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Case Study

Public Health System Financing in Ontario

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May 2025

The views expressed by the authors are not intended to represent the views of the North American Observatory on Health Systems and Policies.

Suggested citation

Seabrook, M., Pakes, B., Pawa, J., Roerig, M., Tan, S., & Allin, S. (2025). A Case Study of Public Health System Financing in Ontario. Toronto: North American Observatory on Health Systems and Policies.

Acknowledgements

We would like to thank the key informants and advisors who participated and contributed to this research. We are grateful for Mariana Morales Vazquez's support with the coding analysis.

This work was supported by the Canadian Institutes of Health Research through a Catalyst Grant Award for the project "Sustainable financing to transform Canada's public health systems" (#PO5-187041).

About

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making.

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Contents

List of Abbreviations

alPHa	Association of Local Public Health Agencies
AMO	Association of Municipalities of Ontario
AOPHBA	Association of Public Health Business Administrators
COMOH	Council of Medical Officers of Health
HPPA	*Health Protection and Promotion Act*
MOH	Medical Officer of Health
OPHA	Ontario Public Health Association
PHU	Public Health Unit
SARS	severe acute respiratory syndrome

About the Study

This case study of Ontario is part of a multi-province comparative study aiming to shed light on public health system financing processes and uncover potential strategies for supporting stable public health funding. The study builds on previous research led by the North American Observatory on Health Systems and Policies (NAO) that profiled various provincial public health systems (Smith et al., 2022). It also supports the Chief Public Health Officer's call for sufficient and stable public health funding (Tam, 2021). The study is led by Dr. Sara Allin (NAO, University of Toronto), with the support of a team of researchers, advisors, knowledge users, and trainees from across Canada.

Executive Summary

This summary report provides an overview of the public health system budget-setting processes in Ontario, and uncovers some of the key factors influencing public health system resource allocation decisions. We interviewed 16 key informants from Ontario with past or present positions in the public health system, including medical officers of health, financial officers, and other executive roles from 6 public health units, Boards of Health, the Ministry of Health, and public associations. This document summarizes what we heard from these interviews, supplemented by sources identified through a jurisdictional review and shared by local experts and knowledge users. These results shed light on the processes and challenges of financing public health, including planning and decision-making, and provides a foundation for discussions around future policy directions for strengthening public health financing in Ontario and across Canada.

Key Takeaways

- The unique cost-sharing arrangement between the province and municipalities was highlighted as giving both jurisdictions a formal role in the public health system, potentially limiting unilateral policy change.
- Variations in public health unit governance structures impact the roles and influence of key actors, such as Medical Officers of Health and Boards of Health in budget-setting.
- Among the many actors that support the advancement of public health system goals, those with robust relationships with the provincial government, such as the Association of Municipalities of Ontario and certain Boards of Health were seen as particularly influential in protecting provincial funding allocations to public health.
- To help ensure the sustainability of public health funding, key informants raised several considerations. One such consideration was to amend the *Health Protection and Promotion Act* to include a provincial responsibility for funding public health programs. They also noted that ensuring community representation on Boards of Health may help increase the prioritization of public health programs.

Introduction & Background

Following the COVID-19 pandemic, many public health experts renewed calls to strengthen Canada's public health systems and financing, building on recommendations throughout the past two decades, including after the Walkerton and severe acute respiratory syndrome (SARS) outbreaks (CIHR, 2021; Denis et al., 2020; Guyon et al., 2017; B. W. Moloughney, 2006; Naylor et al., 2003; Raine, 2015; Tam, 2021). However, there has been limited research focusing on public health financing, particularly examining how public health systems are financed in Canada (Fiset-Laniel et al., 2020; Graham & Sibbald, 2017, 2021; Jacques et al., 2023; Jacques & Noël, 2022).

Our study aims to shed light on public health financing systems and inform ongoing efforts to bolster public health financing in Canada. We examined the process of decision-making for public health resource allocation and sought to uncover the factors that influence these processes throughout this case study of Ontario. Most provinces and territories aside from Ontario introduced regional health structures throughout the 1990s, shifting public health services at the same time. As a result, there are significant differences in the governance structures of public health services in Ontario compared to other provinces and territories (Church & Barker, 1998; B. Moloughney, 2016).

Methods

We conducted a case study of the Ontario public health financing system in two steps. The first step involved a jurisdictional review of academic and grey literature to collect relevant documents on budget-setting processes, policies, political shifts, major events, and reforms in the province between 2000–2023. We included 29 academic papers and 79 grey literature documents. The second step involved conducting in-depth qualitative interviews with 16 key informants who are influential in public health budget-setting, including financial officers, and other executive roles from 6 public health units (PHUs), Boards of Health, the Ministry of Health, and public association representatives. The PHUs we included represent a range of structures including autonomous, semi-autonomous, and regional Boards of Health, and cover urban, suburban, and rural contexts. Participants were recruited through a combination of theoretical, snowball, and respondent-driven sampling. Taking an inductive and deductive analytical approach, we synthesized data from the literature and interviews to describe the funding status and budget-setting process of the public health system at the local and provincial levels, identify factors that influence public health financing decisions, and propose policy considerations for improving public health financing. This report has been reviewed by 5 key informants and 4 knowledge users to validate our findings and analysis.

This study received ethics approval from the University of Toronto Ethics Board (REB# 44620).

Analytic Overview

This section presents our findings regarding the Ontario public health funding status and budget-setting process, followed by an analysis of the factors that influence decision-making during budget-setting and concluding with policy considerations for improving public health financing.

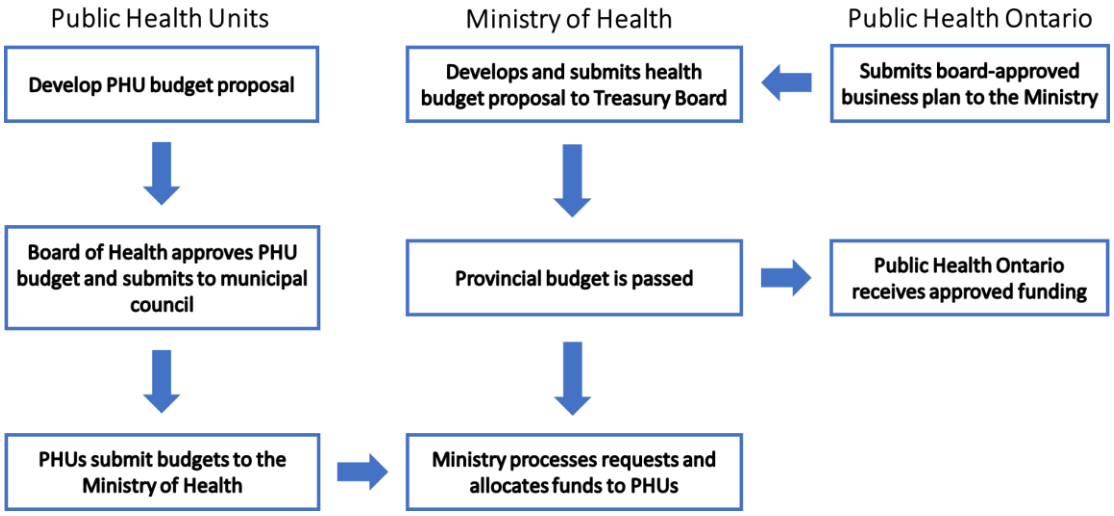
Funding Status

Ontario's public health system consists of three main actors: the provincial government (specifically the Ministry of Health) responsible for resource allocation and strategic oversight of the public health system, Public Health Ontario, a Crown Agency responsible for providing scientific and technical advice and support to the health sector, and 34 diverse PHUs responsible for delivering on the Ontario public health standards (**Appendix A**). Of the 2.2% of the Ontario Ministry of Health budget reported in expenditure estimates to be allocated to Population and Public Health programs in 2024-25, 59% is allocated to the 34 PHUs for programs mandated by the Ontario Public Health Standards, and 10% is allocated to Public Health Ontario (Government of Ontario, 2024). Public Health Ontario receives 91% of its funding from the Ministry of Health (Ontario Agency for Health Protection and Promotion, 2024), and experienced a slight base budget reduction in 2019 after a decade of a flatlined budget (Auditor General of Ontario, 2023; Government of Ontario, 2024). PHUs receive the majority of their funding from a cost-sharing arrangement between the provincial Ministry of Health and municipalities. This cost-share has historically been set to a maximum of 75% provincial funding and a minimum of 25% municipal funding; however, for many PHUs the provincial share has decreased and municipal shares have increased over time. The share reportedly varies considerably by PHU, where some may be closer to a 50%-50% split between the municipality and province. As a result, public health spending per capita varies by PHU. Some provincial programs such as Healthy Smiles Ontario that were previously 100% funded by the Ministry of Health have recently been transitioned to be cost-shared. Though Ontario public health programs sometimes have other local, provincial, and federal sources of funding, such as the Healthy Babies, Healthy Children grant from the Ministry of Children, Community, and Social Services, the following section focuses on municipal and Ontario Ministry of Health budget cycles as the main funding sources.

Budget-Setting Process

Broadly, PHUs prepare their budgets and present them to their Board of Health for approval (**Figure 1**). Once approved, the PHU budget is submitted to municipal councils, which involves an additional stage of approval in some municipalities. In parallel, the Ministry of Health incorporates Public Health Ontario's Business Plan into the overall health budget, which is submitted to Treasury Board for approval as part of the provincial budget. After the provincial budget is approved, the Ministry of Health receives and processes PHU budget submissions to determine allocations of funding.

Figure 1. Summary of budget-setting for the Ontario public health system



Note: This summary figure may not represent all PHUs. For instance, municipal councils act as the Board of Health in certain regional municipalities.

Local budget cycle

The municipal financial year runs from January 1 to December 31 in most Ontario municipalities (Wideman, 2022). Budget-setting processes vary by PHU[1]; since this description is based on publicly available documents and 16 key informant interviews, we are not able to capture budget-setting processes for all PHUs. For example, PHU budget planning tends to start in spring to early summer, and while some PHU finance teams plan based on instructions from the city finance department/mayor's office on how much the budget can change by, others are directed by their Board of Health to submit a budget based on current need. Some key informants reported budgets are mainly based on historical spending, while others described that PHU senior leadership teams, including the Medical Officer of Health (MOH), adjust their previous year's budget based on a variety of factors such as the PHU strategic plan, updated program plans, local needs and priorities, health equity considerations, as well as for inflation, collective agreement salary increases, and other cost pressures. After accounting for these factors, these PHU leadership teams generally present a balanced budget to their Board of Health in the fall. Some PHUs first pass through a Board of Health budget subcommittee. Notably, some regional PHUs have little strategic Board of Health oversight of the PHU budget; their budgets are approved as part of the overall municipal budget process since their Boards of Health are entirely made up of regional councillors. Though municipalities are formally obligated to provide funding for budgets approved by Boards of Health in the *Health Protection and Promotion Act* (1990), some non-autonomous PHUs have an additional level of approval where the budget

[1] For example, while the *Health Protection and Promotion Act* states that PHUs determine their budget and municipalities are obligated to provide the indicated funds (1990), the *City of Toronto Act* (2006) mandates that the city will supply the workforce that it deems necessary to carry out mandatory public health programs.

is passed on to city council and the mayor's office for final approval and integration with the city budget by December. Due to staggered financial cycles, Boards of Health must approve their budgets before they receive notice of provincial funding allocations for the year. Once the PHU budget is developed and approved by the Board of Health (and city council if needed), the PHU submits an annual service plan and budget to the Ministry of Health and can apply for one-time funding for specific projects by early April.

In some PHUs, the public and community organizations have opportunities to provide input on PHU budget-setting by approaching Board of Health representatives with concerns or attending Board of Health meetings directly. Community members are also invited to attend the budget presentation day in some PHUs to ask questions and provide feedback. In non-autonomous PHUs they may participate in the city-wide budget consultation process before the budget is finalized by city council.

Provincial budget cycle

The provincial financial year runs from April 1 to March 31. Provincial budget-setting begins in early summer, when the Ministry of Health divisions update their budgets and identify cost pressures, savings, and priorities. Public Health Ontario develops an annual business plan taking into account provincial priorities conveyed by the Chief Medical Officer of Health, which must be approved by the Board of Directors before being submitted to the Minister of Health by January 1st for approval (Ministry of Health and Long-Term Care & Public Health Ontario, 2015; *Ontario Agency for Health Protection and Promotion Act*, 2007). Assistant Deputy Ministers bring forward their division's priorities to the Ministry's senior management team. The Deputy Minister and Minister of Health set the final budget priorities to be sent to the Treasury Board. After the provincial budget is passed by April 1st, Ministry of Health staff process PHU budget submissions and allocate funding. This process is reportedly completed by fall at the earliest, which key informants note creates considerable uncertainties for PHUs as this is nearing the end of the municipal fiscal year.

The Ministry of Finance receives pre-budget submissions directly from influential actors in the public health system including Association of Municipalities of Ontario (AMO), the Association of Local Public Health Agencies (alPHa), and the Ontario Public Health Association (OPHA) (Association of Local Public Health Agencies, 2024; Ontario Public Health Association, 2023). These associations as well as some PHUs also present to the Standing Committee on Finance and Economic Affairs during pre-budget consultations (Association of Local Public Health Agencies, 2022; Standing Committee On Finance And Economic Affairs, 2022, 2024).

Factors Influencing Financial Decision-Making

Drawing on a conceptual framework developed in our earlier work (Seabrook, 2024), we consider the following intersecting factors that influence budgetary decision-making for public health programs and services:

1. **External factors**, consisting of system-wide impacts from outside the public health system such as economic shocks, public health emergencies or other contextual influences,
2. **Structural factors**, including the way the public health system is organized, as well as the laws and policies that guide their decision-making processes, and
3. **Political factors**, including the values and relationships between key stakeholders that influence decision-making.

Timelines of influential external and structural factors are presented in **Appendices B** and **C**.

External factors

Public health crises were commonly noted by key informants as an external factor that influences public health system funding by increasing the visibility of public health issues and pressuring governments to invest in emergency responses. These funds are generally limited to crisis response, but post-SARS a window of opportunity opened for more general investment in the public health system. **Local revenues** generated by municipalities were also described to limit or facilitate local level public health system funding.

Structural factors

Key structural factors that were seen to influence public health system financing decisions include the cost-sharing arrangement for PHUs between provinces and municipalities, the different fiscal years between municipalities and the province, PHU governance structures, and relevant public health legislation and policies.

The PHU **cost-sharing arrangement** between the province and municipalities was set in 2007 to a maximum of 75% provided by the province and a minimum of 25% provided by the municipality (Funding Review Working Group, 2013). Municipalities can provide more than their 25% share, and have increasingly done so, but if they provide less, the province may reduce their own contribution to create a 75%-25% split (Funding Review Working Group, 2013). The actual cost-share between the province and municipalities varies greatly due to differences in historical provincial allocations across PHUs, local flexibility in municipal allocations to PHUs, and municipal revenue-raising capacity. Key informants noted that the cost-sharing arrangement supports stable funding by giving both the province and municipalities a stake in the public health system, and as a result, each jurisdiction has some authority over funding decisions. This division of authority may also limit unilateral decision-making, such as province-wide budget cuts and reforms.

Municipal and provincial **fiscal years** are staggered by three months (or one fiscal quarter). Key informants highlighted that a key challenge in local public health finance was that PHUs receive provincial funding in the municipality's third financial quarter at the earliest. The delay in receiving provincial funding was said to frequently pose barriers to hiring staff, completing projects, and risk over- or under-spending the amount granted in the current cycle.

PHU governance structures vary across the province, and have been broadly categorized into autonomous, autonomous-integrated, semi-autonomous, regional, and single-tier structures (Smith et al., 2021). These structures contribute to differences in budget-setting processes and influence the level of power of different key actors such as MOHs, Boards of Health, and municipal councils in budget setting. For instance, while an MOH in a municipal semi-autonomous structure may be responsible for presenting the PHU budget to the Board of Health, some regional structures have levels of administration between the MOH and Board of Health. Board of Health membership also varies across municipalities; while most have community member representation, the few regional and single-tier Boards are entirely made up of municipal councillors (Smith et al., 2021). Key informants suggested that Boards of Health with community member representatives may be less influenced by competing municipal interests when setting public health budgets.

The **legislative framework** for public health systems shapes the processes for public health financing and determines the responsibilities of different actors and authorities. The *Health Protection and Promotion Act*

(HPPA; 1990) assigns municipalities the sole responsibility for funding public health programs and obligates municipalities to fund yearly budgets approved by the local Board of Health. Since the cost-sharing arrangement is not legislated in the HPPA, some key informants noted there is some uncertainty around yearly PHU funding requests. Key informants also reported that despite the HPPA mandate for PHUs to comply with the Ontario Public Health Standards, historical and current funding levels are insufficient to fulfill them (Association of Local Public Health Agencies, 2024). However, the standards can be used by PHUs to support funding requests.

Public Health Ontario's legislative framework limits their overall spending authority. Specifically, the *Ontario Agency for Health Protection and Promotion Act* (2007) and *Public Health Ontario Memorandum of Understanding* ensure a tight financial accountability relationship between Public Health Ontario and the Ministry of Health, requiring all Public Health Ontario expenditures be closely aligned with provincial strategic priorities, and that any unplanned expenditures be approved by the Ministry (Ministry of Health and Long-Term Care & Public Health Ontario, 2015).

Political factors

Influential political factors highlighted by key informants consisted of the roles of political priorities, public opinion, and advocacy, the perceived invisibility of public health and effective methods for framing funding requests, as well as key relationships between actors involved in budget-setting and transparency of provincial decision-making.

Key informants highlighted that **political priorities** at both the provincial and municipal levels have an important influence over funding availability and predictability, and that political alignment determines the types of public health programs funded. **Public opinion** has the power to sway political priorities of elected officials, impacting spending decisions, and local community support for public health programs garners political support from the municipality. **Advocacy** mainly occurs through formal internal channels and relationships with the province (e.g. Boards of Health, AMO, alPHa) with limited influence, but has gone public when needed – most recently in response to the 2019 provincial Public Health Modernization announcement leading to a reformulation of the planned reform. However, key informants discussed how at the provincial level, healthcare lobbyists are much more powerful and have more resources dedicated to advocacy than public health groups, focusing provincial priorities on healthcare spending.

Many key informants brought up the perception of the relative **invisibility of public health** system impacts, compared to healthcare, causing challenges in making the funding case to elected officials. They find that aligning rationales with political priorities, such as reducing healthcare pressures, and telling 'stories of success' demonstrating the value of public health programs can be effective **framing strategies** for accessing new funding, in addition to basing requests in clear and compelling evidence.

There are multiple **key relationships** that support stable public health financing. At the local level, MOHs and CAO/CEOs play a key role in making the case to Board of Health members, and particularly municipal councillors, about the value in funding public health, especially from a scientific perspective. MOHs also have a key relationship with the Chief Medical Officer of Health which provides valuable insight into provincial public health priorities for budget-setting, and committees such as the Council of Medical Officers of Health (COMOH) provide opportunities for strategic planning and communications between MOHs. In terms of influencing provincial decision-making, key informants agreed that the AMO has the most power over protecting public health allocations, ensured in part by the Memorandum of Understanding requiring

the province to consult with AMO on fiscal matters. AMO has a specific Health Transformation Taskforce consisting of municipal elected officials and staff providing health policy advice to the province (Association of Municipalities Ontario, 2023). alPHa represents PHUs in provincial consultations and its members are considered subject-matter experts. PHU business administrators have direct communication with a combination of financial analysts, managers, and directors in the Office of the Chief Medical Officer of Health, sometimes advocating and consulting as a whole through the Association of Public Health Business Administrators (AOPHBA). Though the Public Health Ontario Memorandum of Understanding outlines that the agency should have regular communications with the Office of the Chief Medical Officer of Health for policy coordination and advising decision-making, there is no specification regarding input on funding decisions for the public health system (Ministry of Health and Long-Term Care & Public Health Ontario, 2015; Public Health Ontario, 2024).

Key informants also expressed concern with low levels of **transparency** in decision-making and resource allocation processes at the provincial level, creating financial uncertainty in PHU spending. In contrast, some municipalities were considered to have highly transparent budget-setting processes, as their Board of Health meetings are open to the public, allowing for community input and greater accountability, while others have low transparency.

Policy Considerations

Long-Term Funding Model

Key informants highlighted fiscal uncertainty as a key challenge in public health financing and call for greater funding predictability. For instance, it was suggested to index public health allocations to inflation, provide base budget increases rather than one-time funding, and transition to a 3-year budget. Multi-year funding allocations could help address the challenges with staggered municipal and provincial financial years, reducing barriers to hiring permanent staff and enabling the creation of long-term public health programs. The 2023 Auditor General Report also recommended restoring base budget funding for Public Health Ontario that was replaced by one-time funding in 2019-20 (Auditor General of Ontario, 2023).

Adjusting the Provincial Allocation Formula

Given some concerns raised with the equity of provincial resource allocation across PHUs, some recommend that the funding formula should be revised to include a standard minimum allocation per capita and better account for local context such as geography and local needs. Two key informants noted that a revision of the funding formula is being undertaken by the province as part of their *Strengthening Public Health* strategy (Office of the Chief Medical Officer of Health, 2023), but that its impact will depend on whether the revision is accompanied by new investment.

Specifying Provincial Funding in Legislation

Key informants suggested a legislated mandate for the province to fund public health programs could strengthen the stability of public health system funding. Some proposed amending the HPPA to formalize the province's responsibility to fund public health programs.

Increasing public health visibility

Key informants shared that improved demonstration of public health system impacts will be key to sustaining funding over time. Some support the development of standard performance indicators across the province building on existing indicators currently collected by PHUs, including those that capture structure, process and outcome measures. Work addressing these aims is underway by Public Health Ontario in partnership with PHUs to develop a performance scorecard that reports on metrics that show the impact of public health and supports continuous quality improvement of public health programs (Public Health Ontario, 2024).

Board of Health Representation

Key informants discussed how ensuring community member representation on Boards of Health may reduce the influence of competing interests from other municipal services when setting public health budgets and allow for community representatives to contribute public health expertise to Board decision-making.

Greater Transparency

Though key informants acknowledge increased transparency in recent years, they still highlight a need for greater clarity and communication around the expected funding allocations from the province to enable improved fiscal planning at the local level, particularly considering the misalignment in budget cycles between the province and the municipalities.

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Appendix A. Ontario's Public Health System Financing Structure

Figure A1. Structure of Ontario's public health financing system

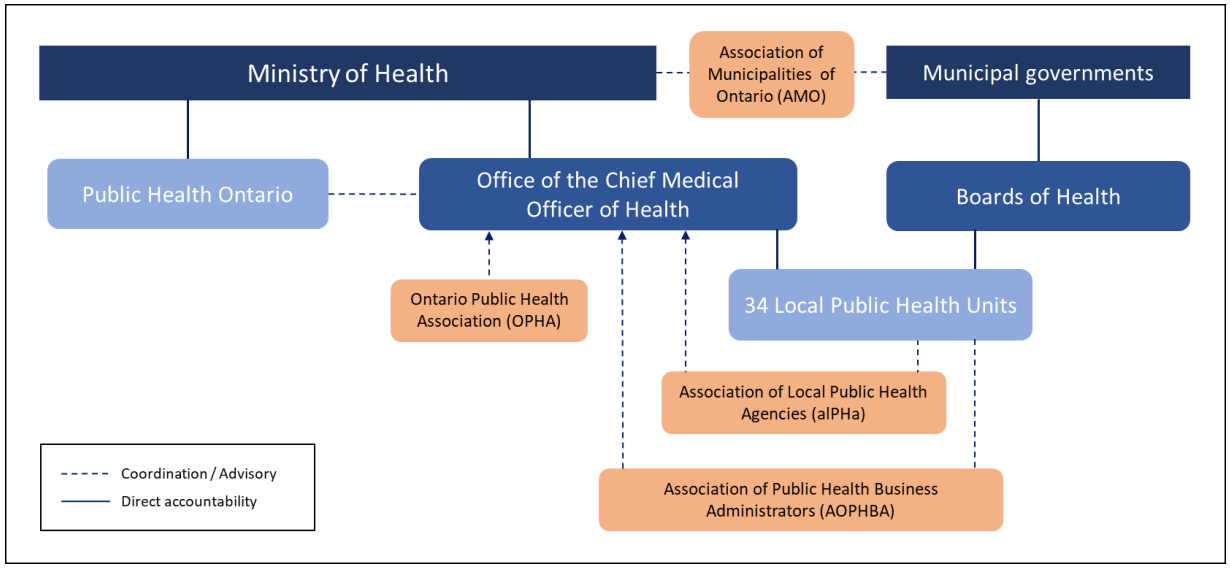

Figure A1 positions the major government bodies and external organizations involved in or influential over public health system financing in Ontario, as informed by our review and described by our key informants. It is not comprehensive of all existing actors and relationships involved in public health system financing in Ontario.

The Ontario Ministry of Health is responsible for directing the province's health system, including public health programs and services. Reporting to the Deputy Minister of Health, the Office of the Chief Medical Officer of Health develops public health initiatives, determines provincial health needs, manages the province's response to public health emergencies (Public Health Ontario, 2020), and liaises with PHU representatives.

The 34 local PHUs deliver public health programs (Public Health Ontario, 2020). PHU structures vary depending on municipal characteristics, but are generally led by a local MOHs, sometimes with a CEO or CAO co-lead, who report to their local Board of Health (Smith et al., 2021). Boards of Health also vary in their membership composition of municipal councilors and citizen representatives (Smith et al., 2021). PHUs are accountable to the Ministry of Health for implementing the Ontario Public Health Standards (Ministry of Health, 2021b).

Public Health Ontario is a provincial government agency with a mandate to provide technical information and recommendations to the Ministry, the Chief Medical Officer of Health, and PHUs to inform their decisions. Public Health Ontario is also responsible for conducting critical laboratory testing for surveillance across the province, supporting PHUs in monitoring population health, conducting public health research, and providing support during health emergencies (Public Health Ontario, 2020). The agency reports finances directly to the Minister of Health, but liaises with the Office of the Chief Medical Officer of Health (Auditor General of Ontario, 2023; Ministry of Health and Long-Term Care & Public Health Ontario, 2015).

Outside of the government sector, different stakeholder organizations liaise with, advocate to, and advise the provincial government. The AMO, composed of representatives from the 444 municipalities in Ontario, informs and consults with the provincial government on policies relevant to municipalities, including public health (Association of Municipalities Ontario, n.d.). For example, AMO facilitated conversations with the Ministry of Health to discuss questions raised by municipal governments about the Strengthening Public Health strategy (Association of Municipalities Ontario, 2022). The alPHa is a not-for-profit organization that represents and advocates on behalf of Ontario's 34 PHUs for a strong, efficient, and impactful public health system. alPHa's membership consists of PHU representatives, Board of Health members, members from the COMOH, as well as groups representing public health professions such as epidemiologists, nurses, and inspectors (Association of Local Public Health Agencies, n.d.). The Ontario OPHA is a non-profit organization that provides leadership, advocacy, and consultation on public health issues. OPHA's members represent the various disciplines in public health, health care, academic, non-profit, and private sector (Ontario Public Health Association, n.d.). The AMO, alPHa, and the OPHA all seek to advise provincial budget-setting for public health by submitting recommendations during the Legislative Assembly of Ontario's pre-budget consultations (Association of Local Public Health Agencies, 2024; Ontario Public Health Association, 2023; Standing Committee On Finance And Economic Affairs, 2022).

Appendix B. Impact of Major Public Health Events on Public Health Funding

Date range	Major event	Impact on public health funding
2000	*E. coli* outbreak in Walkerton	- An inquiry to the outbreak identified a weakness in the public health system's response to the outbreak and made several recommendations for improving the Ontario drinking water system, including investments (O'Connor, 2002).
2003	SARS outbreak	- The outbreak triggered multiple reports examining public health system capacities to respond to outbreaks, including the National Advisory Committee on SARS report (Naylor et al., 2003), and led to the first targeted federal funding transfer to support provincial public health systems of $400M over 3 years (Ministry of Health Services, 2005). - High pressure from SARS reports caused the Ontario Ministry of Health to develop *Operation Health Protection*, a 3-year plan to renew the public health system (Ministry of Health and Long-Term Care, 2004).
2009	H1N1 outbreak	- The province provided special funding (over $11 million) to the OAHPP to support expenditures related to the H1N1 emergency (Ontario Agency for Health Protection and Promotion, 2009).
2016-present	Opioid overdose crisis	- In October 2016, the Ministry of Health announced the implementation of their first comprehensive Opioid strategy to prevent opioid addiction and overdose (Ontario Health, 2016). - The provincial government pledged to allocate $3.8 billion over a decade to implement the *Roadmap to Wellness*, Ontario's comprehensive strategy aimed at constructing a modern, interconnected, and high-caliber mental health and addictions system across people's entire life span (Ministry of Health, 2021a).
2020-2023	COVID-19 pandemic	- The provincial government provided one-time COVID-19 extraordinary funding to support the response during the pandemic from 2020-2023, including laboratory testing, increased workforce, the COVID-19 vaccine program, and other initiatives (Financial Accountability Office of Ontario, 2023).

Appendix C. Impact of Public Health System Structural Changes on Financing

Date range	Structural change	Impact on public health system and financing
1990	*Health Protection and Promotion Act*	- The *HPPA* assigns municipalities the sole responsibility for funding public health units, and states that the province may grant funds to PHUs. - It also obligates municipalities to fund the levy approved by the local Board of Health.
1998	Downloading of public health financing to municipalities	The province downloaded full responsibility for funding public health programs to municipalities. This decision was partially reversed a year later, when the province agreed to a 50-50 cost-share arrangement (Deber et al., 2006).
1998 - 2003	Ontario Heart Health Program	Implementation of the Ontario Heart Health Program led to an average investment of $1.66 per capita in 5 years, combining local and provincial funding (Riley et al., 2008).
2003	National Advisory Committee: Learning from SARS	Recommended increasing public health funding ($300M in annual federal transfers to the provinces/territories) (Naylor et al., 2003).
2004	Operation Health Protection	- A three-year strategy developed to address the deficiencies in the public health system revealed during the SARS outbreak (Ministry of Health and Long-Term Care, 2004). Commitment to increase the provincial share of funding for mandatory programs delivered by PHUs from 50% in 2004 to 75% in 2007, consisting of a $469 million investment (Ministry of Health and Long-Term Care, 2004, 2009). By 2011, only 17 out of 36 PHUs had reached the 75:25 funding ratio for mandatory programs (Lyons, 2016).
2005-2010	Creation and dissolution of the Ministry of Health Promotion and Sport	Created in 2005, the Ministry of Health Promotion developed multiple new provincial public health programs including Smoke-Free Ontario, Health Eating, and Active Living (Government of Ontario, n.d.).
2007	*Ontario Agency for Health Protection and Promotion Act*	- Established the Ontario Agency for Health Protection and Promotion, now known as Public Health Ontario, as part of Operation Health Protection (Ministry of Health and Long-Term Care, 2004). A Memorandum of Understanding between the Ministry of Health and Long-Term Care and Public Health Ontario was signed in 2015, formalizing communication and financial accountability pathways (Ministry of Health and Long-Term Care & Public Health Ontario, 2015).

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