



Long Range Resource Planning Options 2004 - 2008



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Leeds, Grenville & Lanark District Health Unit
Long Range Resource Planning Options 2004 - 2008

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Executive Summary

In 1999, the Board of Health for the Leeds, Grenville and Lanark District Health Unit issued a Statement of Commitment (Appendix A), supporting Option 4 from our Long Range Resource Planning Options 1999 – 2004. Since then we have pursued the fulfillment of this long range resource plan in order to achieve compliance with the requirements of the Mandatory Health Programs and Services Guidelines (the Mandatory Programs) of the Ministry of Health and Long-Term Care.

There has been good compliance with the budgets and the municipal levies predicted within the plan. Some differences have occurred with the staffing positions that were created, in response to unanticipated needs. The outcome has been that from 1998 to 2000, our compliance with the Mandatory Programs, as measured with the Mandatory Program Indicator Questionnaire (MPIQ) has increased from 66.8 % to 79.2%, compared to the provincial average of 70.9% and 78.2% respectively. Although we have not yet heard from the Ministry of Health and Long-Term Care what our compliance level was in 2001, we have estimated it to be 82.5%. These improvements in compliance were achieved despite numerous challenges that were unanticipated in 1999. These challenges include new requirements for program delivery from the Ministry of Health and Long-Term Care, as well as the arrival of a number of emerging public health issues. Response to these challenges made demands on our resources that were not anticipated with the creation of the plan in 1999.

The mandate of the Board of Health includes ensuring that the Health Unit has the resources required to fulfill its legislated responsibilities to protect, promote and enhance the health of the population, as stated within the Health Protection and Promotion Act (Appendix B). Having a long range resource plan is essential in order to ensure that the Health Unit has the resources to respond to the public health needs of the community. The Long Range Resource Planning Options 2004

- 2008 was written in order to provide the Board of Health with financial projection options to provide these required resources for the next five years.

Three financial projection options were created, based on an assessment of our anticipated needs. All of the options include the resources required to make the changes in our organizational structure that have been recommended to the Board, as well as clerical staff enhancements identified as essential. **Option 1** also includes all of the program staff enhancements identified by the directors as being necessary to comply with the Mandatory Programs: a total of 29.22 Full Time Equivalents (FTEs). **Option 2** includes half of the program staff enhancements identified as necessary: a total of 17 FTEs. **Option 3** includes none of the program staff enhancements identified as necessary: a total of 7 FTEs (only staffing for the structure change, and clerical staff). Financial projections for the three options, that include the anticipated annual budgets, and municipal levies for each year from 2004 - 2008 are provided for each of the three options. Also included is the projection of costs to maintain the current staff level (status quo).

In order to safeguard the health of our citizens, it is very important that we continue to pursue compliance with the Mandatory Programs. The per capita cost of the Leeds, Grenville and Lanark District Health Unit has been slightly lower than the provincial average, and has risen at a lower rate than the provincial average, as well as the average of other similar health units. This has been achieved despite the added costs associated with providing services to a primarily rural population. Having adequate staffing levels is also important to the sustainability of our workforce. In addition, continuous quality improvement methods will continue to be used to achieve efficiencies and enhance compliance with the Mandatory Programs.

Recommendations

1. It is recommended that the Board of Health for the Leeds, Grenville and Lanark District Health Unit receive the Long Range Resource Planning Options 2004 - 2008 as information.
2. It is also recommended that the Board of Health take into consideration the information within the Long Range Resource Planning Options 2004 - 2008 when drafting the 2004 budget of the Health Unit.
3. It is also recommended that the findings of the Long Range Resource Planning Options 2004 - 2008 be communicated to stakeholders.

1.0 Introduction

On April 29th, 1999 the Board of Health for the Leeds, Grenville and Lanark District Health Unit issued a Statement of Commitment¹, indicating its support for Option 4 from our Long Range Resource Planning Options 1999 – 2004. This multiyear financial plan projected increases in human and financial resources to allow the Board of Health to achieve the requirements of the Mandatory Health Programs and Services Guidelines² of the Public Health Branch of the Ministry of Health and Long-Term Care.

Public health strategies have always been essential to the health of our citizens. Over the twentieth century we experienced an improvement in the life expectancy of thirty years for the Canadian population, due primarily to public health measures and improvements in general living conditions. Public health programs and strategies have had an enormously beneficial impact on the health and well-being of communities, and this is no less true in the counties of Leeds, Grenville and Lanark. The effectiveness of these services is well documented in the scientific literature, as is their cost effectiveness in reducing overall health care costs and increasing economic productivity through reductions in illness-related absenteeism and death.³ As the public health unit for Leeds, Grenville and Lanark, we work with the community to protect, promote and enhance health by determining issues, and developing and providing quality preventative health programs and services.⁴ With its commitment to its long range resource plan in

¹ See Appendix A, Board of Health Response: Statement of Commitment.

² To see the Mandatory Health Programs and Services Guidelines go to http://www.healthunit.org/about_us/mhp_dl.htm on the website of the Leeds, Grenville and Lanark District Health Unit. For more information on our programs and services visit our website at www.healthunit.org, or telephone 345-5685 or 1-800-660-5853.

³ For more information on the importance of public health see Appendix I: Throne Speech Submission Letter from alPHA to Ernie Eves.

⁴ This is our Mission Statement, taken from the Strategic Plan of the Leeds, Grenville and Lanark District Health Unit 2001 to 2003. This can be viewed on the Health Unit website at http://www.healthunit.org/about_us/strat_plan/strat_plan.htm.

1999, the Board of Health demonstrated its belief that the optimal financing of public health units represents a wise social investment.

The Mandatory Health Programs and Services Guidelines (often referred to as the “Mandatory Programs”, and issued in December 1997 by the Ministry of Health) of the Health Protection and Promotion Act⁵, makes exacting demands for the provision of public health programs that necessitated an increase in public health funding to achieve compliance. In recent years, boards of health throughout the province have pursued compliance with the Mandatory Programs. The Ministry of Health and Long-Term Care has communicated that the Mandatory Health Programs and Services Guidelines are to be viewed as “minimum standards” to be completely achieved, and preferably exceeded; The standards are viewed as a floor rather than as a ceiling. By adopting this paradigm, boards of health can lead their respective health units to ever increasing levels of excellence, with the resulting health benefits to their communities.

It is also the mandate of the Board of Health of the Leeds, Grenville and Lanark District Health Unit to ensure that our funds are applied wisely and are used efficiently. Thus it is imperative that we demonstrate what has been achieved before consideration is made regarding future financial projections for the Health Unit. It is for this reason that this report, entitled Long Range Resource Planning Options 2004 - 2008, has been created.

In order to determine the degree of our success with the fulfillment of the Mandatory Programs it is necessary to review how we actually implemented the plan with regard to increases in our resources, as well as what we achieved with regard to our programs and services. Appendix C documents the Health Unit

⁵ See Appendix B for a copy of Sections 4 to 9, and 72 of the Health Protection and Promotion Act, pertaining to the mandate of the Board of Health, and the payment of funds accordingly to health units by the obligated municipalities. A copy of the entire Act can be view at the following website:
http://192.75.156.68/DBLaws/Statutes/English/90h07_e.htm

budget and municipal levy projections from the 1999 to 2004 long range resource plan adopted by the Board of Health, compared to the actual budgets and municipal levies that occurred for the years 1999 to 2003. The annual budgets projected in the previous plan were adhered to up to and including 2002. Deviation was necessary in 2003 as a result of increases in salary and benefit costs that were unpredictable with the current level of accuracy four years ago. The actual municipal levy however dropped below the planned level in 2002 and has remained there. This has not been a problem while retained municipal surplus is available to supplement levies. It is expected that at the end of 2004 the prior years' surplus will be depleted and the only available surplus will be that resulting from the unspent enhancement dollars from each individual year.

Another indicator is our performance on the Mandatory Program Indicator Questionnaire (MPIQ). It has been noted that the MPIQ is not a perfect tool for measuring health unit compliance with the Mandatory Programs. Much of what is required for the proper fulfillment of the requirements of the Mandatory Programs is not measured completely with the MPIQ. However, this continues to be the only tool for this purpose, and is the standard that the Ministry of Health and Long-Term Care uses to assess and compare the performance of the health units across the province. Despite our improving MPIQ scores we are aware of a number of areas where we need to improve program delivery in order to protect and promote the health of the citizens of Leeds, Grenville and Lanark.

Appendix D documents the performance of the Leeds, Grenville and Lanark District Health Unit on the MPIQ relative to the other health units in Ontario for the years 1998 to 2000. These data show that as a health unit we have improved our compliance from 66.8% in 1998 (with a provincial average compliance rate of 70.9%) to 79.2% in 2000 (provincial average of 78.2%). Thus our increase in compliance, at 12.4%, has been better than both the provincial average and the average for the health units in eastern Ontario, which were 7.3% and 10.8%

respectively. It should also be noted that we have gone from being 4.1% below the provincial average in 1998 to being 1.0% above average in 2000. The Ministry of Health and Long-Term Care has not yet released the results on our compliance for 2001, however from our own review of our data we have estimated our compliance to have risen further to be approximately 82.5% ⁶. Thus the enhancements in our staffing, as envisioned in the 1999 to 2004 long range resource plan, has correlated well with the our increasing compliance scores on the Mandatory Program Indicator Questionnaire (MPIQ). It is very likely that our increasing compliance is due at least in part to the increases that we have had in staff positions (see Appendix E).

Our performance on the MPIQ is particularly impressive given the unanticipated challenges faced since the inception of the 1999 to 2004 long range resource plan. These challenges include the annual delay in the rollout of the new staff positions that has occurred due to the late approval of our budgets by the Ministry of Health and Long-Term Care in December of each of these years. The practice of the Board of Health has been to allow for the filling of these positions up to the portion funded by the municipalities (50%), with the remaining positions being filled upon the approval of our budget by the Ministry of Health and Long-Term Care. The result has been that half of the new positions were not filled until the year following their approval. Provincial shortages in some disciplines, such as Public Health Inspectors and Epidemiologists, have made it difficult for us to keep our positions filled, resulting in some unavoidable temporary position gaps. We have recently been successful in recruiting an epidemiologist. The Board's endorsement in 2002 to offer tuition bonuses to third and fourth year PHI students in exchange for guaranteed placement, has facilitated recruitment.

⁶ We do not yet have comparison data on the performance of the other health units of the province on the MPIQ for the year 2001.

The net result of these challenges has been some delays in rolling out the staffing enhancements from the long range resource plan 1999 to 2004, thus hindering our ability to meet the full requirements of the Mandatory Programs.

In addition to the delays in filling staffing positions, since 1999, a number of needs arose that made unanticipated demands on our services. These included new requirements for program delivery dictated by the Ministry of Health and Long-Term Care, as well as emerging public health issues. Since its inception in 1997, the Healthy Babies Healthy Children program has experienced great growth. Although this program is supported with 100% provincial funding, this funding does not include allocated administrative costs such as office space. The Association of Local Public Health Agencies (alPHA) has been advocating on behalf of health units for Healthy Babies administrative funding. This has been a fundamental reason to continue the contracting out of lay home visiting. Similarly in 2000, the Ministry commenced a universal influenza immunization program with provincial funding at a level that does not completely cover all associated expenses. Also, in 2001, the Ministry of Health and Long-Term Care required that we work with our communities to create a plan to respond to an influenza pandemic. Other unanticipated challenges have included the following:

- the arrival of raccoon rabies to our district in 1999,
- ground water contamination concerns post-Walkerton in 2000,
- West Nile virus in Ontario in 2001,
- the public anxiety over anthrax, post-September 11, 2001,
- and the provincial outbreak of Severe Acute Respiratory Syndrome (SARS)

Responding to the Severe Acute Respiratory Syndrome (SARS) outbreak provincial emergency in the spring of 2003 required us to allocate human resources from our ongoing programs, both within the Department of Clinical Services and from throughout the agency. Considerable time was required of the

medical officer of health and the directors, the epidemiologist, public health nurses, clerical staff, and the webmaster in order to ensure sufficient surveillance for possible cases, to monitor and implement directives from the province, and to maintain communications with the health care agencies and practitioners within our district. In addition, our health unit provided direct resources to two affected health units within the Greater Toronto Area to assist with contact tracing and follow-up. While these response activities were absolutely necessary, they did negatively impact on our other programs. In response to SARS, the provincial government has publicly communicated a commitment to “expand the number of staff in public health units” (see Appendix K).

It should also be noted that we anticipate that our response to the new Control of West Nile Virus Regulation 199/03⁷ and to the new drinking water regulation will both increase our resource demands; Due to the timing of the revisions to the Safe Water Mandatory Program Guidelines we are not able to assess the actual increase in resources required to meet the impending and potential demand. The costs recently approved by the Board of Health for 2003 West Nile virus prevention and control plan have been incorporated into future years of this long range plan, although probable future West Nile virus enhancements have not been projected.

We have been required to respond to these challenges in a variety of ways that include the provision of public and health care provider education, environmental and human surveillance, and communication and collaboration with provincial ministries and with our municipalities. Our responses to all of these situations, while successful, have impaired our ability to meet the basic requirements of the Mandatory Programs.

⁷ For more information see Appendix L: [Mosquito Control Budget June 12, 2003.](#)

We have pursued provincial resource enhancements when they have been available to assist us in responding to the needs of our communities. Examples of this have included water response funding in 2000, the MERX grant to support our Leeds Grenville Lanark By-law Education Campaign, and the Early Child Development Injury Prevention, Reproductive and Perinatal and Child Health Survey Strategy funding. It should be noted, however, that the MERX grant does not cover the costs of staffing that are presently devoted to the campaign. Also the extent of our activities to address tobacco as a health issue was not anticipated with the creation of the 1999 long range resource plan.

There were some differences between the anticipated staffing position enhancements in the 1999 to 2004 long range resource plan and those that were actually created, as documented in Appendix E. These differences include the creation of a Webmaster (to create and maintain the Health Unit website and intranet system), the Tobacco Coordinator, the Quality Improvement Planning Consultant, the Production Artist, and special project staffing time. These positions serve to support the work of our front-line staff, thus better allowing them to deliver our services to the community. Enhancements in a number of positions (most notably for public health nurses positions) were not filled to the totals anticipated in the plan. The decisions on the creation of positions were determined by the Senior Management Committee and approved by the Board with each annual budget, in keeping with our priorities as they arose.

The differences that arose between the plan and its implementation are reflective of our need to respond to situations that were not anticipated in 1999 with the creation of the plan. In addition, there were differences between the predicted adjustments to salary grids (2% annually within the 1999 plan), and the actual outcomes of contract negotiations/Board of Health awards. These deviations lead to unpredicted salary increases to the base budget in the amounts of \$54,000 in 2002, \$26,000 in 2003 and \$15,000 in 2004. Our ability to adapt our resource

allocation has been critical to our capacity to meet these unanticipated needs, while continuing to pursue compliance with the requirements of the Mandatory Programs.

Despite the unanticipated challenges, and with the adjustments that were made in the rollout of the 1999 to 2004 long range resource plan, we have made good progress on compliance with the Mandatory Programs. Having a long range resource plan has been essential in providing the resources necessary in our achievement of increasing compliance with the Mandatory Programs, and to meet the changing public health needs of our citizens. It is with the goal of continuing our pursuit for compliance that we now develop an updated Long Range Resource Planning Options 2004 - 2008 report.

2.0 Methods

Our experience with the 1999 to 2004 long range resource plan has taught us that it is very difficult to predict the needs, demands and challenges that will arise. For this reason it is our intention to annually review and redraft our five-year Long Range Resource Plan, in recognition that it is a living document. In the Long Range Resource Planning Options 1999 to 2004, we provided the Board of Health with a range of options for funding projections. Our original intentions with the Long Range Resource Planning Options 2004 - 2008 were to take a similar approach, and to use similar methods to quantify our staffing needs. We did find, however, that when we tried to take this approach with our methods, the estimates for staffing enhancements were excessively high, in the range of 50 FTEs. In addition to this, these methods are very labour intensive, which make them less desirable, considering that we intend to annually provide the Board with five- year financial projections.

We adopted the following methods for creating the staffing and financial projections contained within the Long Range Resource Planning Options 2004 - 2008: The directors each reviewed their programs as dictated within the Mandatory Programs, as well as the level of compliance for our programs as reflected in our MPIQ scores. They then submitted their estimates for the staffing enhancements required for the years 2003, 2004, and 2005 to comply with the requirements of the Mandatory Programs. The Medical Officer of Health and the Director of Corporate Services reviewed these staffing enhancement requests, taking into consideration the following:

- the changes to our organizational structure that have been proposed to the Board of Health⁸,
- the present level of the financial reserves of the Health Unit⁹,

⁸ For more information see Appendix J: Health Unit Structure Review.

⁹ At present we have a significant reserve fund (\$246,092 as of December 2002) to be used to smooth municipal levy increases. This reserve represents the cumulative municipal surplus since 1998. This surplus was generated

- OMERS contributions have been reintroduced in 2003 with predicted cost of \$95,500 which will escalate to \$300,000 in 2004 due to the planned return to full contribution rates (6%) and the expected approval of the regulations to allow the assessment on earnings over YMPE to increase from 7.5% to 8.8%.
- other anticipated financial costs (such as anticipated adjustments in salary grids, the costs of benefits, and the anticipated expenses related to increasing office space needs),
- and the objective of keeping the annual municipal levy increases for the years 2004, 2005, 2006, 2007 and 2008 at fiscally responsible levels.

With these described methods, three staffing, budgetary and municipal levy enhancement projection options for the years 2004 - 2008 are documented in the next section.

partly as a result of receiving the approval from the Ministry of Health and Long-term Care for our budget in December of each year, with the resulting delays in rolling out position enhancements.

3.0 Human Resource Needs Assessment Results

The **three human resource projection options** were created in the following ways:

Option 1: includes the staff required to make the recommended changes to our organizational structure, five clerical positions, and all (22.22 FTEs) of the program-staff identified by the directors as being necessary to meet the requirements of the Mandatory Programs. The staff enhancements would be rolled out over the period 2004 - 2008.

Option 2: includes the staff required to make the recommended changes to our organizational structure, five clerical positions, and approximately half (10 FTEs) of the program-staff identified by the directors as being necessary to meet the requirements of the Mandatory Programs. The staff enhancements would be rolled over the period 2004 to 2007, and then maintained in 2008.

Option 3: includes the staff required to make the recommended changes to our organizational structure, five clerical positions, and none of the program-staff identified by the directors as being necessary to meet the requirements of the Mandatory Programs. The staff enhancements would be implemented in 2004, and then maintained from 2005 to 2008.

The information on the table to follow documents the staffing enhancements for each of the three human resource projection options.

**Human Resources Needs Assessment
Additional FTE By Discipline**

	Option #1	Option #2	Option #3
Manager	2.00	2.00	2.00
PHI	4.55	3.00	
PHN	9.67	5.50	
Clerical	8.50	5.00	5.00
Dietitian	0.50		
Nutritionist	1.00	1.00	
Hygienist	1.00	0.25	
Dental Asst	1.00	0.25	
Special Projects	1.00		
Total FTE	<u>29.22</u>	<u>17.00</u>	<u>7.00</u>

4.0 Financial Projections

4.1 Background

While our financial management has always been commended by the auditors, the development of our 1999 long range resource plan was our first serious effort in the area of long range financial planning, other than retention of a reserve for our frozen sick bank liability and mortgage reduction efforts. It is our belief that in the economic climate of the nineties the focus had been on budget reductions with inadequate attention given to the effect reductions would have on the ability to deliver mandatory programs on an ongoing basis. Reductions to Public Health resources at Leeds, Grenville and Lanark District Health Unit between 1995 and 1998 were approximately \$1.2 million.

This resource reduction resulted from:

- permanent Social Contract reductions
- Pay Equity
- introduction of Equity Funding
- elimination of planned budget gapping
- loss of allocated costs recovered from divested programs
- decision to withdraw from the amalgamation process and achieve 50% of the expected savings

Office closures and staff reductions were necessary to accommodate these events. In addition, revenue generating efforts were initiated. These changes were made with the intention of having the least possible effect on service delivery; However, the new Mandatory Health Programs and Service Guidelines made exacting demands for the provision of public health services, and it was determined in the 1999 plan that existing resources were no longer adequate to meet the service delivery guidelines and needs.

The staff enhancements approved in the 1999 plan have been rolled out (see Appendix E), the human resources and therefore the financial resources of the Health Unit continue to be inadequate to fulfill our mandate

As a direct result of the 1999 long range resource plan, the Board of Health Bylaw #7 was implemented “To Authorize the Retention of Yearend Municipal Surpluses” (Appendix H). This reserve has allowed us to avoid significant municipal levy increases while continuing to strive for complete compliance.

The financial projections will identify future known changes to the cost of doing business. The objective will be to recognize the funding required and to plan for appropriate future budget changes and hence municipal levy projections.

4.2 Funding Formula

Prior to 1998, General Programs were cost-shared between the Ministry of Health and the local municipalities on a 75%/25% basis. There were, at that time, a number of Public Health programs that were funded entirely by the Ministry of Health. They included Sexual Health, AIDS, CINOT, Tobacco Enforcement, and Hepatitis B. All of these programs were downloaded to the municipalities (100% funded) as of January 1, 1998. As of January 1, 1999 the cost sharing of these mandatory programs converted to 50/50 and that formula has remained. The Healthy Babies/Healthy Children Program introduced by the Ministry of Health in October 1997 has continued to be fully funded by the Ministry, and is excluded from the projections.

4.3 Potential Future Incremental Costs of Current Staff

In order to forecast future staffing costs, some assumptions had to be made:

- Current staff complement is maintained.

- Current employees remain in current positions.
- 2005 through 2008 salary adjustments are projected at 2%
- Existing salary grid structures remain unchanged.
- Cost of EHT remains stable
- Costs of other legislated benefits (CPP, EI, WSIB) increase gradually

There are obvious flaws with some of these assumptions. They predict the mere costly/conservative outcomes by assuming that the same employees remain engaged with this agency. Incremental grid movement has been incorporated into the forecasts. 80% of current employees have reached their grid maximum. In reality with employee turnover, extending these salaries into future years results in a conservative estimate since new employees tend to be less experienced and therefore start employment at a lower step on the salary grid than those being displaced.

Based on these assumptions, salaries for the currently approved Public Health positions (95.43 FTE as detailed in Appendix F) will increase by 14.0% by 2008. Benefit costs will increase by 65% over the same time period, largely due to the reintroduction of OMERS contributions and the proposed increase to the maximum contribution rates. The base budget must therefore increase by 21% (\$1.1 million) to accommodate the projected salary and benefit costs for 2003 approved positions by 2008.

4.4 OMERS

Due to an unexpected large surplus, OMERS granted a contribution holiday for both employees and employers commencing August 1, 1998. This holiday ended January 1, 2003 with the reintroduction of OMERS premiums at a level of 2.1% (2.6% for earnings exceeding YMPE (Years Maximum Pensionable Earnings)). OMERS premiums will return to their previous level (6.0%) at the beginning of 2004. A regulation change to increase the rate of assessment on earnings exceeding YMPE from 7.5% to 8.8% is currently under review and has been incorporated into the projections within this report.

4.5 Human Resources Options

The results of the Human Resources Needs Assessment (Section 3) are translated into Public Health base budget and municipal levy projections, for the years 2004 through 2008 on pages 23 and 25. The options with additional staff incorporate the cost of the reintroduction of OMERS for those employees as well as the salary adjustments already approved by the Board.

There are four scenarios laid out as follows:

- The first is the **status quo** to support the current approved Public Health staffing level (95.43 FTE) with all the known costs built in requiring a 15% increase in 2004 and approximately 3% annual increases for the following four years.
- **Option #1** is the maximum staff complement (29.22 additional FTE) Directors feel would be required to meet the Ministry of Health requirements requiring a 62% base increase by 2008 (23% in 2004, 8% in each year 2005-2007 with 5% in 2008).

- **Option #2** is the medium staff complement (17.00 additional FTE) requested by Directors requiring a 23% increase in 2004 and future increases of 6% in 2005 dropping annually to 3% in 2008 (48% base increase by 2008).
- **Option #3** is the structure change and addition of support staff (7.00 FTE) requested (36% base increase by 2008). An additional budget increase is required in 2004 of 22% and annual increases of less than 3% thereafter.

NOTES: With reference to the following charts

1. This long-range financial plan incorporated annual 2% salary increases for projection purposes only for years beyond the current Collective Agreements. In no way is this intended to imply any obligation on the part of the Board of Health for future decision making or negotiations, but is strictly for presentation purposes. The cost of individual movement along the salary grids has also been incorporated.
2. There have been no assumptions made with regards to change in population size or trends that may affect service delivery requirements.
3. Population percentages of the funding municipalities have remained constant throughout this exercise (2000 population data from the local assessment office).
4. All figures are based on the assumption that Ministry budget approval continues to be received late in the calendar year and that the current Board of Health practice in allowing us to spend only the municipal share of any enhancement within the year continues as well. Additions to the municipal reserve are therefore annually estimated at the municipal share of 25% of the

current year's total public health budget increase. The Ministry share of any enhancement will not be spent until approval is received.

5. Municipal levies are based on the assumption that the Ministry of Health will fund our current base at 50% in addition to all approved base enhancements.
6. A two percent annual increase has been incorporated for general administrative costs, i.e. telephone, staff development, office expenses, etc.
7. A two percent increase in travel costs is predicted for 2006.
8. Occupancy costs have been increased in 2004 and in 2005 in anticipation of acquiring at least 1000 additional square feet in each of these years. The lease with Social Services expires in September 2008, so only a four month impact is included in these projections.
9. The Board of Health previously supported in principle the concept of a three year replacement plan for agency computer equipment. The current base budget amount for maintenance and replacement of \$50,000 has been annualized at \$85,000. To date this has been funded from yearend surplus.
10. In any of the options demonstrated, the current municipal reserve will be depleted by the end of 2004 and additions in each year resulting from unspent enhancement dollars will be used to supplement the municipal levy in the subsequent year.
11. Loss of revenue from Safe Communities (\$17,500) has been built into projections.

12. All options include the addition of temporary staff to deliver the annual flu campaign (Appendix M).

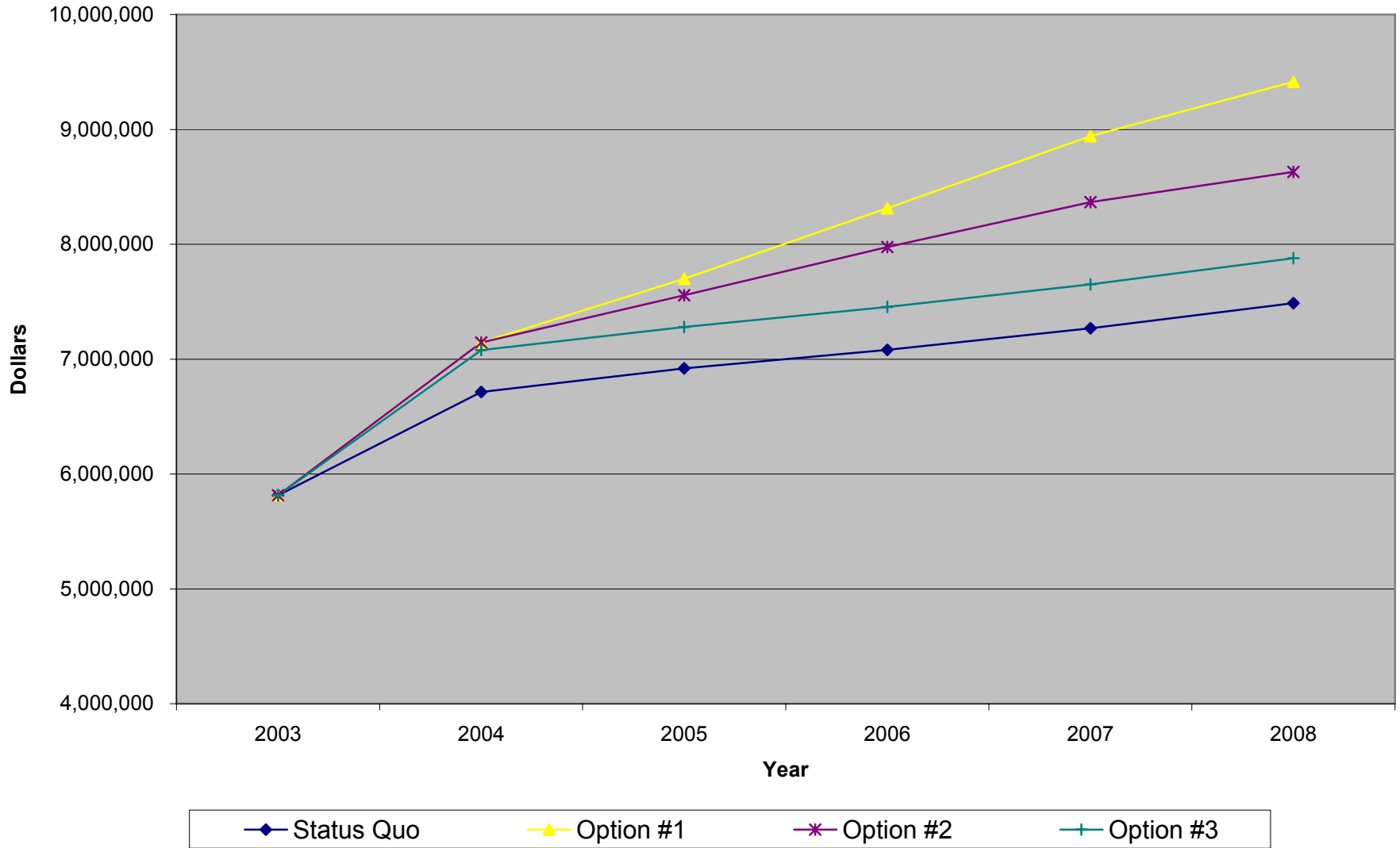
13. All options include the additional cost to protect our communities against West Nile virus as planned in 2003. Program enhancements have not been projected.

14. The Board has approved the development of a GIS system. Costs have been incorporated for ongoing maintenance, programming/development costs (2005 and 2007) and two more GPS units (2004).

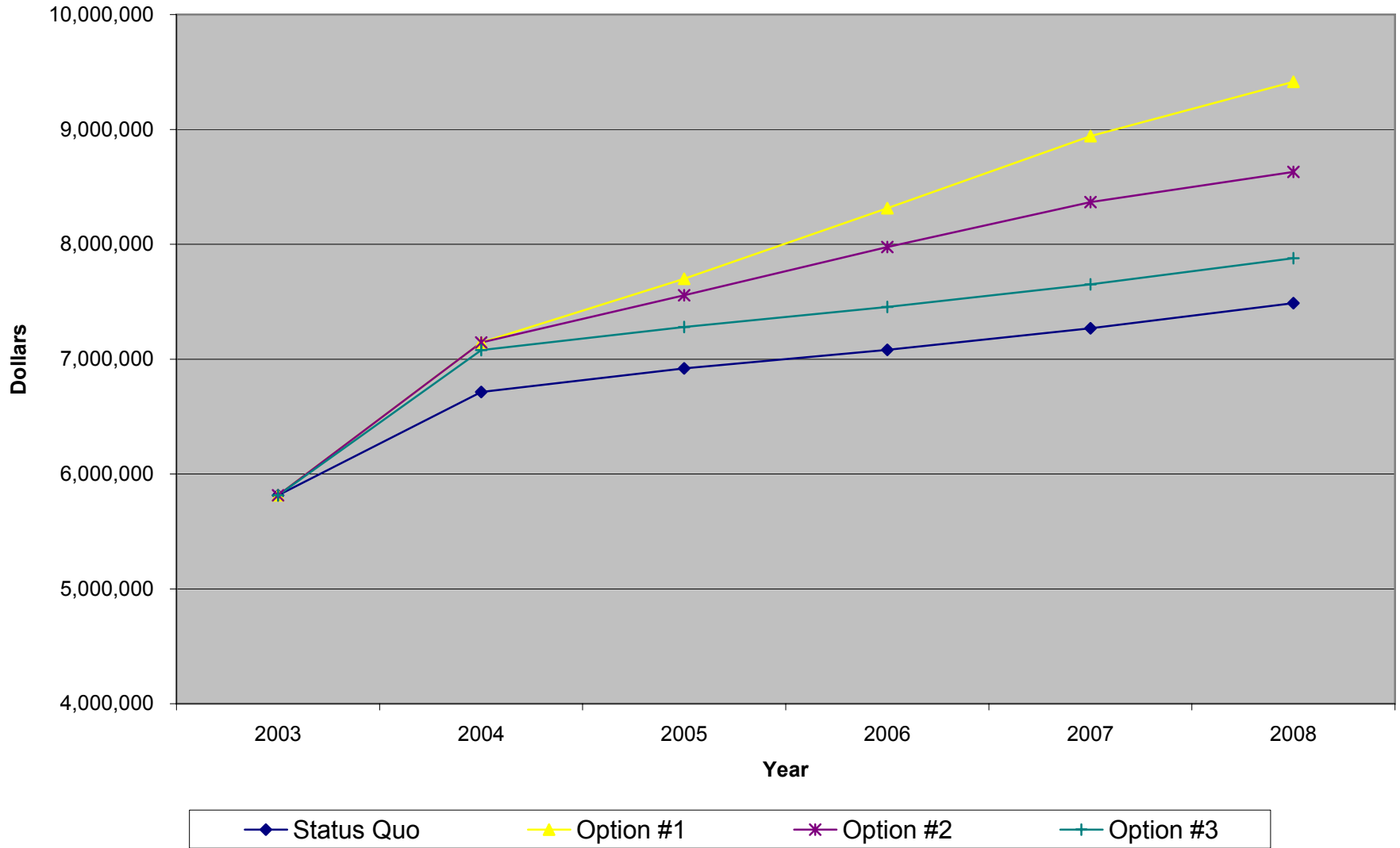
Projected Public Health Budget 2004 - 2008

	<u>FTE Added</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
<u>Status Quo</u>	0.00	5,814,153	6,714,456	6,920,146	7,081,708	7,269,217	7,486,439
<u>% Budget Increase</u>			15.48	3.06	2.33	2.65	2.99
<u>Option #1</u>	29.22	5,814,153	7,145,758	7,698,453	8,314,482	8,942,221	9,414,122
<u>% Budget Increase</u>			22.90	7.73	8.00	7.55	5.28
<u>Option #2</u>	17.00	5,814,153	7,145,758	7,556,092	7,976,133	8,366,854	8,629,284
<u>% Budget Increase</u>			22.90	5.74	5.56	4.90	3.14
<u>Option #3</u>	7.00	5,814,153	7,077,457	7,280,458	7,454,699	7,651,123	7,879,133
<u>% Budget Increase</u>			21.73	2.87	2.39	2.63	2.98

Projected Public Health Budget 2003 - 2008



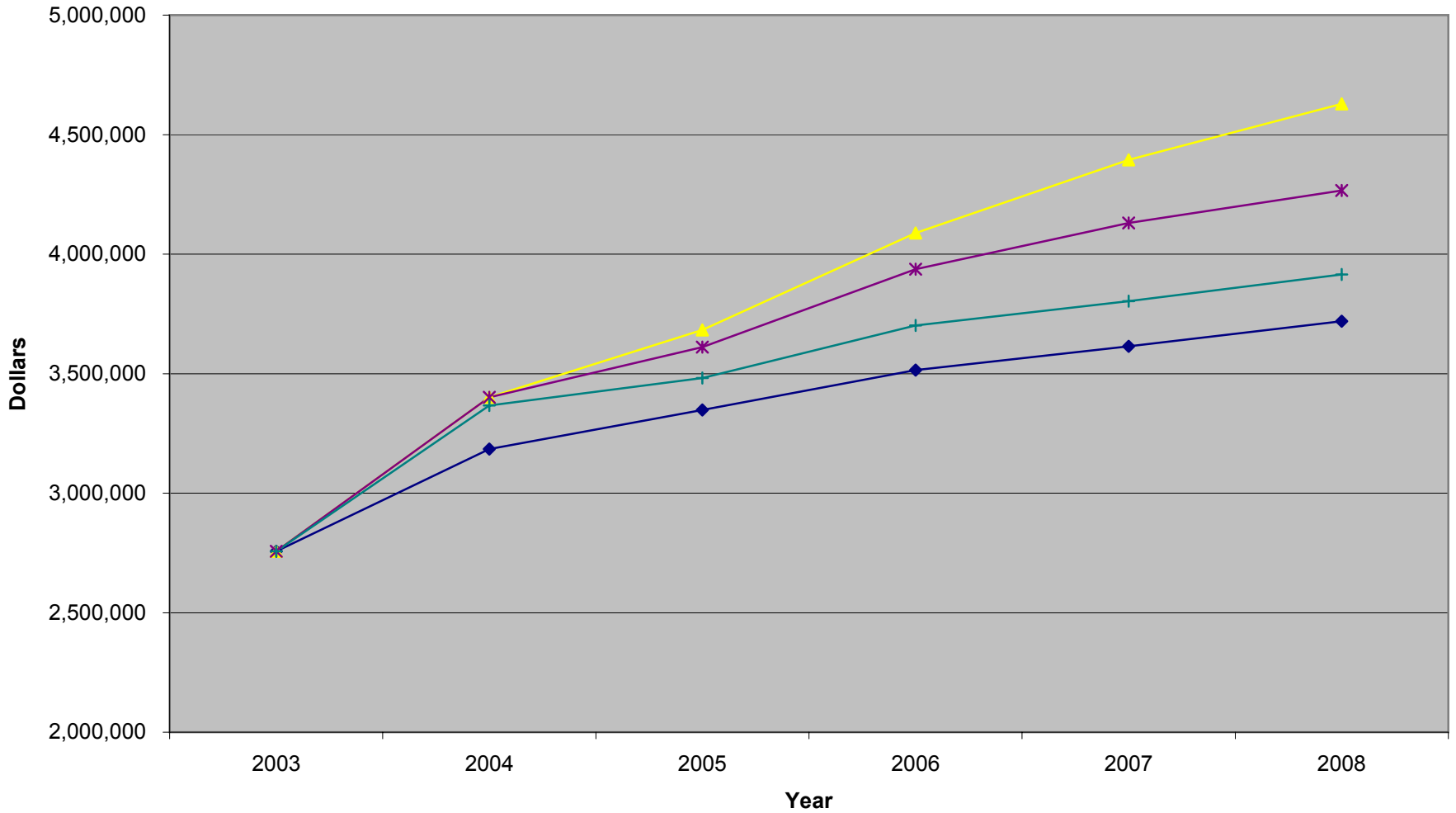
Projected Public Health Budget 2003 - 2008



Projected Municipal Levy 2004 - 2008

	<u>FTE Added</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
<u>Status Quo</u>	0.00	2,757,443	3,185,046	3,347,535	3,515,143	3,614,413	3,719,781
<u>% Levy Increase</u>			15.51	5.10	5.01	2.82	2.92
<u>Option #1</u>	29.22	2,757,443	3,400,697	3,682,776	4,088,154	4,394,107	4,628,594
<u>% Levy Increase</u>			23.33	8.29	11.01	7.48	5.34
<u>Option #2</u>	17.00	2,757,443	3,400,697	3,611,595	3,936,775	4,130,922	4,265,802
<u>% Levy Increase</u>			23.33	6.20	9.00	4.93	3.27
<u>Option #3</u>	7.00	2,757,443	3,366,547	3,482,316	3,701,974	3,803,782	3,915,014
<u>% Levy Increase</u>			22.09	3.44	6.31	2.75	2.92

Projected Municipal Levy 2003-2008



2003-2008 PUBLIC HEALTH BUDGET PROJECTIONS

Maintain Status Quo

	2003 Approved Budget	2004	2005	2006	2007	2008
Existing Salaries	4,598,862	4,766,520	4,898,211	5,021,044	5,130,717	5,235,132
Existing Benefits	721,244	972,841	1,016,596	1,064,108	1,112,403	1,189,619
Staffing Subtotal	5,320,106	5,739,361	5,914,807	6,085,152	6,243,120	6,424,751
Staffing \$ Increase		419,255	175,446	170,345	157,968	181,631
Staffing % Increase		7.88	3.06	2.88	2.60	2.91
Staff Enhancements						
Salaries						
Benefits						
Other Costs						
Travel	197,068	197,068	197,068	201,009	201,009	201,009
All Other Costs (incr 2% per yr)	266,979	272,319	277,765	283,320	288,987	294,766
Increased Rent or Lost Revenue		29,000	40,500	40,500	40,500	66,280
Computer Replacement/ Enhancement Plan	30,000	72,770	82,000	66,000	66,000	66,000
GIS		25,500	22,000	12,000	28,000	24,000
Flu Program		54,438	55,526	56,637	57,770	58,925
WNV Treatment		324,000	330,480	337,090	343,831	350,708
Total Budget	5,814,153	6,714,456	6,920,146	7,081,708	7,269,217	7,486,439
\$ Increase		900,303	205,690	161,562	187,509	217,222
Percent Budget Increase		15.48	3.06	2.33	2.65	2.99
Ministry Funding 50%	2,907,077	3,357,228	3,460,073	3,540,854	3,634,609	3,743,220
Municipal Levy	2,757,443	3,185,046	3,347,535	3,515,143	3,614,413	3,719,781
\$ Levy Increase		427,603	162,489	167,608	99,271	105,368
Percent Levy Increase		15.51	5.10	5.01	2.82	2.92
Reserve Applied to Levy	149,633	172,182	112,538	25,711	20,195	23,439
Municipal Surplus Reserve	246,092					
Projected Additions to Municipal Reserve Surplus*	75,723	112,538	25,711	20,195	23,439	27,153
Yearend Reserve	172,182	112,538	25,711	20,195	23,439	27,153

Includes financial commitments currently in place and the maintenance of efficient technology.

*Based on an estimate that 25% of the budget increase in any year goes unspent in the year of approval due to late Ministry of Health budget approval, 50% of that surplus is municipal.

2003-2008 PUBLIC HEALTH BUDGET PROJECTIONS

Based on Program & Structure Needs 2004 - 2008

	2003 Approved Budget	2004	2005	2006	2007	2008
Existing Salaries	4,598,862	4,766,520	4,898,211	5,021,044	5,130,717	5,235,132
Existing Benefits	721,244	972,841	1,016,596	1,064,108	1,112,403	1,189,619
Staffing Subtotal	5,320,106	5,739,361	5,914,807	6,085,152	6,243,120	6,424,751
Staffing \$ Increase		419,255	175,446	170,345	157,968	181,631
Staffing % Increase		7.88	3.06	2.88	2.60	2.91
Staff Enhancements-Option #1		7.00	6.50	7.00	6.00	2.72
Salaries		324,176	602,435	951,212	1,287,978	1,475,533
Benefits		66,164	125,005	201,562	279,234	335,241
Other Costs		19,462	45,367	74,500	100,292	113,409
Equipment		21,500	5,500	5,500	5,500	3,500
Total Enhancement		431,302	778,307	1,232,774	1,673,004	1,927,683
Travel	197,068	197,068	197,068	201,009	201,009	201,009
All Other Costs (incr 2% per yr)	266,979	272,319	277,765	283,320	288,987	294,766
Increased Rent or Lost Revenue		29,000	40,500	40,500	40,500	66,280
Computer Replacement/ Enhancement Plan	30,000	72,770	82,000	66,000	66,000	66,000
GIS		25,500	22,000	12,000	28,000	24,000
Flu Program		54,438	55,526	56,637	57,770	58,925
WNV Treatment		324,000	330,480	337,090	343,831	350,708
Total Budget	5,814,153	7,145,758	7,698,453	8,314,482	8,942,221	9,414,122
\$ Increase		1,331,605	552,695	616,029	627,739	471,901
Percent Budget Increase		22.90	7.73	8.00	7.55	5.28
Ministry Funding 50%	2,907,077	3,572,879	3,849,226	4,157,241	4,471,111	4,707,061
Municipal Levy	2,757,443	3,400,697	3,682,776	4,088,154	4,394,107	4,628,594
\$ Levy Increase		643,254	282,079	405,378	305,953	234,487
Percent Levy Increase		23.33	8.29	11.01	7.48	5.34
Reserve Applied to Levy	149,633	172,182	166,451	69,087	77,004	78,467
Municipal Surplus Reserve	246,092					
Projected Additions to Municipal Reserve Surplus*	75,723	166,451	69,087	77,004	78,467	58,988
Yearend Reserve	172,182	166,451	69,087	77,004	78,467	58,988

Includes financial commitments currently in place and the maintenance of efficient technology.

*Based on an estimate that 25% of the budget increase in any year goes unspent in the year of approval due to late Ministry of Health budget approval, 50% of that surplus is municipal.

2003-2008 PUBLIC HEALTH BUDGET PROJECTIONS

Based on 7.0 FTE Enhancements in 2004 & 50% of the Remaining Enhancements - 2005 through 2008

	2003 Approved Budget	2004	2005	2006	2007	2008
Existing Salaries	4,598,862	4,766,520	4,898,211	5,021,044	5,130,717	5,235,132
Existing Benefits	721,244	972,841	1,016,596	1,064,108	1,112,403	1,189,619
Staffing Subtotal	5,320,106	5,739,361	5,914,807	6,085,152	6,243,120	6,424,751
Staffing \$ Increase		419,255	175,446	170,345	157,968	181,631
Staffing % Increase		7.88	3.06	2.88	2.60	2.91
Staff Enhancements-Option #2		7.00	4.00	3.50	2.50	
Salaries		324,176	494,274	692,442	848,204	876,786
Benefits		66,164	102,562	146,728	183,891	199,206
Other Costs		19,462	37,110	53,255	65,542	66,853
Equipment		21,500	2,000	2,000	-	-
Total Enhancement		431,302	635,946	894,425	1,097,637	1,142,845
Travel	197,068	197,068	197,068	201,009	201,009	201,009
All Other Costs (incr 2% per yr)	266,979	272,319	277,765	283,320	288,987	294,766
Increased Rent or Lost Revenue		29,000	40,500	40,500	40,500	66,280
Computer Replacement/ Enhancement Plan	30,000	72,770	82,000	66,000	66,000	66,000
GIS		25,500	22,000	12,000	28,000	24,000
Flu Program		54,438	55,526	56,637	57,770	58,925
WNV Treatment		324,000	330,480	337,090	343,831	350,708
Total Budget	5,814,153	7,145,758	7,556,092	7,976,133	8,366,854	8,629,284
\$ Increase		1,331,605	410,334	420,041	390,721	262,430
Percent Budget Increase		22.90	5.74	5.56	4.90	3.14
Ministry Funding 50%	2,907,077	3,572,879	3,778,046	3,988,067	4,183,427	4,314,642
Municipal Levy	2,757,443	3,400,697	3,611,595	3,936,775	4,130,922	4,265,802
\$ Levy Increase		643,254	210,898	325,179	194,147	134,880
Percent Levy Increase		23.33	6.20	9.00	4.93	3.27
Reserve Applied to Levy	149,633	172,182	166,451	51,292	52,505	48,840
Municipal Surplus Reserve	246,092					
Projected Additions to Municipal Reserve Surplus*	75,723	166,451	51,292	52,505	48,840	32,804
Yearend Reserve	172,182	166,451	51,292	52,505	48,840	32,804

Includes financial commitments currently in place and the maintenance of efficient technology.

*Based on an estimate that 25% of the budget increase in any year goes unspent in the year of approval due to late Ministry of Health budget approval, 50% of that surplus is municipal.

2003-2008 PUBLIC HEALTH BUDGET PROJECTIONS

Based on 7.0 FTE Enhancements in 2004 Only

	2003 Approved Budget	2004	2005	2006	2007	2008
Existing Salaries	4,598,862	4,766,520	4,898,211	5,021,044	5,130,717	5,235,132
Existing Benefits	721,244	972,841	1,016,596	1,064,108	1,112,403	1,189,619
Staffing Subtotal	5,320,106	5,739,361	5,914,807	6,085,152	6,243,120	6,424,751
Staffing \$ Increase		419,255	175,446	170,345	157,968	181,631
Staffing % Increase		7.88	3.06	2.88	2.60	2.91
Staff Enhancements-Option #3		7.00				
Salaries		267,452	281,955	291,066	296,888	302,826
Benefits		54,587	58,506	61,677	64,365	68,802
Other Costs		19,462	19,851	20,248	20,653	21,066
Equipment		21,500			-	-
Total Enhancement		363,001	360,312	372,991	381,906	392,694
Travel	197,068	197,068	197,068	201,009	201,009	201,009
All Other Costs (incr 2% per yr)	266,979	272,319	277,765	283,320	288,987	294,766
Increased Rent or Lost Revenue		29,000	40,500	40,500	40,500	66,280
Computer Replacement/ Enhancement Plan	30,000	72,770	82,000	66,000	66,000	66,000
GIS		25,500	22,000	12,000	28,000	24,000
Flu Program		54,438	55,526	56,637	57,770	58,925
WNV Treatment		324,000	330,480	337,090	343,831	350,708
Total Budget	5,814,153	7,077,457	7,280,458	7,454,699	7,651,123	7,879,133
\$ Increase		1,263,304	203,001	174,241	196,424	228,010
Percent Budget Increase		21.73	2.87	2.39	2.63	2.98
Ministry Funding 50%	2,907,077	3,538,728	3,640,229	3,727,350	3,825,562	3,939,567
Municipal Levy	2,757,443	3,366,547	3,482,316	3,701,974	3,803,782	3,915,014
\$ Levy Increase		609,104	115,769	219,658	101,807	111,232
Percent Levy Increase		22.09	3.44	6.31	2.75	2.92
Reserve Applied to Levy	149,633	172,182	157,913	25,375	21,780	24,553
Municipal Surplus Reserve	246,092					
Projected Additions to Municipal Reserve Surplus*	75,723	157,913	25,375	21,780	24,553	28,501
Yearend Reserve	172,182	157,913	25,375	21,780	24,553	28,501

Includes financial commitments currently in place and the maintenance of efficient technology.

*Based on an estimate that 25% of the budget increase in any year goes unspent in the year of approval due to late Ministry of Health budget approval, 50% of that surplus is municipal.

Municipal Share of Local Public Health Programs

Status Quo

	BROCKVILLE	GANANOQUE	LANARK	PRESCOTT	SMITHS FALLS	UNITED COUNTIES	GRAND TOTAL	PER CAPITA
2000 Population	19,970	4,908	49,237	3,783	8,640	61,675	148,213	
% of Population	13.47%	3.31%	33.22%	2.55%	5.83%	41.61%	100.00%	
<u>2002 ACTUAL LEVY</u>	\$357,244	\$87,799	\$880,802	\$67,674	\$154,561	\$1,103,306	\$2,651,387	\$17.89
<u>2003</u>	\$371,534	\$91,311	\$916,035	\$70,381	\$160,744	\$1,147,438	\$2,757,443	\$18.60
<u>2004</u>	\$429,148	\$105,471	\$1,058,086	\$81,295	\$185,671	\$1,325,374	\$3,185,046	\$21.49
<u>2005</u>	\$451,042	\$110,852	\$1,112,066	\$85,443	\$195,143	\$1,392,990	\$3,347,535	\$22.59
<u>2006</u>	\$473,625	\$116,402	\$1,167,746	\$89,721	\$204,913	\$1,462,736	\$3,515,143	\$23.72
<u>2007</u>	\$487,001	\$119,689	\$1,200,724	\$92,255	\$210,700	\$1,504,044	\$3,614,413	\$24.39
<u>2008</u>	\$501,198	\$123,179	\$1,235,727	\$94,944	\$216,843	\$1,547,890	\$3,719,781	\$25.10

Municipal Share of Local Public Health Programs

Option #1

	BROCKVILLE	GANANOQUE	LANARK	PRESCOTT	SMITHS FALLS	UNITED COUNTIES	GRAND TOTAL	PER CAPITA
2000 Population	19,970	4,908	49,237	3,783	8,640	61,675	148,213	
% of Population	13.47%	3.31%	33.22%	2.55%	5.83%	41.61%	100.00%	
2002 ACTUAL LEVY	\$357,244	\$87,799	\$880,802	\$67,674	\$154,561	\$1,103,306	\$2,651,387	\$17.89
2003	\$371,534	\$91,311	\$916,035	\$70,381	\$160,744	\$1,147,438	\$2,757,443	\$18.60
2004	\$458,205	\$112,612	\$1,129,726	\$86,800	\$198,242	\$1,415,112	\$3,400,697	\$22.94
2005	\$496,212	\$121,953	\$1,223,434	\$93,999	\$214,686	\$1,532,492	\$3,682,776	\$24.85
2006	\$550,832	\$135,377	\$1,358,102	\$104,346	\$238,317	\$1,701,179	\$4,088,154	\$27.58
2007	\$592,055	\$145,509	\$1,459,741	\$112,156	\$256,152	\$1,828,494	\$4,394,107	\$29.65
2008	\$623,650	\$153,274	\$1,537,639	\$118,141	\$269,821	\$1,926,069	\$4,628,594	\$31.23

Municipal Share of Local Public Health Programs

Option #2

	BROCKVILLE	GANANOQUE	LANARK	PRESCOTT	SMITHS FALLS	UNITED COUNTIES	GRAND TOTAL	PER CAPITA
2000 Population	19,970	4,908	49,237	3,783	8,640	61,675	148,213	
% of Population	13.47%	3.31%	33.22%	2.55%	5.83%	41.61%	100.00%	
<u>2002 ACTUAL LEVY</u>	\$357,244	\$87,799	\$880,802	\$67,674	\$154,561	\$1,103,306	\$2,651,387	\$17.89
<u>2003</u>	\$371,534	\$91,311	\$916,035	\$70,381	\$160,744	\$1,147,438	\$2,757,443	\$18.60
<u>2004</u>	\$458,205	\$112,612	\$1,129,726	\$86,800	\$198,242	\$1,415,112	\$3,400,697	\$22.94
<u>2005</u>	\$486,621	\$119,596	\$1,199,787	\$92,183	\$210,536	\$1,502,872	\$3,611,595	\$24.37
<u>2006</u>	\$530,435	\$130,364	\$1,307,814	\$100,483	\$229,492	\$1,638,187	\$3,936,775	\$26.56
<u>2007</u>	\$556,594	\$136,793	\$1,372,310	\$105,438	\$240,810	\$1,718,976	\$4,130,922	\$27.87
<u>2008</u>	\$574,768	\$141,260	\$1,417,118	\$108,881	\$248,673	\$1,775,103	\$4,265,802	\$28.78

Municipal Share of Local Public Health Programs

Option #3

	BROCKVILLE	GANANOQUE	LANARK	PRESCOTT	SMITHS FALLS	UNITED COUNTIES	GRAND TOTAL	PER CAPITA
2000 Population	19,970	4,908	49,237	3,783	8,640	61,675	148,213	
% of Population	13.47%	3.31%	33.22%	2.55%	5.83%	41.61%	100.00%	
<u>2002 ACTUAL LEVY</u>	\$357,244	\$87,799	\$880,802	\$67,674	\$154,561	\$1,103,306	\$2,651,387	\$17.89
<u>2003</u>	\$371,534	\$91,311	\$916,035	\$70,381	\$160,744	\$1,147,438	\$2,757,443	\$18.60
<u>2004</u>	\$453,604	\$111,482	\$1,118,381	\$85,928	\$196,251	\$1,400,901	\$3,366,547	\$22.71
<u>2005</u>	\$469,202	\$115,315	\$1,156,840	\$88,883	\$203,000	\$1,449,076	\$3,482,316	\$23.50
<u>2006</u>	\$498,798	\$122,589	\$1,229,812	\$94,489	\$215,805	\$1,540,481	\$3,701,974	\$24.98
<u>2007</u>	\$512,516	\$125,960	\$1,263,633	\$97,088	\$221,740	\$1,582,845	\$3,803,782	\$25.66
<u>2008</u>	\$527,503	\$129,644	\$1,300,585	\$99,927	\$228,224	\$1,629,132	\$3,915,014	\$26.41

4.6 Laurier Boulevard Facility

The Health Unit is now in its twelfth year of occupancy at the Laurier Boulevard facility. As buildings age, there are significant costs of upkeep that may be unavoidable.

The General Reserve (valued at \$380,852 as at December 31, 2002), which resulted from the sale of the former Charles Street facility to the Brockville General Hospital, continues to be available to cover the municipal share of major future maintenance/expansion needs of the Laurier facility or other costs approved by the Board of Health. Application will be made to the Ministry of Health for one time funding (50%) for any such item as they are addressed since they are over and above normal operating costs.

It should be noted that a formula determining the ownership of this reserve between the municipalities has never been calculated or agreed to. The allocation would be difficult given the history of the source of funds which lead to the reserve and the increased number of municipalities involved since original construction of the Charles Street facility in 1961.

5.0 Discussion

As in the Long Range Resource Planning Options 1999-2004, the underlying premise of this report is that resource planning that projects farther into the future than the traditional one year budget is required to better assure the capacity of the Health Unit to protect and promote the health of the public. Our experience since 1999 has shown us that although it is very difficult to predict future demands, it is essential to have a long range resource plan if we are to successfully meet the challenges that arise.

It is very important that we continue to pursue the goal of the Board of Health to meet the requirements of the Mandatory Programs. Incomplete compliance with the indicators of the Mandatory Programs is suggestive of lost opportunities to improve the overall health of the population that we serve, and in some situations increased risk of immediate illness or death to our clients. As stated earlier, the Ministry of Health and Long-Term Care has communicated that the Mandatory Health Programs and Services Guidelines (under continued review) are to be viewed as “minimum standards” to be completely achieved, and preferably exceeded; The standards are viewed as a floor rather than as a ceiling. In order to ensure service quality and effectiveness, the Health Unit needs sufficient resources to maintain adequate public health programs and services. Under the Health Protection and Promotion Act, it is the mandate of the Board of Health to ensure that the Health Unit meets its legislated obligations, and to determine the resources required to achieve this.

According to Section 4 of the Health Protection and Promotion Act, “every board of health (a) shall superintend, provide or ensure the provision of the health programs and services required by the Act and the regulations to the persons who reside in the health unit served by the board; and (b) shall perform such other functions as are required by or under this or any other Act.” Section 72(2) states

“the obligated municipalities in a health unit shall ensure that the amount paid is sufficient to enable the board of health (a) to provide or ensure the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the guidelines: and (b) to comply in all other respects with this Act and the regulations.”¹⁰ It should also be noted that planning, for the purpose of ensuring sufficient human and financial resources, is also contained within the Strategic Plan of the Leeds, Grenville and Lanark District Health Unit 2001 to 2003.

In recognition of the added costs to municipalities of downloaded previously 100% Provincial funded programs, in 1998 the Ministry of Finance created a Community Reinvestment Fund (CRF) which has been ongoing. A portion of this fund relates to Public Health. Municipalities representing 55% of the tri-county population revealed that they received \$371,000 in 2002 from CRF for Public Health. It is therefore estimated that the obligated municipalities of Leeds, Grenville, and Lanark received \$673,000 in total from CRF in 2002 for Public Health, thus reducing the municipal share of Public Health costs from 50% to 36%. Ear marking Public Health CRF dollars for that purpose would assist municipalities in meeting their obligations under the legislation.

The projections for staffing enhancement options in the Long Range Resource Planning Options 2004 - 2008 are much more modest than what the projections were, based on our initial methods. The methods used to develop them were deliberately chosen to give weight to cost containment. Despite this they do predict staffing enhancements that go beyond those within the 1999 to 2004 plan.

¹⁰ See Appendix B for a copy of Sections 4 to 9, and 72 of the Health Protection and Promotion Act, pertaining to the mandate of the Board of Health, and the payment of funds accordingly to health units by the obligated municipalities. A copy of the entire Act can be view at the following website: http://192.75.156.68/DBLaws/Statutes/English/90h07_e.htm

Our pursuit of staffing enhancements as a means to enable us to comply with the requirements of the Mandatory Programs is by no means unusual, as most health units throughout the province have taken this course of action. The cost of our operations (\$30.40 per capita in 2000, \$32.78 in 2001, and \$33.64 in 2002) has been very close to the provincial per capita average of \$30.46 in 2000, \$33.76 in 2001, and \$36.70 in 2002. From these figures it is also apparent that the rate of increase in our costs has been less than the provincial average (an increase of \$3.24 per capita for the Leeds, Grenville and Lanark District Health Unit versus the provincial average increase of \$6.24 per capita). Absolute reasons for the local efficiencies can not be verified despite their substance.

Serving a primarily rural population poses a number of inherent challenges for service provision that increases the need for human and financial resources. According to the 2001 population census, the population of Leeds, Grenville and Lanark is 159,101. Within this population the largest community (and our only city) is Brockville, with 21,375 people. Approximately 60 % of our population is found in rural locations. Sources of the added costs of servicing a geographically dispersed population include more travel expenses and travel time for staff, more municipal councils with whom to communicate, more local newspapers to utilize for campaigns, and more offices to service local communities.

Despite this, our costs of operation are lower than most other health units that serve largely rural populations. Appendix G provides the per capita costs of each health unit in the province for the years 2000, 2001 and 2002. The average per capita cost of the seven health units that we typically use as comparators¹¹ was \$32.58 in 2000, and \$38.56 in 2002 (compared to ourselves at \$30.40 in 2000, and \$33.64 in 2002), with the average increase in per capita costs for these two years being \$5.98 (compared to our cost increase of \$3.24). We are limited in our

ability to determine the reasons why our per capita costs have been lower than these other health units. The provision of answers to such questions would require a more detailed comparison of these health units. However we do observe from the data that our per capita costs, as well as the increase that we have had during these years, have been less than the average of other similar health units.

The need for these enhancements has been discussed earlier in this report, citing the many instances of enhanced public health needs and demands for service that were not anticipated with the creation of the original plan. In addition to this, it should be noted that the report entitled Long Range Resource Planning Options 1999-2004 provided a range of optional projections for staffing enhancements to meet the Mandatory Programs. In that report the projection with the highest estimate for staffing enhancement needs was 29.61 FTEs, whereas the projection adopted by the Board was for 18.64 FTE (with the lowest option being for 13.65 FTE). Thus the staffing enhancements within the 1999 to 2004 plan were chosen to be moderate, and were not meant to address the public health demands that have arisen since then.

All three of the staffing projection options provided in the Long Range Resource Planning Options 2004 - 2008 are in keeping with the results of our organizational structure review, and thus commence with management and clerical increases. As noted in the structure review, more management positions are needed to adequately support the number of staff that we now have. In addition, there is a common view throughout the Health Unit for the need for more clerical positions. The roles of managers and clerical are essential to the functions of all programs, and support the roles of all staff. Thus by necessity, shortages in these positions inadvertently result in other disciplines of staff fulfilling these roles. Among other issues, this results in a loss of direct service provision by front-line staff. Thus

¹¹ Eastern Ontario Health Unit, Grey Bruce Health Unit, Haliburton-Kawartha-Pine Ridge District Health Unit, Kingston, Frontenac, Lennox and Addington Health Unit, Peterborough County-City Health Unit, Hastings & Prince

enhancements in managers and clerical staff would serve to free up staff time throughout the agency to better allow us to fulfill our service obligations within the Mandatory Programs.

As noted earlier, there were some differences between the position enhancements anticipated in the 1999 to 2004 long range resource plan and the positions that were actually created (see Appendix E). Decisions made in this regard were in response to needs that were not anticipated in 1999. Our decisions in this regard have been validated by our performance on the MPIQ.

In general, the created positions that were unanticipated in 1999 provide support services to front-line staff throughout the Health Unit, in order to enhance the ability of staff to deliver service. The decisions to create such positions at the expense of designated positions for front-line staff speaks to the need to have these support staff in place before creating more front-line staff positions.

It should be noted that with such support staff now present we would be in a better position to make good use of new front-line staff enhancements. The need for such enhancements, to comply with the requirements of the Mandatory Programs, was identified by the program department directors, as reflected in the financial and staffing projection for Option 1 (page 15, and pages 23 to 26 and pages 28 and 32). Presently, staff workload issues persist. Thus in addition to helping us achieve compliance, having these staff enhancements would make for more sustainable workloads, and thus reduce staff turnover. It would also be in keeping with our organizational Statement of Beliefs and Values, from our Strategic Plan, which states that our workplace must reflect and reinforce practices to protect and

promote the health of our staff.¹² Option 2 (page 15 and pages 23 to 26 and pages 29 and 33) provides the projected costing that includes approximately half of the front-line staffing enhancements requested by the directors. It should be noted that the professional disciplines and the numbers of staff enhancements in Option 2 are similar to the positions in Appendix E that were chosen not to be rolled-out from the 1999 to 2004 long range resource plan. The provision of such staff enhancements would serve to significantly enhance our ability to meet the requirements of the Mandatory Programs and the public health needs of our communities.

In all three of the financial projection options, the total municipal levy for the year 2003 is capped at a 4% increase over the 2002 actual levy. For each of the years 1999 to 2003, the municipal levies have been less than or equal to those predicted in the 1999 to 2004 long range resource plan (see Appendix C). It is only in the year 2004 that the municipal levies in the Long Range Resource Planning Options 2004 - 2008 will surpass those predicted in the 1999 to 2004 long range resource plan. This is consistent with the general finding that forecasts, including financial needs assessments, become increasingly less accurate the farther they project into the future. Our ability to work for five years within the levy projections created in 1999 speaks well of the value of the original plan.

The projected costs and timelines for staffing enhancements for 2004 - 2008 are based on the assumption that we continue to receive approval for our annual budget in December of each year from the Ministry of Health and Long-Term Care. In addition, some provision has been made in each of the financial projection options for increases in office space to support our staffing needs. Further determination of the exact cost of such space will be required as time

¹² The Statement of Beliefs and Values of the Health Unit can be viewed within our Strategic Plan 2001 to 2003 on our website at http://www.healthunit.org/about_us/strat_plan/strat_plan.htm.

passes, and will be included in the five-year financial projections to be presented to the Board in the years to come.

While all attempts have been made to be comprehensive, it is not possible for a report such as this to predict and include all costs that may arise in the future. The Rapid Risk Factor Surveillance System (RRFSS) serves as an example of an expense not included in our projections. In the present year we have participated in this program which provides us with timely monthly survey results from a sample of citizens in our district with their views on a range of public health issues. The cost of this program of approximately \$40,000 for the year is being covered 100% provincially within the Early Child Development, Perinatal and Child Health Survey Strategies Funding. It is not anticipated that the 100% provincial funding will be available to cover this program after this year. Staff of the Health Unit will conduct an evaluation on the value of this program and will make recommendations on merits of continuing to fund RRFSS within our base budget (or other alternative funding sources that may be identified) in future years. The cost of continuing this program has not been included in our projections as the decision to continue it has yet to be made.

The pursuit of compliance with Mandatory Programs is of critical importance to the health of our citizens. Thus in addition to these staffing enhancements, we will need to achieve further efficiencies with strategies that include identifying and employing best practices, and making use of shared information and planning resources from other health units and partner agencies, if we are to fully comply. These strategies, and many others, are embodied within the principles and practices of Continuous Quality Improvement (CQI). Based on the experiences of private sector industries, CQI methods are used to systematically find and employ ways to more effectively and efficiently provide high quality products and services. Quality improvement has been defined as “(doing) the right thing right

the first time, on time, all the time, and to strive always for improvement and client/customer satisfaction”¹³.

Quality improvement is an important component of the Health Unit Strategic Plan 2001 to 2003. The Board of Health has expressed its commitment to quality improvement by initiating and maintaining our accreditation status with the Ontario Council on Community Health Accreditation (OCCHA) since 1989, and more recently by designating permanent funding for a Quality Improvement position. Quality improvement methods will help us to not only improve the effectiveness of our programs, but to also be more efficient so that we can continue to increase our compliance with the Mandatory Programs. It may be that achieving 100% compliance with the MPIQ and the Mandatory Programs becomes increasingly more difficult to complete as we approach it – the dynamics of diminishing returns. With limited resources for us to rise to this challenge we will need the efficiencies from CQI if we are to continue making gains in service provision.

Having commitment from the Board of Health for a long range resource plan is essential if we are to successfully meet the challenges that arise. Commitment to our 1999 to 2004 long rang resource plan allowed us to gain the resources required for us to meet the changing public health needs of our communities. Our experience with this plan has shown us, however, that it is very difficult to predict the exact nature of the needs that will arise. Thus it is our recommendation that in the fall of each year we review, and if indicated, revise staffing and financial projection options within our five-year Long Range Resource Plan, and present them to the Board of Health.

¹³ Rogers, B. (1994). Occupational Health Nursing Concepts and Practice. Philadelphia, PA: W.B. Saunders Company.

It is also our recommendation that the Board of Health receive the Long Range Resource Planning Options 2004 - 2008 as information, and that the Board use this information in the development of future annual budgets. It should be recognized that this commitment of the Board of Health would be conditional on the ongoing financial support from the Ministry of Health and Long-Term Care for 50% of the Public Health budget. Furthermore, it should also be understood that the future financial decisions of the Board of Health would be subject to modification based on the annual review of the Long Range Resource Planning Options. In this way we will be able to plan in response to a changing environment.

6.0 Recommendations

1. It is recommended that the Board of Health for the Leeds, Grenville and Lanark District Health Unit receive the Long Range Resource Planning Options 2004 - 2008 as information.
2. It is also recommended that the Board of Health take into consideration the information within the Long Range Resource Planning Options 2004 - 2008 when drafting the 2004 budget of the Health Unit.
3. It is also recommended that the findings of the Long Range Resource Planning Options 2004 - 2008 be communicated to stakeholders.