous strain on all of the health human resources across the province. There has been an awful lot of work done to find creative solutions for things like contact tracing, for example, and the kind of expertise that could be brought in, but there is a number of factors that would go into that.

So it would be hard for us to be able to provide a definitive response on that as to whether the funding was sufficient because the response, funding is part of it but there is a number of other factors with respect to that response.

COMMISSIONER FRANK MARROCCO (CHAIR):

But the funding portion of it, is it your view that the funding portion of it was sufficient, regardless of the personnel issues, for example?

ELIZABETH WALKER: So the extraordinary costs of the health units, if they had been identified through the additional funding, were being covered or have been covered by the province, yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

And the people to do the contact tracing, that would have been the responsibility then of the local health unit to find the people to do it? Assuming that you have provided them with the money, then they would have the responsibility of going out, and I just picked contact tracing because that is where we are at, and finding the people to do the contact tracing; is that right?

ELIZABETH WALKER: So there has been a shared response to that. So absolutely, that has been the role of the public health units to bring in additional capacity if it is required.

There has actually been a portion of our Ministry, and we would have to bring this back for further discussion because there is other folks who have been a lot more involved in that contact tracing discussion and plans, for example, than we have, but through that effort, there has been additional capacity identified, as I mentioned, at a provincial level. So there were opportunities then for that surge capacity.

So I am more than happy if you have sort of more -- to be able to bring this back and perhaps get someone to speak with you that has a little bit more detail than we do on how some of

those contact tracing capacity, how that was supported.

COMMISSIONER FRANK MARROCCO (CHAIR):

So just to pick one aspect of the capacity, finding the people to do the contact tracing after the province has provided the money was a shared responsibility between the province and the local health unit?

ELIZABETH WALKER: So yes, again, I would have to refer I think to -- I wouldn't want to go too far down here because I have not been involved directly with that capacity side, but we could certainly bring it back and I could refer the question to the area who has been a lot more involved than we have to deal with that and --

COMMISSIONER FRANK MARROCCO (CHAIR):

I wasn't -- sorry, go ahead, I didn't mean to interrupt.

ELIZABETH WALKER: No, that is okay, but they would be able to provide you with a more definitive response on how that has actually worked out than we would be able to.

COMMISSIONER FRANK MARROCCO (CHAIR):

I really was trying to understand whether the responsibility for finding, for

example, the people to do contact tracing was the local health unit's responsibility or the province's responsibility, and I took your answer to be it is a shared responsibility, and that because there is 34 health units and there is 34 stories about what was involved, I was just trying to understand who had the responsibility.

ELIZABETH WALKER: Understood, so yes, it is both of us. So the way that the additional surge capacity has been established is that public health units absolutely would be, as they are for all of their hiring decisions, they are responsible for providing or for seeking and bringing on board additional capacity as they need to.

But there was also in parallel to that an initiative at the provincial level to bring on additional contact tracing capacity and warm bodies again at the provincial level that public health units could request additional support for.

COMMISSIONER FRANK MARROCCO (CHAIR):

So if they were doing contact tracing because somebody in a long-term care residence tested positive, the contact tracer, just to pick one specific example of the support, would be a responsibility of both the local health unit and

the province?

ELIZABETH WALKER: So the initial case investigation, so when a positive case comes in, the initial case investigation is done by the health unit and then followed up with further contact tracing of that individual's contacts by the health unit.

But if the contacts, for example, on a daily basis became more than they had the capacity to be able to follow up with in a timely way, they were able to reach out to the province for that additional surge capacity. So that is where it became a shared responsibility. We were working jointly with the health units to support that.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

ELIZABETH WALKER: Does that answer your question?

COMMISSIONER FRANK MARROCCO (CHAIR): More or less. More or less.

COMMISSIONER JACK KITTS: Can I follow up on that? Could we go back to slide 5? I want to further explore this shared accountability to see if I actually understand it now.

So it is a unique model that involves

shared authority and accountability of both the province and the municipal levels, and the province would be Public Health Ontario and the Chief Medical Officer of Health, the three-legged stool?

ELIZABETH WALKER: Yes, for different functions, yes.

COMMISSIONER JACK KITTS: Okay. So Commissioner Coke asked -- or sorry, Commission Marrocco asked about the swabbing and testing and contact tracing.

Could you give me an example of how that shared accountability lines up in the pandemic plan? You have said that the local plan is to be created by the local public health units - and I assume the provincial plan is by Public Health Ontario and the Chief Medical Officer of Health - how they line up and then specifically how would the PPE supply or IPAC measures fit into that shared accountability.

ELIZABETH WALKER: So I am not sure I would be able to provide you with that level of detail.

In terms of the roles and responsibilities, as you see them there, they would apply regardless of whether it was swabbing or

contact tracing or however, whatever aspect of the pandemic.

But with respect to the particular pandemic plans that each of the health units would have or the provincial pandemic plan that is put in place by our Health System Emergency Management Branch, we wouldn't be able to -- I wouldn't be able to comment on that. I don't have that level of knowledge.

COMMISSIONER JACK KITTS: Okay, and so I wonder if you could check with someone about how they lined up that shared accountability, their PPE and IPAC measures specifically, but the alignment, I guess.

U/T ELIZABETH WALKER: Absolutely so PPE and IPAC, yes, we can certainly do that and I can bring that back to the right folks.

COMMISSIONER JACK KITTS: Yes, and the pandemic plan.

U/T ELIZABETH WALKER: And the pandemic plan, yes, okay.

So I am not sure there is anything further from us on the slides. I don't know if there is anything or any further questions?

Otherwise, we are happy to turn it over

to colleagues at Public Health Ontario to provide their presentation.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, it doesn't seem like we have any further questions.

ELIZABETH WALKER: Well, we'll certainly be here if there are.

CATHY CAMPOS: Okay, so I think we are ready to go.

Thank you, Brent and Liz.

We'll start with this slide, and really it is a follow-up to the commentary that Brent has made in terms of the implications of funding to PHO.

So I think Brent had mentioned, and it is a very important point, that PHO's annual base funding allocation had been flat since 2013 fiscal, and during that same period, as was mentioned, PHO's volumes, and these would be the non-COVID volumes, had increased materially by 25 percent.

It was in '19/'20 that, as you saw, PHO's base funding allocation was reduced by 13.2 million, equivalent to 9 percent, and this further increased PHO's opening deficit.

As a result and in fiscal 2019/20

compensation and non-compensation budget reductions were made to PHO's cost structure. The financial impact of those reductions was 13 million dollars.

So on April 24th, 2020, when we received our '20/'21 funding letter, we then realized that the funding allocation had changed, and rather than a 9 percent reduction, it was a 3 percent funding reduction. And while this is improved, it is still a funding reduction.

And like '19/'20, as Brent had mentioned, these funding reductions in base funding have been added back or reinstated on a one-time basis only.

And as a result of this, again, because of our volume growth over time and the fact that our base funding has decreased, it continues to be a risk for PHO, especially with the growing demands of the agency.

As Brent mentioned, and just to clarify, COVID-specific costs have been separately funded through a reimbursement process. So when we refer in these slides to base funding operations, this would exclude specific costs that we have incurred related to our COVID-19 response.

COMMISSIONER FRANK MARROCCO (CHAIR):

Is there a process? If the funding is being reimbursed for COVID, do you have to have a process where the funding is approved before you spend the money in order to get reimbursed for it; is that how it works?

CATHY CAMPOS: Yes, what we refer to is guidance in the procurement directive that sets out approval requirements during emergency situations.

So there are instances, and depending on the amounts, where there is prior Ministry approval required and there are instances where that delegation sits within the authority of the agency.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay, so some expenses you can incur on your own, and others you need permission before you can -- well, you can incur them, but before you can -- some you can decide to incur on your own; others, if you want reimbursement, you have to get approval?

CATHY CAMPOS: That is correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

CATHY CAMPOS: The next slide really speaks to what has been the impact to PHO as a

result of both the base funding reduction in 2019 and '20 and the cumulative impact of flat-lined funding over the prior years, and we have highlighted the key points.

The first is that there has been a reduction in our labour force as a result of the compensation reductions I referred to.

Because of our fixed or flat funding envelope, it has made it challenging to proactively repair aging infrastructure because we do not have access to separate funding or a separate stream of funding for aging infrastructure.

And the same would apply to the next point, that, again, within that same base funding allocation we need to carve out funding to support technology, especially updated laboratory technology. So we haven't been able to invest especially in areas of automation.

And the last point is that the agency has had what we would refer to as a public health science contingency fund budget, and that fund served as a provision for outbreaks, and in these emergency circumstances and when faced with flat-lined funding and in terms of budget reductions, that over time we have reduced and

virtually eliminated that emergency fund.

But to be clear, that emergency fund was not material enough or designed for the massive financial impact that COVID has had.

So I'll pause there.

COMMISSIONER FRANK MARROCCO (CHAIR):

And, sorry, I just missed that last sentence. Could you just repeat what you just said?

CATHY CAMPOS: Yes, the contingency fund over time has been reduced, and I was just clarifying that the budgetary value of that provision that has been reduced would not be material -- was not material in comparison to the amount that has been spent or realized related to COVID expenditures.

COMMISSIONER FRANK MARROCCO (CHAIR):

So does that mean the fund was sufficient or the fund was insufficient?

CATHY CAMPOS: That fund in particular that we are referring to would not have been nowhere near intended for a response as big as COVID-19.

COMMISSIONER FRANK MARROCCO (CHAIR):

So there was a need for -- in order for

you to do what you are supposed to do, there was a need to subsidize you or fund you to do that?

CATHY CAMPOS: Absolutely, over and above our base funding, in order --

COMMISSIONER FRANK MARROCCO (CHAIR): And over and above the contingency fund.

CATHY CAMPOS: Yes, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, if that's it, thank you for a very thorough presentation. It will give us some food for thought, and we will consider this as carefully as we can and try to understand.

The goal is to try to understand, where there wasn't sufficient resources to assist the long-term care homes, to try to figure out whether that was material or not to what happened to the people who were in those homes. And this is a very important first step in us understanding that.

So thank you all very much for the time and the obvious effort that was put into this.

COMMISSIONER JACK KITTS: Yes, thank you.

COMMISSIONER ANGELA COKE: Thank you.

ELIZABETH WALKER: Thank you for the

opportunity.

-- Adjourned at 2:40 p.m.

REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 17th day of December, 2020.

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