

Attitudes toward Public Health Funding:

Results of a Survey that Explored Differences in Support by Ontario Municipal Elected Officials  
for Local Public Health Programs

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## ABSTRACT

Public health funding in Ontario has been the subject of some debate partly due to arrangements whereby funding (and governance) is split between the provincial and municipal governments. While funding contributions from municipalities for public health are prescribed by law, there is evidence of reluctance on the part of some municipalities to pay their required portion. In addition, the policy stance taken by the Association of Municipalities of Ontario (AMO) is that public health should not be funded from the property tax base.

Since many public health programs are interconnected to the traditional services provided by municipalities, it was hypothesized that this reluctance to fund may be due to the differences in characteristics of the diverse public health programs found in local public health organizations.

A survey was sent to all municipal politicians in Ontario to attempt to discover if there was a difference in their attitudes towards municipal funding of public health by type of public health program. Public health programs were divided into two types—protection-type programs and promotion-type programs.

It was found that while the respondents exhibited strong overall support for government funding of both types of programs, municipal politicians in Ontario showed a significant preference for committing municipal funds to protection-type programs than for promotion-type programs.

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## Table of Contents

	<u>Page</u>
1. Introduction	5
2. Local Public Health in Ontario	7
i. Viewpoint of Ontario Municipalities	7
ii. Public Health: One Goal: Two Very Different Strategies	9
iii. Necessity and Complications of Multi-level Funding and Control	15
3. Structure of Public Health Units in Ontario	17
4. Hypothesis	19
5. Methodology	20
i. Survey Design	20
ii. Collection	21
iii. Response Rate	23
iv. Assessing Representativeness of Respondents	25
v. Selection of 12 Public Health Programs	27
6. Analysis	31
i. Support for Government Funding of Public Health Programs	31
ii. Difference in Municipal Funding Support for Protection vs. Promotion Programs	36
7. Summary	46
Works Cited	47
Appendices	49

## **1. INTRODUCTION**

This research explores the willingness of municipal elected officials (councillors and heads-of-council) to commit municipal revenue to local public health programs. It finds that this willingness is strongly affected by the type of public health program under consideration. This question was asked in reply to statements found in reports commissioned by the Ontario government in response to the Walkerton water tragedy in 2000 and the SARS outbreak of 2003, claiming that many Ontario Public Health Units (PHUs) suffer from a lack of municipal administrative and political support. For example the final report on SARS states that:

Ontario's 36 local health units are the front line of protection against infectious disease. That chain of protection is only as strong as its weakest link. Some health units are well governed, some poorly... these weak links often result from the system of two governments, provincial and municipal, being involved in the operation of local health units (Campbell, 2<sup>nd</sup> Interim Report, 71).

Commissioner Campbell goes on to state that the only 'serious' solution to the present problem (which is defined essentially as encroachment of the Medical Officer of Health's powers by bureaucratic and political interests at the local government level, particularly in matters involving PHUs' budgets) is to "upload the funding and control of public health 100 per cent to the province and to get municipalities out of the public health business". He gives the present system a respite, however, until the end of 2007 and states that the "burden of persuasion" is on those who believe that the present system of split governance should be preserved.

Justice O'Connor makes three recommendations in Part One of the Walkerton Inquiry regarding local PHUs. All Boards of Health should be required to have a full-time local Medical Officer of Health. Second, the province should audit local health units to ensure their compliance with provincially established standards and third, the role of the local health unit in regard to municipal water systems should be clarified and strengthened (O'Connor, 499). These recommendations leave the current municipal/provincial split governance intact while

underscoring provincial responsibility to enforce standards locally. However, the recommendation for provincial ‘auditing’ of PHUs spoke to findings whereby PHUs were suspected or known to be not following provincial requirements.

Ontario PHUs are governed by provincial statute: the Health Protection and Promotion Act. This Act states that municipalities are obligated to pay to their PHU any and all “expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act” (Section 72 (1) Health Protection and Promotion Act, R.S.O. 1990, Chapter H.7). Municipalities have no choice but to pay for any and all expenses that their board of health or their medical officer of health deems necessary to carry out the functions of the PHU. This obligation is offset by the requirement that each board of health’s membership include municipally-elected officials.

A ‘board of health’ is defined by the Act as either one of six regional local governments or the County of Oxford; or a single-tier municipality acting as a board of health or an agency, or a board or organization prescribed by regulation. This in effect leads to two major types of PHUs: those who are directly integrated into the administration of a lower or upper-tier municipality or those who are administered by an entity separate from the municipality: an agency, board or commission.

Blame for PHU difficulties has been directed at the split municipal-provincial governance model; however, other important factors may be at the root of the problem. This research explores one possibility—the types of public health programs that PHUs deliver are affecting the willingness of local political actors to support them. Differentiation of public health programs is rarely articulated when issues of funding and/or compliance with provincial standards are explored. This research investigates whether or not municipal elected officials’ willingness to fund public health from the property tax base is affected by the type of public health program being considered, e.g. protection-type or promotion-type program.

## **2. LOCAL PUBLIC HEALTH IN ONTARIO**

### **i. Viewpoint of Ontario Municipalities: Public Health Funding**

The Campbell Report on SARS consists of two interim reports and a Final Report. In the first interim report the municipal perspective is captured in a statement from the Association of Municipalities of Ontario. One idea summarizes the AMO view—public health will continue to be less than adequate unless the province makes policy changes that include removing financing of public health programs from the property tax base (Campbell, 1st Interim Report, 216).

AMO did not contribute further to Commissioner Campbell's investigation. Campbell writes that “during the preparation of this second interim report the Commission repeatedly asked the AMO for its assistance and position on a number of the issues addressed in this report, including the continuation of local public health governance. The Association of Municipalities of Ontario unfortunately found itself unable to take a position” (96). However, AMO was able to present a response in 2006 to a provincially-commissioned committee that examining how public health capacity could be maximized (AMO's Response to the *Final Report of the Capacity Review Committee: Revitalizing Ontario's Public Health Capacity*, August 1, 2006). AMO stated unequivocally that public health should not be funded from the local property tax base but that given the reality of continued split accountability and financing, municipalities must retain governance responsibility. In particular, concern was expressed about the report's recommendation to have a “special purpose arms length body” governance design which violates the ‘pay for say’ principle that AMO advocates.

Public health funding has been a recognized issue of policy contention for municipalities since the province of Ontario announced, in 1996, complete downloading of financial responsibility for public health during an exercise which saw other previous provincial responsibilities downloaded to municipalities. The 100% download put local PHU's into an immediate fiscal crisis and focused the attention of municipal actors on the fiscal aspects of public

health in an unprecedented way. Ontario reversed its decision within the year, instead adjusting the cost-sharing ratio to 50-50. However, this exercise, along with the accompanying downloading of social service costs resulted in Ontario municipalities shouldering more health and social service costs than municipalities in any other province with the exception of the NWT and Nunavut (Kitchen, 20). It is important to note that while 'health and social services' are frequently referred to as one entity during discussions of provincial downloading, social services expenditures alone increased as a percentage of total municipal expenditures from 14.6 to 25.0 during the period from 1988 to 2000, while health expenditures increased during this same period from 2.9 to 3.3 (Kitchen, 20).

The perception that the increase in public health expenditures is larger than it truly is may be partially due to the quick succession of changes to public health funding that occurred after 1996. Cost-sharing was first instituted in 1935 as part of ongoing provincial efforts (beginning in 1882) to encourage municipalities to provide local boards of health (some municipalities had established these as early as 1833). Grants varied generally by population until 1967 when the current system of PHUs was instituted which included 75% funding from the province for local public health (Powell). This level of funding remained until 1996 when the province announced it was downloading 100% of PHU costs to their participating municipalities before reverting to 50% funding in 1999. Since then, in response to recommendations made after Walkerton and SARS, the provincial share of public health costs have risen and are projected to be at the 75% level again by the end of 2007.

Although this ten-year 'roller coaster' of funding changes may have influenced the municipal perception of local public health funding it is important to note that conflicts regarding funding, governance, requirements to meet with provincial standards and structures of health units have been ongoing since the first Public Health Act was passed in 1884 (Powell). In addition, AMO's position, that mandatory public health programs be funded 100% by the province, has been in place since at least 1982 (Powell, 345). Furthermore, debate and changes to local public



health governance, funding and standards are known to occur on a more or less regular schedule that mirrors the arrival and departure of major communicable disease outbreaks. John Duffy's historical look at public health in the United States, for example, articulates as one of its four main themes the constant back and forth between apathy about recommended public health control measures and sharp reactions to periodic disease outbreak crisis. The phenomena of the creation and dismantling of boards of health in response to periodic outbreaks noted by Duffy occurred in early Ontario as well. A history of public health in London, Ontario confirms this: "Between 1830 and 1885, there were at least 10 temporary boards of health in the London district. Each was organized during a medical crisis—most usually during epidemics..." (Middlesex-London Health Unit, 9). What may be needed, rather than another change in governance or structure, is another way of looking at which public health programs are best delivered at the local level and why.

## **ii. Public Health: One Goal: Two Very Different Strategies**

Public health organizations frequently struggle with being misunderstood by the public they serve. 'Public health' is often confused with 'publicly-funded health care'—the two terms may be interchangeable in countries without publicly-funded health care; but is less so in countries such as Canada. Public health specifically focuses on the goal of preventing diseases before they incur, thereby avoiding the costs of treatment and the ill-effects of suffering from disease. Public health, by definition, focuses on the health of populations, rather than individuals.

Historically public health in the western world evolved from a need to control the spread of communicable diseases which caused illness, disability, death and fear in local communities. The international growth of trade in the 18<sup>th</sup> and 19<sup>th</sup> centuries brought increased mobility of infectious diseases. At the same time, increasing urbanization led to issues of sanitation among people living in shrinking environments. Thus, early public health focused on community

sanitation and attempts to control infectious diseases (Duffy, Rosen). One major scientific breakthrough changed public health at the end of the 19<sup>th</sup> century: the discovery of incontrovertible proof of the ‘germ theory’ of infectious disease; until then, leading medical professionals disputed the cause of infectious disease outbreaks. This discovery quickly brought about the invention of antibiotics, vaccines and sanitary engineering advances. In many ways it was believed that the era of communicable disease threats was over, at least in those parts of the world that could afford the medical and engineering innovations. However, public health programs remained an important aspect of the western world’s health system as it was recognized that other determinants of health (e.g. socioeconomic, education,) still left some groups vulnerable to infectious diseases. A growing concern with chronic diseases—which appeared as life spans lengthened and as more of the natural environment became converted to a built environment—also shifted public health focus. Funding and policy in public health began to favour these new threats—programs that emphasized health behaviour changes grew as funding for protection programs began to stagnate. Public health history and policy accounts of public health in the western world for most of the past 100 years supports this view: for example, Heather MacDougall’s history of the Toronto Department of Health accepts a shift from “communicable to lifestyle diseases” as a natural evolution of public health in the twentieth century (295).

Beginning with HIV in the early 1980’s and ending with the multi-country SARS outbreak in 2003, it is now widely recognized that the era of communicable diseases is not over. In addition to high-profile, novel disease outbreaks other communicable disease threats loom more quietly, e.g. the rise in antibiotic-resistant communicable diseases such as TB and MRSA. Also emerging are risks of disease from the environment due to infrastructure decay, pollution and the arrival in the west of new species of insects and animals that act as vectors of disease.

The two types of programs, traditional public health interventions designed primarily to combat disease that were obtained from other people, animals or the environment and the

'lifestyle' or chronic disease prevention programs, can be termed 'health protection-type' and 'health promotion-type' programs.

Before the differences inherent in these two types of programs are outlined further, it is important to recognize that a complete division between the two is neither possible nor desirable. For example, enforcement of recreational water sanitation regulations is an example of a health protection-type program but some of the strategies designed to encourage a user to avoid use of the facility while ill with a gastrointestinal upset frequently rely on the tools of health promotion (education, influence on facility policy development, mass media campaigns). Conversely, the encouragement of healthier eating habits is generally thought of as a health promotion-type program but can have health protection elements when a public health organization seeks to limit food choices available to the public by statute or policy. However, generally speaking, most public health programs can be readily categorized as using strategies that consist primarily of either protection or promotion approaches and thus can be classified as either protection or promotion type programs.

Health promotion includes those activities which primarily aim to change individual, family, neighbourhood and societal behaviours to establish increased population health. Examples include promotion of healthy eating, physical activity and smoking cessation. It can also include overt attempts to influence public policy outside of the health portfolio to increase population health (e.g. advocating for a more substantial income for those who require income support). The goal is a healthier population. From an economic perspective, achievement of this goal provides two benefits—a populace that is more able to contribute to production (less chronic illness, longer lives) and that will incur less costs in terms of claims to the publicly-funded health insurance system. Health promotion is thus concerned with direct economic externalities.

Economic externalities can be thought of as the cost that an individual incurs because other individuals are engaging in unhealthy behaviours. This is an issue that, in the private market, is often dealt with by insurance companies. Premiums paid by consumers are based on

both their own choices (to maintain a healthy weight or not) and the choices of others (how many obese people are covered by a policy). Insurance companies deal with this by basing their costs on the prevalence of those with conditions or habits that mean costs down the road, by adjusting individual premiums based on the individual's choices and by excluding those whose behaviours are predictive of future high costs. A government-run health insurance plan, however, is more limited in its ability to control costs in these ways. It does not (usually) adjust individual premiums based on individual behaviour and, in Canada, by law cannot exclude those who are engaging in more risky behaviour. It can and does attempt to base costs on the prevalence or habits of disease conditions and is motivated to decrease these costs by decreasing the prevalence of bad health behaviours. The externality here is the increased cost to every individual (with adjustments for equity in the tax system) for the bad choices of other individuals. Since the 'insurance company' in effect here is the provincial government, it makes sense for this level of government to fully fund and administer the health care system, including those activities which are specifically designed to decrease the costs involved. For this reason, activities with the primary goal of reducing health care costs should be funded and administered by the provincial government. The activities can be contracted out to private companies, NGO's or other levels of government such as municipalities or municipal agencies. However, the full cost should be borne by the level of government who is responsible for the health care system. This is not the current case in Ontario where health promotion programs are partially paid for using property taxes.

Health protection, on the other hand, has as its objective the protection of people from diseases which may be transferred from contaminated food or water, other vectors (such as insects or animals) or from another person who is communicable with a disease. This includes non-biological disease-causing factors that arise from the environment such as environmental tobacco smoke or lead in water or paint. If health protection is lacking, and people acquire diseases from their environment, economic analysis will also show the same two economic effects as health promotion—a negative effect on production and increased costs to the publicly-funded health care

system. However, there is an important third consequence, not found in health promotion, which is the effect on the municipality where the health protection problem appears.

When considering the impact of each type of program on a municipality, promotional programs, with their main economic externalities being related to the publicly-funded health care system, have little direct impact on municipal government. This is not to say that communities do not differ in their rates of lifestyle diseases—promotional programs need to be targeted to match the unique needs of communities. Protection programs, most of which involve environmental public health programs (provision of safe food and water, eradication of infectious disease risk from the environment and the abatement of other environmental contaminants) directly involve municipal government. Health protection programs and services are as essential to a local community as road maintenance and police protection. The Walkerton water tragedy illustrates that while a disease outbreak in a community may produce large externalities the “costly effects beyond that municipality’s are never as high as the damage caused within the municipality itself” (Sancton and Janik, 51). The costs of a disease outbreak in a community go beyond the medical costs to treat the affected population within and outside of a community. The costs also include the cost of reputation damage which may impact the all-important economic development goal of virtually all communities—people may lose trust in community leaders and managers and either move away or choose not to locate their home or business in that particular place.

Health protection goals are the intent of several municipal services including land control, provision of drinking water, sewage treatment, waste disposal and by-laws and license requirements around establishments such as restaurants, funeral homes, boarding homes and personal service settings. The claim that Ontario municipalities should not be funding their local public health protection programs, that the provincial government should instead do so, is analogous to private corporations giving over their quality assurance programs to a cost-shared umbrella organization to administer it for them. While this does exist in some forms (accreditation agency standards for private hospitals and labs, for example) generally private

companies have a recognized moral and legal responsibility for the safety of their own products. Risk management strategies are used to ensure that products are safe; demand will fall sharply if a product becomes known to be or believed to be contaminated. Recently, municipalities have been thought of as a ‘product choice’ that a consumer can make. This public choice theory states that people can and will simply change the location of their home or business to match the level of taxes and services they want. Municipal leaders have responded by marketing their municipalities and highlighting low taxes and, increasingly, superior services that their city or town provides. Leaving public health protection to another level of government puts municipalities in a position whereby they do not control or manage their own public health protection risks.

The following table summarized the inherent differences in public health protection-type programs and promotion-type programs as they relate to municipalities.

**Table 1. Summary of Protection and Promotion Characteristics**

	<b>Protection</b>	<b>Promotion</b>
Economic externality re: publicly funded health care system	Yes	Yes
Economic externality re: more productive, healthier citizens	Yes	Yes
Effect on others perception of Municipality/municipality’s reputation	Yes	Possibly
Related to Other Municipal Services	Yes	No

Complete provincial funding of protection-type programs has another possible downside: provincial politicians are also sensitive to costs and to taxes and should a government come to power with these goals to the exclusion of all others, public health could suffer across the province with consequences more far reaching than those coming from one health unit battling fiscal constraint from one municipality.

Information from the relations between federal and provincial governments may be cautionary here: "...efforts to constrain public health spending [referring here to publicly funded health care] in federations will be easiest when control over the key policy instruments is effectively lodged at one level of government, whether at the federal or the state/provincial level. In cases when control over the key levels of cost containment is divided, the prospects for cost containment would seem to depend heavily on the effectiveness of mechanisms of intergovernmental coordination" (Banting and Corbett, 27). These authors conclude "the consolidation of power at one level clearly does create the capacity for governments to squeeze the system when needed" (Banting and Corbett, 29). 100% provincial funding and control could seriously jeopardize health protection in Ontario in the future, once the memory of Walkerton and SARS fade; thus, municipalities have a vested interest in retaining some control over health protection-type programs.

### **iii. Necessity and Complications of Multi-level Funding and Control**

Municipal elected officials stand accused in the Campbell Report of being reluctant to meet their statutory obligations to fund public health. The Report contains first-person accounts from medical officers of health giving examples where municipal politicians and administrators attempt to move public health funds to other areas of the municipal budget. "Basic protection against disease should not have to compete for money with potholes and hockey arenas" states Campbell (1st Interim Report, 215). Municipalities in Ontario are obligated by law to provide the monies as requested by their health unit. The terms of this obligation are set out in the Health Protection and Promotion Act, Section 72.

While primarily health protection-type programs can be shown to be interconnected with municipal services it is still necessary to have provincial funding in place to support these types of programs. First, economies-of-scale dictate that health protection, particularly regarding the

control of infectious diseases, is a program that requires the participation of more than one level of government—the technical and scientific expertise necessary to implement the most current surveillance, laboratory and research are well beyond the fiscal capacity of municipal governments and possibly provincial governments as well. Second, infectious diseases and environmental contamination do not respect municipal, provincial or national boundaries. Third, disease surveillance, using modern technology, requires the involvement of a government that has as far reaching powers as possible. Lastly, communicable diseases have a unique characteristic evident in any historical account of a disease outbreak, including the 2003 SARS outbreak: a potential to decrease societal stability. Contaminated water and food increase scarcity of these essential elements of life and undermine people's trust in their systems of government. Fear of acquiring a disease that is spread person-to-person or through an intermediary such as disease-carrying insects, affects people's behaviours and beliefs. Actually acquiring a disease this way can cause panic that threatens the entire infrastructure of society and government. Thus, health protection-type programs may need to be administered and financed by every level of government—municipal, provincial, national and international.



### **3. STRUCTURE OF PUBLIC HEALTH UNITS IN ONTARIO**

Public health, as a public program that requires administration, is unique in its tendency to have a medical doctor as the administrative head of its organizations. In Ontario, this is encouraged by statute; while the HPPA sets out a requirement that each PHU engage a full-time medical officer of health, it does allow for the appointment of an ‘acting’ medical officer of health in health units where this position is vacant. Two issues have arisen, outlined in both the O’Connor report on Walkerton and the Campbell report on SARS, as a result: in some cases, PHUs have not recruited a medical officer of health, preferring to rely on a community physician to be an ‘acting’ medical officer. In others, particularly in PHUs that are part of a regional local government system, conflict between the fulltime medical officer of health and the municipal CAO occurs as to who has the ‘ultimate’ say in financial and management issues involving public health programs and staff.

PHUs can be categorized as being either ‘autonomous’ or ‘integrated’. Autonomous PHUs are managed by a board of health that is at ‘arms-length’ from the municipalities they serve. Boards have a requirement to have municipal appointees, and these most often are elected municipal officials. Integrated PHUs are part of the administrative structure of a municipality. These municipalities may be regional, single-tier or upper-tier. There is one unique integrated PHU, Haldimand-Norfolk, which consists of two single-tier towns sharing the administrative functions of health and social services.

According to research conducted for the Capacity Review Committee, 27 out of 36 PHUs have a fulltime medical officer of health (75%) (Starfield Consultants, 108). More notable is the

breakdown between autonomous and integrated PHUs\* in terms of the administrative head of the organization:

**Table 2. Structure-Type and CAO vs. MOH in Ontario Public Health Units**

Type of PHU	total number	MOH/CAO are separate positions
Municipally Integrated	14	14 (100%)
Autonomous	22	6 (27.3%)

Administrative differences between municipally-integrated and autonomous PHUs may affect the attitudes of elected municipal officials. In addition, whether or not a municipal politician holds a position in a single-tier or lower or upper tier municipality may have an effect on their perception of public health. PHUs are associated with upper or single tier municipalities only.

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\* The Starfield Consultants Report published different numbers than what is found here for health units that are municipally-integrated and autonomous. The numbers here were obtained by analyzing each health unit's structure using information from their websites and the Health Protection and Promotion Act.

#### **4. HYPOTHESIS**

For local public health it is possible that elected officials may be more willing to fund some public health programs than others and that these differences may be ascertained by whether or not a public health program fits more with the identity of health protection or health promotion. Possible reasons for this were outlined in section 2 of this report.

It is generally accepted that administrative actors in democratic countries need to have the support of elected officials if they are to influence policy (Sutherland). Therefore the attitudes of elected municipal officials matter in the discussion over public health and, ultimately, policy decisions regarding appropriate funding levels and specific responsibilities for municipalities. A survey was created, administered and the results analyzed to test the following hypothesis:

Elected municipal officials in Ontario are more willing to commit municipal funds to public health **protection-type** programs than to public health **promotion-type** programs.

## **5. METHODOLOGY**

### **i. Survey Design**

An invitation to complete a survey was sent to all elected municipal officials in Ontario. The survey was internet-based and officials were asked to participate by e-mail. E-mail addresses for Ontario municipal councilors and heads of council were obtained by purchasing the 2007 Ontario Municipal Directory Communication Edition published by the Association of Municipal Managers, Clerks and Treasurers of Ontario (AMCTO). The Directory contained listings for 3,255 elected municipal positions. The survey was designed using principles outlined in Dillman's *Mail and Internet Surveys, The Tailored Design Method*. A decision was made to survey the entire population, rather than a sample, as cost was quite low to do so using an internet survey. An on-line commercial survey software program, SurveyMonkey, was used which allowed for the use of more complex design features.

The survey was divided into three main sections. The first section asked for the respondent's demographics, length of time served as an elected official and information about the respondent's involvement with their municipality's associated Board of Health. This section also asked the respondent to agree or disagree with the statement "Municipal taxpayers in Ontario pay too great a proportion of the funding required for health and social services".

The second section asked the respondent questions about the municipality that he/she represents. Questions were asked about the population size, urban or rural characteristic, and the respondent's perception of their constituency's wealth and health. In addition, the respondent was asked which PHU serves their municipality, whether or not the PHU has a full-time Medical Officer of Health, how many Board members their PHU has and how many of these are from the respondent's municipality.

The third section listed twelve public health protection and promotion programs (this designation was not visible to respondents) and asked the respondent to select one of four options. The four options were designed to ascertain the level of support for municipal funding for each

program. The first option was “municipalities should contribute some or all of the funding for this program/service” allowing the respondent to make a selection that either reflected current practice (split provincial and municipal funding) or an even stronger indication of municipal funding support. The second option “100% provincial funding” gave the respondent the opportunity to indicate that the program should be funded wholly by the province. The third option allowed the respondent to indicate that they didn’t know which level of government should fund the program. A fourth option was “there should be no funding for this program/service from either level of government” giving respondents the chance to express a lack of support for any public funding of that particular public health program.

For a copy of the survey, please see Appendix A.

## **ii. Collection**

Responses were collected beginning on April 18, 2007. The survey was closed to responses on June 15, 2007. The survey was sent to a number larger than the population of elected officials due to initial confusion regarding the size of the population—some municipal officials (approximately 391) hold two elected positions due to cross appointment to upper-tier municipal positions and therefore received the survey twice. The survey was also made available in an electronic file form that could be printed, filled out by hand and returned either by regular mail or fax as a result of numerous requests received during the collection period. Reasons communicated to the researcher for preference of a ‘hard copy’ included lack of willingness to complete an on-line survey, technical difficulties with the survey and lack of access to either the internet or a high-speed connection. The following table summarizes the survey collection activities.

**Table 3. Summary of Survey Collection Activities**

DATE	SENT TO	METHOD	RESULTS	
			Responses	Bad Addresses
April 18	3,255 Councillor e-mail addresses From AMCTO Directory	E-mail, sent via SurveyMonkey	226	79 councillors had no e-mail address listed 28 addresses were invalid/rejected 387 duplicates noted and removed 78 chose to 'opt out' of survey
May 6	2,491 Non-responders	E-mail, sent via SurveyMonkey	272	12 chose to 'opt out' of survey
May 21	2,207 Non-responders	E-mail, sent via SurveyMonkey	158	22 'rejected' addresses 122 chose to 'opt out' of survey
May 31	441 Municipal Clerks	E-mail, sent via researcher's personal e-mail account	N/A	.pdf copy of survey sent
June 4	1,295 Non-responders	E-mail, sent via researcher's personal e-mail account	99	Approximately 600 'bad' addresses* investigated and corrected or removed
June 15	N/A	Data Entry of Hard Copies Received Via Fax and Mail	27	Manually entered into online survey by researcher
Total Responses			782	

\* 'bad' addresses found included those where a generic municipal email address or an address for the municipal clerk was used in the AMCTO Directory, rather than a councilor's individual email address. Individual addresses were collected in these cases by checking municipalities' website information.

Contacting potential respondents multiple times has been shown to be the most effective technique for increasing response rates to surveys (Dillman, 149). This strategy also applies to internet surveys (Dillman, 367) and is in fact easier and less expensive to do compared with traditional survey methods such as regular mail. Therefore, three different cover letters containing a link to the on-line survey were composed and sent on each of April 18, May 6 and May 21. The May 21 cover letter was sent again on June 4 as approximately 600 of these e-mail addresses were investigated (using municipal councilor e-mail contact information found on municipal homepages on the internet) and corrected. Please see Appendix B for a copy of the letters. The remaining e-mail addresses (approximately 700) were sent using a different sending e-mail address necessitated by the discovery that survey invitations sent by SurveyMonkey created the possibility that SPAM filters at the recipient's organization or e-mail domain were blocking the survey invitations. The survey invitations appeared to come from the researcher's

own e-mail account but actually were being sent from SurveyMonkey. SPAM filters will block email sent using this method because filters check to confirm that the domain of the sender's e-mail address matches the domain of the sending mail server.

### **iii. Response Rate**

Ascertaining an accurate number of elected municipal officials in Ontario was surprisingly difficult. AMCTO's Ontario Municipal Directory provided 3,255 names when the data was filtered to include elected officials from all municipalities. AMCTO claims inclusiveness for all Ontario municipalities. The AMO website refers to 3,135 positions which they surveyed to gain 2006 election information. Both numbers, however, include duplication whereby one person holds two elected municipal positions due to being a representative of both a lower and an upper tier municipality.

To find the actual number of persons elected to municipal positions the AMO website was used. This website lists the complete list of 2006 municipal election results. The number of councilors and heads-of-council elected and acclaimed was manually counted. In addition, all upper-tier municipality websites were viewed. These included both County governments and Regional governments. It was necessary to assess each upper-tier as there is not consistency in Ontario with regard to how upper-tier councilors are selected. In some cases they are elected at-large to fulfill only the role of an upper-tier councilor; in other cases councilors are appointed to the upper-tier by virtue of their lower-tier elected role. Some regional governments have an elected Regional Chair; others have an appointed Chair—the decision was made not to include Regional Chairs if they are not already included in lower-tier elections. Assessing each upper-tier mechanism allowed for the removal of duplications so that each elected official was counted only one time. 397 names were removed from the list. Table 4 shows the total responses.

**Table 4. Overall Response Rate**

Completed on-line	755
Manual Data Entry (survey received by mail, fax or email)	27
Responded on-line indicating they did not want to do the survey	212
<b>Total Responded</b>	994
Number of Ontario Councillors	2863
<b>Percentage</b>	<b>34.7</b>

The data collected was converted from the on-line survey software to SPSS. When the data was examined it was noted that some respondents had chosen to begin but not end the survey. The most common strategy detected was a willingness to complete the first two sections of the survey but not the third section. Since the third section, responding to questions regarding the 12 public health programs, was essential for the analysis of this research, those survey responses were removed from the analysis. Table 5 shows the response rate after removal of responses that could not be used.

**Table 5. Response Rate Used for Analysis**

Total Responded	994
Less Did not Want to Participate	212
Less Incomplete Surveys	68
<b>Total</b>	714
Number of Ontario Councillors	2863
<b>Percentage</b>	<b>24.9</b>

For the purposes of this paper, the response rate used for analysis, 24.9%, will be the figure referred to when discussing 'response rate'.

#### **iv. Assessing Representativeness of Respondents**

##### Full-time Medical Officer of Health

27 out of 36 PHUs have a fulltime medical officer of health (75%). 545 survey respondents, out of 737 who answered the question 'does your health unit have a full-time



medical officer of health' said yes (74%). This indicates a possible close correlation between the actual population of Ontario municipal councillors and the sample obtained for this analysis.

### Gender

AMO found in a post-election survey (2006) that 23.85% of municipal elected positions are female. This is based on 3,135 elected positions responding to the survey; therefore duplication (one person holding a position in both a lower and an upper-tier municipality) is likely.

30.8% of survey respondents are female. This may indicate an increased interest in 'health' in general on the part of women officials. However without availability of an accurate number of female elected officials in Ontario it is difficult to assess representation by gender. Women are not underrepresented in this survey but may be somewhat overrepresented.

**Table 6 Gender of Respondent**

		Frequency	%
Valid	male	481	67.4
	female	220	30.8
	Total	701	98.2
No Response		13	1.8
<b>Total</b>		<b>714</b>	<b>100.0</b>

### Region

Ontario's 36 PHU's are divided into 'regions'. These are Northwest (2 PHU's), Northeast (5 PHUs), Central East (7 PHUs), Central West (7 PHUs), Southwest (9 PHUs) and Eastern (6 PHUs). Appendix C shows the location and name of each health unit. Responses were received from councilors in every PHU region (as defined by the Ministry of Health and Long-Term Care) and from every individual PHU. The number of councilors per PHU was calculated utilizing the AMO 2006 published election results and Ontario Regulation 553 ('Areas Comprising Health Units') under the Health Protection and Promotion Act which specifies which

municipalities fall within the jurisdiction of each Ontario PHU. Table 7 illustrates this number, along with the number of councillors who responded and the resulting percentages.

Regional representation was achieved with the North region being least represented and Central West being the most. 17.9% of analyzed responses were from the North; 22.5% were from the Eastern region; 24.8% were from Central East; 31.1% from SouthWest and 33.1% of the responses were from Central West.

Two PHU's had very high response rates from their associated municipal councilors—Perth was the highest with 54.7% of their municipal councilors responding and Waterloo had a response rate of 45.8%. This may reflect a greater enthusiasm on the part of particular councilors who may have encouraged others to respond or perhaps these PHU's have recently experienced local public health issues of interest to municipal councilors.

The lowest individual PHU response rates were North Bay Parry Sound (12.5%), Algoma (13.0%) and Thunder Bay (14.5%), reflecting the noted overall response rate of the North region. Outside of the North region, councilors in the city of Toronto (15.5%), KFLA(16.2%) and Renfrew (17.6%) were the lowest responders.

**Table 7. Responses by Region**

<b>HEALTH UNIT BY REGION</b>		<b>Total Number of Municipal Councilors By Health Unit</b>	<b>Number of Councilors Who Responded By Health Unit</b>	<b>%</b>
<u>North Region</u>				
North Bay-Parry Sound		184	23	12.5
Northwestern		107	20	18.7
Timiskaming		127	28	22.0
Algoma		131	17	13.0
Sudbury		124	18	14.5
Thunder Bay District		89	25	28.1
Porcupine		65	17	26.2
<b>REGION TOTAL</b>		<b>827</b>	<b>148</b>	<b>17.9</b>
<u>Central East Region</u>				
Simcoe Muskoka		192	48	25.0
Haliburton Kawartha Pine Ridge		81	21	26.0

<b>HEALTH UNIT BY REGION</b>		<b>Total Number of Municipal Councillors By Health Unit</b>	<b>Number of Councillors Who Responded By Health Unit</b>	<b>%</b>
Peterborough		51	17	33.3
York Region		75	19	25.3
Durham		61	14	22.3
Peel		32	7	21.9
Toronto		45	7	15.5
<b>REGION TOTAL</b>		<b>537</b>	<b>133</b>	<b>24.8</b>
<u>Eastern Region</u>				
Hastings and Prince Edward		89	17	19.1
Leeds, Grenville and Lanark		161	44	27.3
Eastern Ontario		103	27	26.2
Kingston, Frontenac, Lennox & Addington		68	11	16.2
Ottawa		24	7	29.2
Renfrew		125	22	17.6
<b>REGION TOTAL</b>		<b>570</b>	<b>128</b>	<b>22.5</b>
<u>Central West Region</u>				
Niagara		106	36	34.0
Hamilton		16	6	37.5
Brant		22	7	31.8
Waterloo		48	22	45.8
Halton		41	15	36.6
Wellington Dufferin Guelph		107	28	26.2
Haldimand Norfolk		16	4	25.0
<b>REGION TOTAL</b>		<b>356</b>	<b>118</b>	<b>33.1</b>
<u>SouthWest Region</u>				
Grey Bruce		125	36	28.8
Huron		78	24	30.8
Perth		53	29	54.7
Oxford		50	14	28.0
Middlesex London		70	23	32.9
Elgin-St. Thomas		49	15	30.6
Chatham-Kent		18	5	27.8
Lambton		69	17	24.6
Windsor-Essex		61	15	24.6
<b>REGION TOTAL</b>		<b>573</b>	<b>178</b>	<b>31.1</b>
Councillor Unsure of Health Unit			5	
<b>TOTAL</b>		<b>2863</b>	<b>710</b>	<b>24.8</b>
Add 'System Missing' =4			714	<b>24.9</b>

In conclusion, based on regional information in particular, the sample used for analysis is a reasonably representative sample of Ontario municipal councillors and heads-of-council.

#### **v. Selection of the 12 Public Health Programs**

An initial list of public health programs was compiled using the Ontario Mandatory Programs and Services as a guide and the websites of all 36 Ontario PHUs. 28 programs were

identified that could be classified either as more strongly belonging to the category of ‘Health Promotion’ or to the category of ‘Health Protection’.

Definitions of public health are ubiquitous. The Ontario Ministry of Health and Long Term Care’s website defines public health as being concerned with “the health and well-being of the whole community, rather than the treatment of illness and disability.” Further on in the same discussion, the Ministry states that public health focuses on three areas: preventing conditions that may put health at risk (health protection), early detection of health problems (screening), and changing peoples and societies attitudes and practices regarding lifestyle choices (health promotion). It goes on to say that health protection tends to work in the area of food and water safety, environmental risks, public sanitation and management of communicable diseases.

While most public health programs involve an element of both health protection and health promotion they can be categorized as more fully belonging to one the other. The list of Ontario Mandatory programs does designate programs this way. However, some Ontario PHU’s are administratively organized in this way and public health professionals are readily able to make this distinction. To test the researcher’s interpretation of a program designation as health promotion or health protection several public health professionals from five different PHUs were recruited in February 2007. They were given the list of 28 programs and asked to mark each one as either ‘health protection’ or ‘health promotion’. Participants could also select ‘unsure’ and record comments. The table below summarizes the results.

**Table 8. Designation of Public Health Programs as Health Protection or Health Promotion, Participant Public Health Speciality**

Public Health Nurse	Public Health Inspector	Physician	Epidemiologist	Dietician	Total Participants
6	14	1	1	1	23

**Table 9. Designation of Public Health Programs as Health Protection or Health Promotion, Participant Years of Experience**

Less than 1 year	2 to 5 years	5 to 15 years	More than 15 years	Total Participants
1	11	9	2	23

**Table 10. Designation of Public Health Programs as Health Protection or Health Promotion, Results of Participant Responses**

23/23 agreement	22/23 agreement	21/23 agreement	<21 agreement
11 programs	7 programs	2 programs	8 programs

Based on these results, 8 programs which failed to find greater than 90% consensus were removed from the pool of possible program questions for the survey. The remaining 20 programs were used to make the question choices for the survey. The following criteria were considered in making the choices:

- A maximum of 12 questions was desired to keep the survey as short as possible.
- The 12 programs must be equally divided between Promotion and Protection designation.
- The description of the program must be both brief and easily understandable to a non public health audience.

**Table 11. Programs Used for the Survey**

(For each question respondents were asked to choose a level of municipal funding support. See Appendix A for a copy of the survey.)

Question	Short form name for analysis	Type of Program Designation
1. Educating citizens about the importance of avoiding alcohol-use during pregnancy	alcohol-use and pregnancy awareness	Promotion
2. Assessing the need for quarantine and/or medical treatment in all cases of animal bites to help prevent the transmission of rabies from an animal to a human	rabies control	Protection
3. Regularly evaluating the microbial quality of drinking water used at rural community centres	drinking water 1	Protection
4. Providing classes in parenting	parenting	Promotion
5. Advocating for healthy food choice options to be available at local restaurants and cafeterias	healthy eating 1	Promotion
6. Giving the public information about healthy nutrition choices	healthy eating 2	Promotion
7. Testing local beach waters for the presence of bacteria that can cause illness to swimmers and other recreational users	recreational water	Protection
8. Monitoring the results of tests for	drinking water 2	Protection

<b>Question</b>	<b>Short form name for analysis</b>	<b>Type of Program Designation</b>
bacteria such as e.coli in municipal drinking water systems to prevent an outbreak of waterborne illness		
9. Offering information to teens about drug addiction	recreational drug use awareness	Promotion
10. Ensuring that infection control safeguards are in place in local barber and hair shops, spas and nail salons	community infection control	Protection
11. Providing information to the public about the benefits of being physically active.	active living	Promotion
12. Investigating outbreaks of food poisoning associated with local restaurants and community events.	outbreak management	Protection

## **7. ANALYSIS**

### **i. Support for Government Funding of Public Health**

Notably, support for public funding of all types of public health programs was quite high in this sample. This supports the hypothesis that municipal councilors do appreciate the value of public health programs per se, but recognize that some public health programs should not be funded from the municipal property tax base.

**Table 12. General Support for all Programs in Survey**

<i>Program</i>	<i>% who chose municipal and/or provincial funding</i>
Recreational Drug Awareness	95.2
Alcohol-Use and Pregnancy	91.9
Health Eating1	90.6
Active Living	89.5
Parenting	84.8
Healthy Eating2	81.6
Average Total	88.9
Drinking Water1	97.7
Recreational Water	96.1
Drinking Water2	95.5
Outbreak Management	94.6
Rabies Control	90.0
Community Infection Control	85.5
Average Total	93.2
<b>Total Average for All Programs</b>	91.05

The following tables list the responses for the individual programs. The first table summarizes the promotion program results (number who responded) followed by the detailed response for each promotion program. These results are then repeated for the protection programs. Note that the cumulative percentages are what were used to formulate the general support for all programs found in Table 12.

**Table 13 Promotion Programs, Number of Responses**

		alcohol-use and pregnancy awareness (promotion)	parenting (promotion)	healthy eating (promotion)	healthy eating (promotion)	recreational drug use awareness (promotion)	active living (promotion)
N	Valid	714	709	709	711	711	711
	Did not Answer	0	5	5	3	3	3

**Table 13a alcohol-use and pregnancy awareness (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	47	6.6	6.6	6.6
	provincial funding only	609	85.3	85.3	<b>91.9</b>
	unsure	35	4.9	4.9	96.8
	no funding	23	3.2	3.2	100.0
	Total	714	100.0	100.0	

**Table 13b parenting (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	128	17.9	18.1	18.1
	provincial funding only	473	66.2	66.7	<b>84.8</b>
	unsure	53	7.4	7.5	92.2
	no funding	55	7.7	7.8	100.0
	Total	709	99.3	100.0	
	Did not Answer	5	.7		
	Total	714	100.0		

**Table 13c healthy eating1 (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	124	17.4	17.5	17.5
	provincial funding only	452	63.3	63.8	<b>81.2</b>
	unsure	36	5.0	5.1	86.3
	no funding	97	13.6	13.7	100.0
	Total	709	99.3	100.0	
	Did not Answer	5	.7		
	Total	714	100.0		



**Table 13d healthy eating2 (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	79	11.1	11.1	11.1
	provincial funding only	565	79.1	79.5	<b>90.6</b>
	unsure	34	4.8	4.8	95.4
	no funding	33	4.6	4.6	100.0
	Total	711	99.6	100.0	
Did not Answer		3	.4		
Total		714	100.0		

**Table 13e recreational drug use awareness (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	79	11.1	11.1	11.1
	provincial funding only	598	83.8	84.1	<b>95.2</b>
	unsure	28	3.9	3.9	99.2
	no funding	6	.8	.8	100.0
	Total	711	99.6	100.0	
Did not Answer		3	.4		
Total		714	100.0		

**Table 13f active living (promotion)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	96	13.4	13.5	13.5
	provincial funding only	540	75.6	75.9	<b>89.5</b>
	unsure	31	4.3	4.4	93.8
	no funding	44	6.2	6.2	100.0
	Total	711	99.6	100.0	
Did not Answer		3	.4		
Total		714	100.0		

**Table 14 Protection Programs, Number of Responses**

		rabies control (protection)	drinking water (protection)	recreational water (protection)	drinking water (protection)	community infection control (protection)	outbreak management (protection)
N	Valid	712	710	712	711	712	710
	Did not Answer	2	4	2	3	2	4

**Table 14a rabies control (protection)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	144	20.2	20.2	20.2
	provincial funding only	497	69.6	69.8	<b>90.0</b>
	unsure	52	7.3	7.3	97.3
	no funding	19	2.7	2.7	100.0
	Total	712	99.7	100.0	
	Did not Answer	2	.3		
	Total	714	100.0		

**Table 14b drinking water1 (protection)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	306	42.9	43.1	43.1
	provincial funding only	372	52.1	52.4	<b>95.5</b>
	unsure	25	3.5	3.5	99.0
	no funding	7	1.0	1.0	100.0
	Total	710	99.4	100.0	
	Did not Answer	4	.6		
	Total	714	100.0		

**Table 14c recreational water (protection)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	municipal funding	334	46.8	46.9	46.9
	provincial funding only	350	49.0	49.2	<b>96.1</b>
	unsure	22	3.1	3.1	99.2
	no funding	6	.8	.8	100.0
	Total	712	99.7	100.0	
	Did not Answer	2	.3		
	Total	714	100.0		

**Table 14d drinking water2 (protection)**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid municipal funding	337	47.2	47.4	47.4
provincial funding only	358	50.1	50.4	<b>97.7</b>
unsure	11	1.5	1.5	99.3
no funding	5	.7	.7	100.0
Total	711	99.6	100.0	
Did not Answer	3	.4		
Total	714	100.0		

**Table 14e community infection control (protection)**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid municipal funding	164	23.0	23.0	23.0
provincial funding only	445	62.3	62.5	<b>85.5</b>
unsure	48	6.7	6.7	92.3
no funding	55	7.7	7.7	100.0
Total	712	99.7	100.0	
Did not Answer	2	.3		
Total	714	100.0		

**Table 14f outbreak management (protection)**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid municipal funding	222	31.1	31.3	31.3
provincial funding only	450	63.0	63.4	<b>94.6</b>
unsure	30	4.2	4.2	98.9
no funding	8	1.1	1.1	100.0
Total	710	99.4	100.0	
Did not Answer	4	.6		
Total	714	100.0		

A majority of respondents show stronger support for municipal funding of protection programs vs. promotion programs. However, there is variation in the extent to which promotion is always lower than protection.

**ii. Significant Difference in Support for Health Protection vs. Health Promotion Programs**

714 responses were used for this analysis (N=714). This analysis, which specifically examined the difference in municipal support for programs designated as promotion-type or protection-type, showed that municipal councillors much more strongly support municipal funding for protection-type programs.

Response choices to the last 12 questions, which asked participants to select which choice best matched, in their opinion, a particular public health program, were assigned values as follows:

<b>Question Response Choices, 12 Programs</b>	<b>Value Assigned</b>
1. Municipalities should contribute some or all of the funding for this program/service	1
2. 100% provincial funding is appropriate for this program/service	0
3. I am unsure which level of government should pay for this program/service	0
4. There should be no funding for this program/service from either level of government	0

The rationale is that choosing the first selection indicated a willingness to commit municipal funds to the particular program. There was no attempt to ask what percentage of total funding should be from municipalities—only a willingness to commit any proportion of the funding was measured.

The responses to the six programs coded ‘protection’ were added together, creating an index with values from 0 to 6. The same was done for the six programs coded ‘promotion’. The means of the two indexes were then compared. See Tables 15a and 15b. A significant difference in municipal support for protection programs vs. promotion programs was found. Out of a possible score of 6, the mean response for municipal support for ‘promotion’ type programs was .77 (>.67 to <.88, 95% confidence interval) and the mean response for ‘protection’ type programs was 2.11 (>1.97 to <2.25, 95% confidence interval). There is less than one chance in 1000 that there is no difference in reality between municipal funding support for protection vs. promotion programs.

**Table 15a Comparing the Means Municipal Support for Protection vs. Promotion**

Program Type	N	Mean	Std. Deviation	Std. Error Mean
Promotion	714	.77	1.394	.052
Protection	714	2.11	1.853	.069

**Table 15b t-distribution**

<i>Test Value=0</i>							
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference		
Promotion	14.851	713	.000	.775	.67	.88	
Protection	30.435	713	.000	2.111	1.97	2.25	

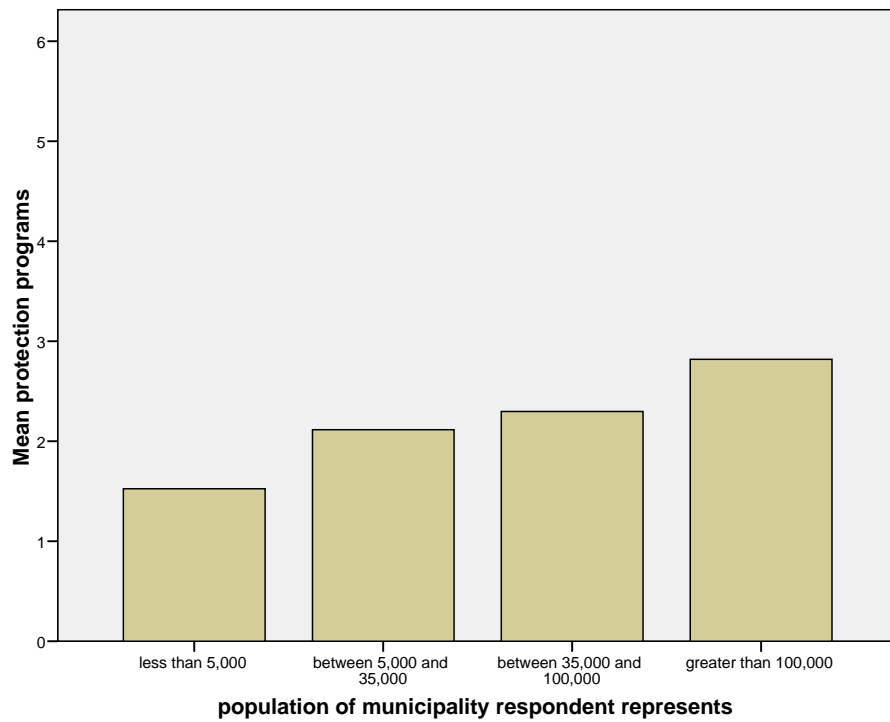
The difference in support for protection vs. promotion programs was also found when the variable size of municipality was controlled for. For protection programs, support for municipal funding increased as the size of the municipality increased. Support for promotion programs also increased as population increased but dropped slightly at the greater than 100,000 population level.

**Table 16 Compare Municipal Support for Promotion and Protection by Population Size of Municipality**

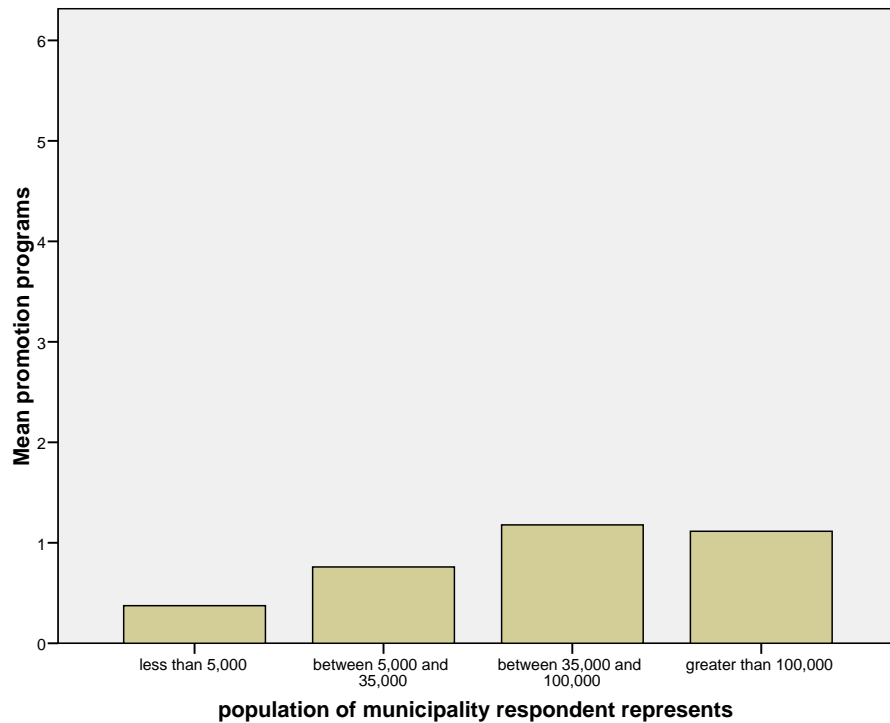
Program	Size of Municipality	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Promotion	less than 5,000	158	<b>.37</b>	.870	.069	.24	.51	0	5
	between 5,000 and 35,000	366	<b>.76</b>	1.327	.069	.62	.90	0	6
	between 35,000 and 100,000	84	<b>1.18</b>	1.764	.192	.80	1.56	0	6
	greater than 100,000	105	<b>1.11</b>	1.734	.169	.78	1.45	0	6
	Total	713	<b>.78</b>	1.394	.052	.67	.88	0	6
Protection	less than 5,000	158	<b>1.53</b>	1.587	.126	1.28	1.77	0	6
	between 5,000 and 35,000	366	<b>2.11</b>	1.811	.095	1.93	2.30	0	6

Program	Size of Municipality	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
	between 35,000 and 100,000	84	<b>2.30</b>	1.881	.205	1.89	2.71	0	6
	greater than 100,000	105	<b>2.82</b>	2.084	.203	2.42	3.22	0	6
	Total	713	<b>2.11</b>	1.854	.069	1.97	2.25	0	6

**Figure 1. Municipal Funding Support for Protection-type Programs by Population Size of Respondent's Municipality**



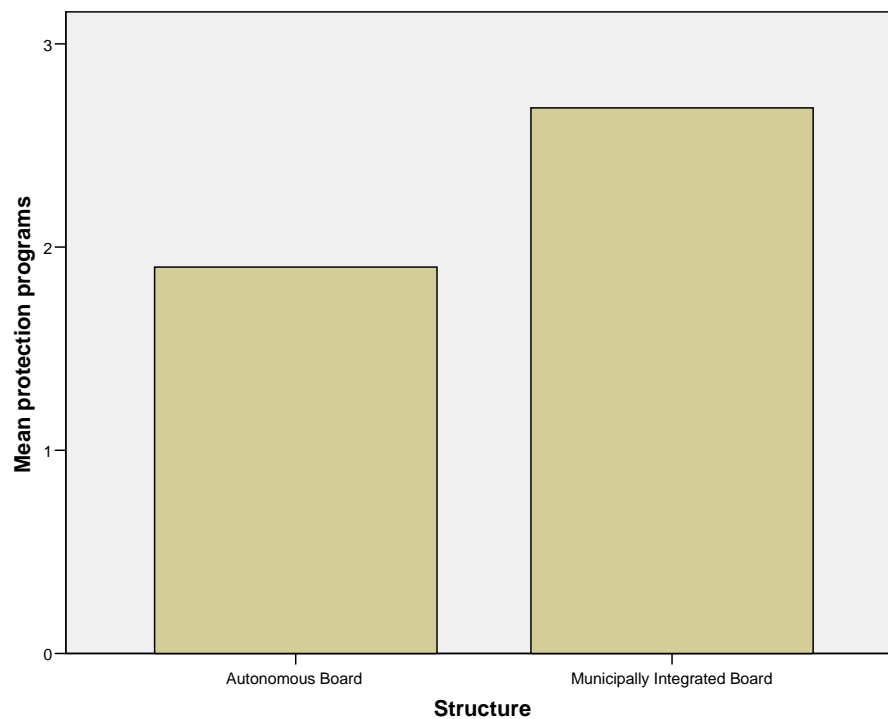
**Figure 2. Municipal Funding Support for Promotion-type Programs by Population Size of Respondent's Municipality**



Structure of the health unit, specifically whether or not the health unit is integrated directly into a municipality or exists as an autonomous board structure was also examined. Councillors from both municipally-integrated and autonomous boards were more supportive of municipal funding for protection (mean 2.69 and 1.90, respectively) than promotion programs (mean 1.20 and .62, respectively). However, councillors from integrated boards are much more supportive of municipal funding for either type of program than are councillors from autonomous boards.

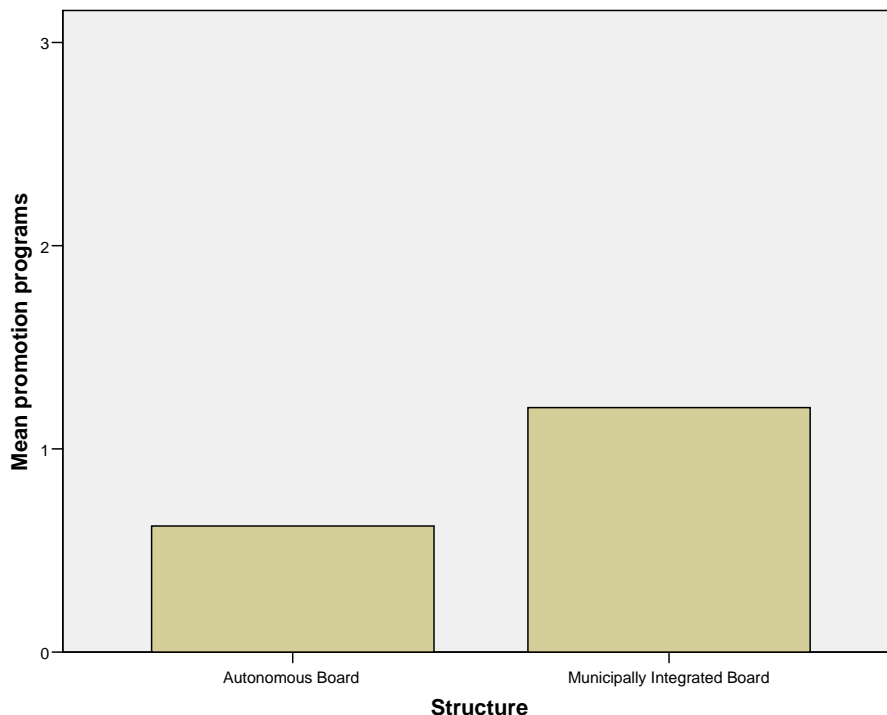
**Table 17 Compare Municipal Support for Promotion and Protection Programs by Health Unit Structure**

Program	Structure	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
promotion programs	Autonomous Board	508	.62	1.226	.054	.51	.73	0	6
	Municipally Integrated Board	197	1.20	1.705	.121	.96	1.44	0	6
	Total	705	.78	1.400	.053	.68	.89	0	6
protection programs	Autonomous Board	508	1.90	1.724	.076	1.75	2.05	0	6
	Municipally Integrated Board	197	2.69	2.066	.147	2.40	2.98	0	6
	Total	705	2.12	1.858	.070	1.98	2.26	0	6

**Figure 3. Municipal Funding Support for Protection-type Programs by Structure of Respondent's Public Health Unit**



**Figure 4. Municipal Funding Support for Promotion-type Programs by Structure of Respondent’s Public Health Unit**



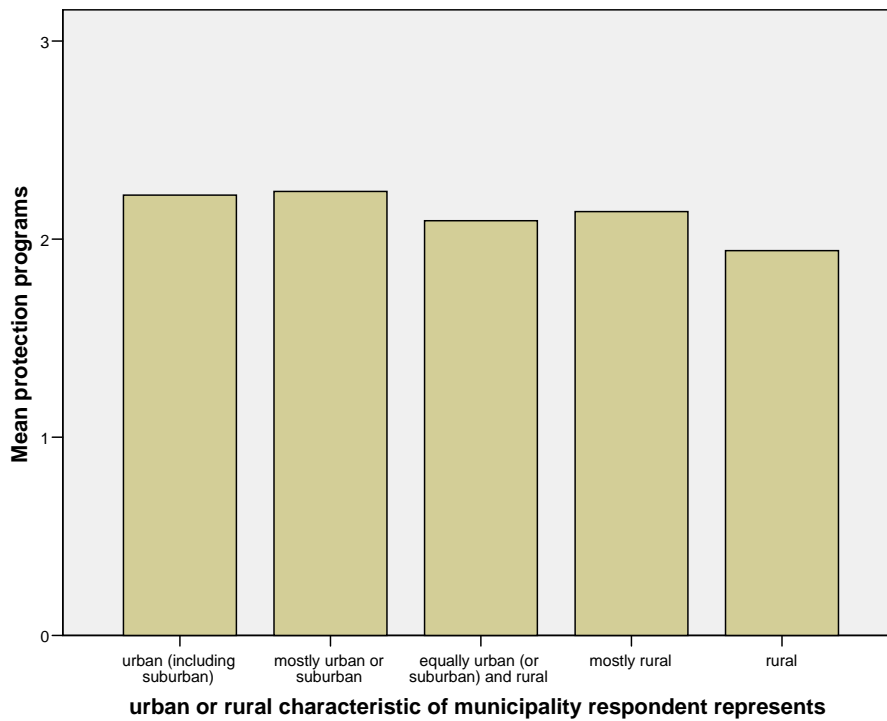
Urban and rural municipalities can have very different public health issues. For promotion programs, willingness to commit municipal funds increased as urban characteristic increased. For protection programs, a similar relationship was noted. For all urban and rural types, municipal funding support was higher for protection programs.

**Table 18 Compare Municipal Support for Promotion and Protection Programs by Urban/Rural Characteristic**

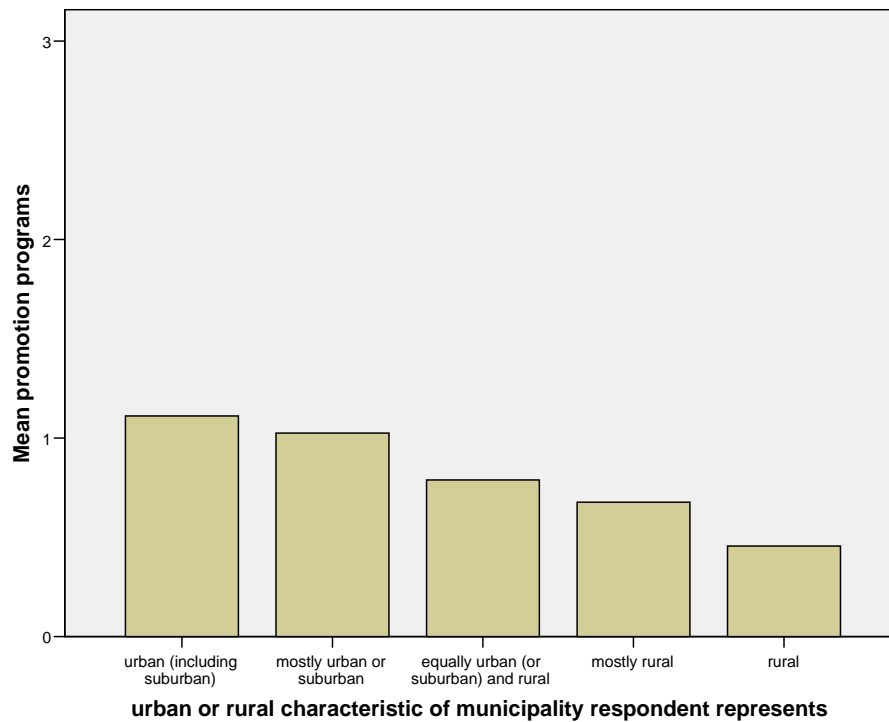
Program	Urban or Rural	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
promotion programs	urban (including suburban)	144	1.11	1.648	.137	.84	1.38	0	6
	mostly urban or suburban	79	1.03	1.544	.174	.68	1.37	0	6
	equally urban (or suburban) and rural	161	.79	1.438	.113	.57	1.01	0	6

Program	Urban or Rural	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
protection programs	mostly rural	158	.68	1.207	.096	.49	.87	0	6
	rural	171	.46	1.113	.085	.29	.62	0	6
	Total	713	.78	1.394	.052	.67	.88	0	6
	urban (including suburban)	144	2.22	1.901	.158	1.91	2.54	0	6
	mostly urban or suburban	79	2.24	2.008	.226	1.79	2.69	0	6
	equally urban (or suburban) and rural	161	2.09	1.870	.147	1.80	2.38	0	6
	mostly rural	158	2.14	1.870	.149	1.85	2.43	0	6
	rural	171	1.94	1.714	.131	1.68	2.20	0	6
	Total	713	2.11	1.854	.069	1.97	2.25	0	6

**Figure 5. Municipal Funding Support for Protection-type Programs by Urban or Rural Characteristic of Respondent’s Municipality**



**Figure 6. Municipal Funding Support for Promotion-type Programs by Urban or Rural Characteristic of Respondent's Municipality**

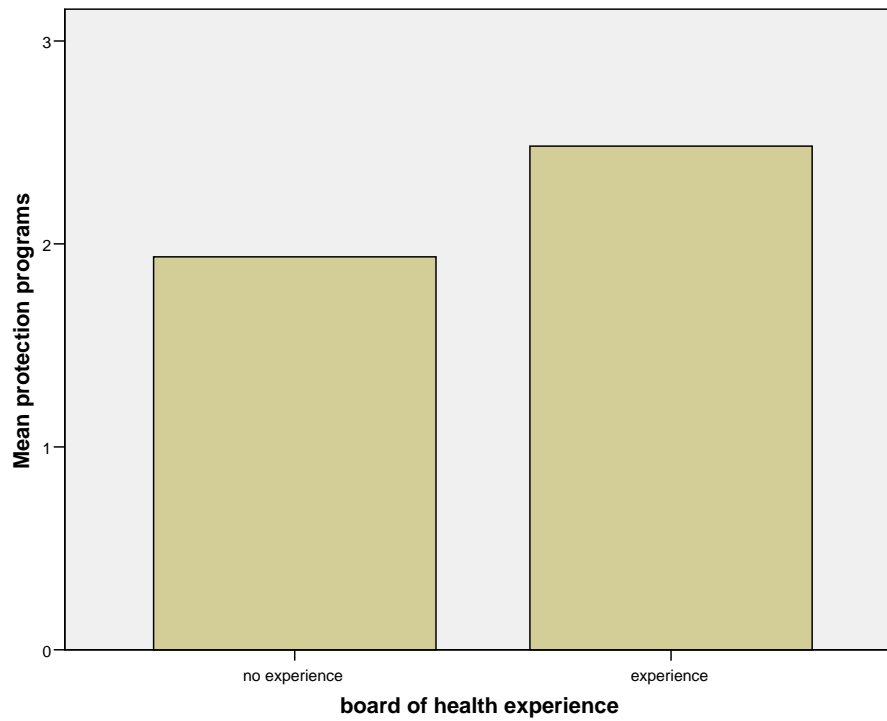


Direct Board of Health involvement by a municipal councilor may influence their support for protection vs. promotion programs. Municipal councillors who have had experience as Board members (defined as a current board member, a past board member or a member of Council or committee of council that acts as a Board) are more likely to be willing to commit municipal funds to both promotion and protection programs. Table 19 shows that this is true in this analysis. Overall, this willingness is stronger for protection programs.

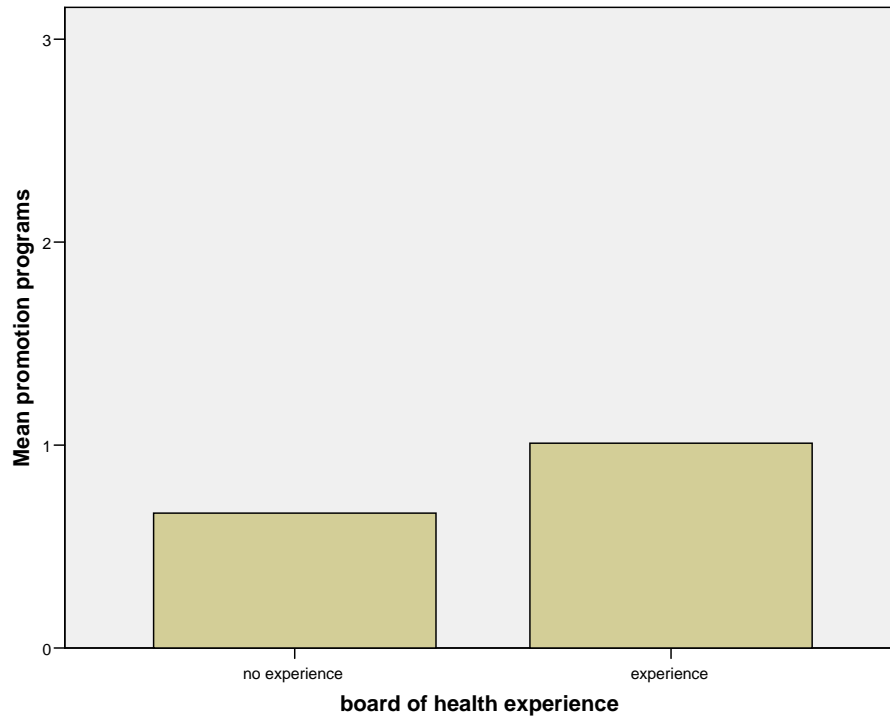
**Table 19 Compare Municipal Support for Promotion and Protection Programs by Respondent's Involvement as a Board of Committee Member**

Program Type	Board of Health Experience	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
promotion programs	no experience	486	.66	1.245	.056	.55	.78	0	6
	experience	228	1.01	1.645	.109	.79	1.22	0	6
	Total	714	.77	1.394	.052	.67	.88	0	6
protection programs	no experience	486	1.94	1.757	.080	1.78	2.09	0	6
	experience	228	2.48	1.997	.132	2.22	2.74	0	6
	Total	714	2.11	1.853	.069	1.97	2.25	0	6

**Figure 7. Municipal Funding Support for Protection-type Programs by Respondent's Experience as a Board of Health Member**



**Figure 8. Municipal Funding Support for Promotion-type Programs by Respondent's Experience as a Board of Health Member**



## **7. SUMMARY**

Research was done to examine municipal politicians' attitudes towards funding local public health when programs were divided into promotion-type and protection-type programs to ascertain whether this division has any effect on their willingness to write the cheque.

When surveyed, Ontario municipal politicians displayed an attitude of strong support for government funding of all public health programs they were asked about. However, there was a significant difference in support for committing *municipal funds* to health protection-type programs versus health promotion-type programs. This support was considerably stronger for protection-type programs.

There are reasons why local governments have a stake in preserving public health protection-type programs. These include a close relationship between municipal services and public health protection. However, the requirements of an effective public health protection system preclude any municipality from fully funding health protection. A split funding and governance model between municipalities and the provincial government meets both the considerations of economies-of-scale and municipal involvement in health protection.

Future policy changes regarding local public health in Ontario and other jurisdictions containing local governments may want to consider the important relationship of protection-type programs to municipal services when trying to locate the appropriate level of government for funding and control of these programs.

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