Consolidated Clause in Board of Health Report 7, which was considered by City Council on October 26, 27, 28 and 31, 2005.

1

Governance Recommendations in “The SARS Commission Second Interim Report” and their Implications for Toronto Public Health

City Council on October 26, 27, 28 and 31, 2005, adopted this Clause without amendment.

The Board of Health recommends that City Council, receive for information, the report (October 11, 2005) from the Medical Officer of Health:

Action Taken by the Board of Health:

The Board of Health:

(i) adopted the staff recommendations in the Recommendations Section of the report (October 11, 2005) from the Medical Officer of Health, with Recommendation (4) being amended to read as follows:

“(4) the Board of Health request that the City Manager delegate authority to the Medical Officer of Health for the management of financial and human resources for Toronto Public Health within the Toronto Public Health (TPH) approved budget in order to address concerns identified in the SARS Commission Second Interim Report; and further, that the Medical Officer of Health report, in consultation with the City Manager, to the June 2006 Board of Health meeting with more detailed recommendations for changes in delegated authorities for human resources and finance.”; and

(ii) requested the Ministry of Health and Long Term Care to monitor the capacity of public health units to absorb the increased Provincial contribution to health unit budgets, and make any necessary adjustments to the funding process if the majority of the increased Provincial funding is not allocated to strengthening public health programs and services.

The Board of Health submits the following report (October 11, 2005) from the Medical Officer of Health:

Purpose:

To present the implications for Toronto Public Health of the governance chapter in “The SARS Comission Second Interim Report - SARS and Public Health Legislation”.

Financial Implications and Impact Statement:

There are no financial implications arising from this report.

Recommendations:

It is recommended that:

1. the Board of Health reaffirm to the Minister of Health and Long Term Care that the boundaries of the City of Toronto Health Unit remain consistent with the City of Toronto boundaries;

2. the Board of Health reaffirm to the Minister of Health and Long Term Care that the current nomination and appointment process and composition of the Toronto Board of Health be maintained;

3. the Board of Health confirm its support to City Council and the Chief Medical Officer of Health for a shared funding model for public health programs with a municipal contribution and the option of 100% provincial funding for special programs;

4. the Board of Health request that the City Manager delegate authority to the Medical Officer of Health for the management of financial and human resources for Toronto Public Health within the Toronto Public Health (TPH) approved budget in order to address concerns identified in the SARS Commission Second Interim Report;

5. this report be forwarded for information to: City Council, the Local Capacity Review Committee, the Chief Medical Officer of Health, the Minister of Health and Long-Term Care, the Minister of Health Promotion and to the Honourable Mr. Justice Archie Campbell; and

6. the appropriate City officials be authorized and directed to take the necessary action to give effect thereto.

Background:

The SARS Commission was established by the Government of Ontario to investigate the introduction and spread of Severe Acute Respiratory Syndrome (SARS). The Honourable Mr. Justice Archie Campbell of the Ontario Superior Court of Justice was appointed Commissioner.


The Commission’s second interim report, “The SARS Commission Second Interim Report – SARS and Public Health Legislation”, was released in April 2005. The report recommends legislative changes to strengthen the *Health Protection and Promotion Act* (HPPA). The report also recommends that emergency management legislation clearly enable to Chief Medical Officer of Health to manage public health emergencies. The Ministry of Health and Long-Term Care (MOHLTC) is currently reviewing Justice Campbell’s report.
Local health integrated networks (LHINs) are briefly mentioned in the Second Interim report. The Board of Health has been briefed on LHINs and will be kept updated as they develop.

The third and final SARS Commission report will address the health and safety protection of health workers, tell the stories of SARS victims and their families and provide further recommendations.

In addition an Ontario Superior Court judgement was released in August 2005 regarding a SARS class action lawsuit.

This Board report discusses the implications for TPH of the governance recommendations of the second interim SARS Commission report and refers to the SARS class action suit.

Comments:

The SARS Commission Second Interim Report – SARS and Public Health Legislation could have significant implications for TPH, the Toronto Board of Health (BOH) and Ontario’s Public Health system. The BOH and TPH have monitored this issue closely. The BOH was briefed on “The SARS Commission Interim Report – SARS and Public Health in Ontario” in the spring of 2004. A BOH task group met in June 2004 to discuss Operation Health Protection and made a verbal recommendation to the BOH to actively participate in consultations on the Public Health Capacity Review, the Mandatory Health Programs and Services Review and the Health Protection and Promotion Agency.

The BOH received a report on Justice Campbell’s second interim report in May 2005 and subsequently reconvened the sub-committee. This sub-committee met in June 2005 to focus on the Governance chapter of the second interim report, its recommendations and the implications for Toronto Public Health.

Currently, a number of BOH members and TPH Divisional Management Team staff are involved in the Public Health Capacity Review and preparation is underway for the Capacity Review Committee visit anticipated in the fall of 2005.


“The SARS Commission Second Interim Report- SARS and Public Health Legislation” (Justice Campbell’s report) is over 500 pages long and contains 112 recommendations. The report is organized into eleven chapters: Medical Independence and Leadership, Local Governance, The Health Protection and Promotion Act Tune-up, Stronger Health Protection Powers, Reporting Infectious Disease, Privacy and Disclosure, Whistle Blowers Protection, Quarantine, Legal Access and Preparedness, Public Health Resources and Emergency Legislation. Toronto Public Health has reviewed the full report and will submit comments on recommendations beyond those which apply to governance directly to Justice Campbell and the Province.
Recommendations from the Local Governance Chapter and their Implications:

A synopsis of the executive summary and local governance chapter of “The SARS Commission Second Interim Report- SARS and Public Health Legislation” is attached (see Attachment 1).

Fifteen recommendations on Local Governance appear under the headings: Governance, Municipal Bureaucracy, Accountability, Monitoring, Board of Health Composition, and Good Governance. Each recommendation and the implications for TPH are addressed below.

(1) “Governance” Recommendation

“The province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review, decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 percent to the province.”

Implications for Toronto Public Health

The BOH has indicated its support for a shared funding model with a municipal contribution for public health programs. The BOH has also identified the need for 100% provincial funding in special circumstances. An example of a program currently receiving 100% provincial funding is the Communicable Disease Liaison Unit. West Nile Virus was originally a 100% provincially funded program but has since become a cost shared program. The BOH has also consistently supported programs such as dental services for seniors which are 100% municipally funded.

Municipal contribution to public health programs ensures “say for pay” as well as City Council attention to public health issues and needs in the community, alignment with Council priorities and fosters corporate linkages.

In the current model, public health funding and governance are closely linked. However, in recognition of the value of local governance, the BOH should continue to advocate for it regardless of the funding formula.

(2) “Municipal Bureaucracy” Recommendations

“The Ministry of Health and Long-Term Care enforce the Health Protection and Promotion Act to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-Term Care should:

Amend and strengthen s. 67 of the Health Protection and Promotion Act to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials;
Take enforcement actions in respect of violations of s. 67;

Amend the *Health Protection and Promotion Act* to clearly state that the medical officer of health is the chief executive officer of the board of health; and

Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief MOH.”

Implications for Toronto Public Health

In Toronto, the Medical Officer of Health (MOH) reports directly to the BOH, and through the Board to City Council. The Board of Health’s role in appointing the MOH and approving the public health budget are delegated to City Council in the *City of Toronto Act*.

All TPH staff are employees of the City of Toronto, and TPH operates within the human resources and financial policies of the Corporation of the City of Toronto. However, the MOH does not currently have full authority to manage the staff and resources used to deliver public health services. For example, changes to the TPH organizational structure and staff complement require approval of the City Manager even if they are within the approved budget and consistent with collective agreements and City policies.

In order to address Justice Campbell’s concerns regarding municipal bureaucracy, the City Manager would have to delegate additional management authority to the MOH.

(3) “Accountability” Recommendation

“Section 7 of the *Health Protection and Promotion Act* be amended to provide that the Minister, on the advice of the Chief Medical Officer of Health shall publish standards for the provision of mandatory health programmes and services, and every board of health shall comply with the published standards that shall have the force of regulations.”

Implications for Toronto Public Health

TPH supports enhanced accountability for programs and services. The Chief Medical Officer of Health has indicated that the Mandatory Health Programs and Services Guidelines will be reviewed. Additional resources would be required to meet enhanced standards. In revising the guidelines, the Chief MOH should include standards based on local needs. TPH will provide input into revising the standards/programs to ensure that the broad and complex needs of Toronto’s population are taken into account.

(4) “Monitoring” Recommendation

“The *Health Protection and Promotion Act* be amended to require by law the regular monitoring and auditing, including random spot auditing of local health units to ensure compliance with provincial standards. The results of any such audits should be made public so citizens can keep abreast of the level of performance of their local health unit.”
Implications for Toronto Public Health

TPH acknowledges the need for enhanced monitoring provided that the monitoring and audit tools are developed with local public health input.

(5) “Board Composition” Recommendations

“The Health Protection and Promotion Act be amended to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also, to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health. In particular, the Ministry of Health and Long-Term Care should:

Appoint a majority of the members of each local board, to reflect the greater proportion of provincial public health funding and influence;

Amend the Health Protection and Promotion Act to provide that where cabinet has not by Order in Council, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health;

Amend the Health Protection and Promotion Act to require that those appointed to boards of health possess a demonstrated experience or interest in the goals of public health – to prevent the spread of disease and protect the health of the people of Ontario – and that they be broadly representative of the community to be served; and

Consider an amendment to the Health Protection and Promotion Act to clarify the roles and priorities of health board members, the first priority being compliance with the Health Protection and Promotion Act and the mandatory public health standards.”

Implications for Toronto Public Health

The City of Toronto Act (No.2) states that all members of the BOH are appointed by City Council. The current composition of the BOH includes six municipal councillors, six citizen representatives selected through a nomination and appointment process and one school trustee. The current citizen member selection process optimizes local health interest and representation. Citizen members on the Board of Health are selected through active recruitment, interview by a sub-committee of the BOH and recommendation to the Nominating Committee of Council. The Local Health Committees enhance BOH linkages with communities across the City and provide a mechanism for local health needs to be brought forward. The BOH needs to ensure sufficient municipal representation to secure municipal contribution, ensure local/municipal needs are addressed and to facilitate linkages with City Council on healthy public policy.

The current composition and selection process for the Toronto BOH has served Toronto citizens well, resulting in boards which have been at the forefront of public health program and policy development.
(6) “Good Governance” Recommendation

“The Ministry of Health and Long-term Care introduce a package of governance standards for local boards of health with reference to those sources referred to above, such as the Scott and Quigley governance framework.”

Implications for Toronto Public Health

The BOH for the City of Toronto Health Unit has a sound approach to governance. Currently the BOH governance framework is based on the Health Promotion and Protection Act and the City of Toronto Agency Board and Commission/Council policies and procedures. There is a nominating committee process, a Board orientation process, an MOH performance evaluation process and a budget subcommittee. TPH recommends no changes to the governance structure or Board appointment process.

Local Health Integration Networks:

Justice Campbell’s report briefly mentions Local Health Integration Networks (LHINs) in the Governance chapter although no recommendation in this chapter addresses LHINs. LHINs are intended to re-align the planning and delivery of health care services across Ontario through 14 geographically based networks. To date information about LHINs makes little reference to an alignment between LHINs and local health units. The Capacity Review Committee (CRC) will explore relationships between LHINs and local health units. However, it is too early to tell what LHINs will mean for public health.

To foster and maintain strategic linkages within the City of Toronto, it is important that the boundaries for TPH remain consistent with the City of Toronto boundaries. As the City of Toronto Health Unit is independent of the LHINs, the BOH and MOH will facilitate linkages with all five Local Health Integration Networks which serve the City of Toronto.

Superior Court Decision on SARS Class Action:

In this action the City of Toronto was the only named municipal defendant. A preliminary motion was brought by the City. The motion involved a determination of the question whether the City of Toronto, as distinct from the Board of Health, owed a statutory duty of care to the plaintiff in the area of public health. In deciding this question Justice Cullity stated in August 2005:

“Responsibility for the management of public health rests with local boards of health and the Province and not with the City. The City of Toronto Act established a board of health for Toronto and provided that the board is deemed to be established under the Health Protection and Promotion Act. As such, the board is a corporation without share capital and it is the legal entity that manages public health in Toronto. It is not pleaded that it is a servant of the City and it is the Minister of Health and Long Term Care who is responsible for ensuring that the board manages public health in accordance with the Health Protection and Promotion Act.”

This judgement recognizes the separate legal status of the Board of Health from City Council.
Conclusions:

“The SARS Commission Second Interim Report – SARS and Public Health Legislation” has significant implications for Toronto Public Health, the Toronto Board of Health and Ontario’s Public Health system.

Justice Campbell points to governance failure in some health units and makes recommendations for reform to strengthen the governance of public health. It is important to recognize that there are several models of public health governance in Ontario, and that the Commission’s recommendations are not equally necessary or appropriate in all health units. The current governance model in the City of Toronto has been associated with effective community participation and progressive public health policy leadership. This report recommends against the implementation of many of the reforms suggested by Justice Campbell for Toronto.

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List of Attachments:


Attachment 1

A Synopsis of:

The Introduction & Executive Summary and Chapter 2 on Local Governance

From:

The SARS Commission
Second Interim Report
SARS and Public Health Legislation

The Honourable Mr. Justice Archie Campbell

April 5, 2005
Prepared By:
Anna Pancham
Toronto Public Health
June 2005
Synopsis: Introduction and Executive Summary

The SARS Commission (The Commission) released their first of three reports in April 2004. The report included a number of recommendations that the Ministry of Health and Long-Term Care (MOHLTC) is acting on in an ambitious 3 year program to improve the public health system in Ontario. This second report, released in April 2005, deals with legislation to strengthen the Health Protection and Promotion Act (HPPA) and emergency powers required for public health emergencies. The Commission states that recommendations in this report are to be considered interim, not final or exhaustive. The April 2005 report is divided into eleven chapters. Those chapters are summarized below. The focus of the third and final report will be to strengthen legislation relating to the health and safety protection of health workers, to tell the stories of SARS victims and their families, to give a general account of what happened during SARS, and to identify what further steps not addressed in the first two reports are required.

Chapter 1: Medical Independence and Leadership

Medical leadership that is free of bureaucratic and political pressure is necessary to effectively fight infectious disease and to build public confidence in a public health response during an outbreak. Distance is essential between senior public health officials and politicians. The Chief Medical Officer of Health (Chief MoH) and her office must be politically independent. A parallel measure should be given to local medical officers of health (MoHs). MoHs must be able to speak out on local public health concerns without fear of political reprisal or dismissal.

Chapter 2: Local Governance

There are 36 local health units (HUs) in Ontario and some function very well while others do not. Our provincial public health system is only as strong as its weakest link. Many of the problems in our public health system are the result of the current split governance model where the provincial and municipal governments are both involved in the funding and governance of the local HUs. Some stakeholders in the public health community support the current structure while others assert that 100% of funding and control of the local HUs needs to be uploaded to the province. This Commission recommends that the government make a decision about what governance structure is best for Ontario by the end of 2007. Further recommendations include: strengthening the HPPA to include measures to protect the authority of the local MoH; regular monitoring and auditing of HUs; providing legally enforceable standards; increasing provincial appointments; setting qualifications for local boards of health (BoHs) and introducing a package of governance standards for local BoHs.

Chapter 3: The Health Protection and Promotion Act Tune-up

The Health Protection and Promotion Act (HPPA) is the legal engine that protects Ontarians from infectious disease. SARS highlighted some inadequacies in the Act. For example total clarity is required regarding the power and authority available early in an outbreak to initiate an effective response. The Act needs to be revised to remove ambiguities. The Commissions offers four examples of changes required: simplify disease categories; clarify the three streams of power to intervene; simplify the process by which the Chief MoH can exercise powers and to clarify and strengthen the powers in section 22. This section states that an MoH, by a written
order, may require a person to take or refrain from taking any action in order to control the spread of a communicable disease. Clarification is required of detention (as a last resort) of noncompliant infected individuals who pose a risk to public health and of entrance (as a last resort) of private dwellings of noncompliant infected individuals who pose a risk to public health.

Chapter 4: Stronger Health Protection Powers

Public health officials require better access to health risk information, greater daily authority, more resources and expertise to investigate, intervene and enforce public health risks. The Commission suggests daily public health activities that require clarification in the HPPA: management of infectious diseases in hospitals and other health care institutions; acquisition of health risk information; investigation of health risks to the public and establishing an adjudication process between the Chief MoH and local MoHs where disease classifications can be reviewed.

Chapter 5: Reporting Infectious Disease

The conditions of reporting infectious diseases in Ontario are unnecessarily complex. Fast access to detailed information about cases of infectious disease is essential to investigate potential danger to the public. The Commission recommends a series of changes to the HPPA to strengthen disease reporting and to provide broad power to the Chief MoH to obtain the information needed to protect the health of the public.

Chapter 6: Privacy and Disclosure

Privacy is important, however it cannot stand in the way of reporting which is required by law, to protect the public against disease. The Commission recommends that statutory amendments are made to clarify the duty to disclose personal health information in cases of infectious disease to public health officials. The HPPA needs to be amended to ensure that local MoHs can share, with appropriate safeguards, personal health information when necessary. Obtaining this health information brings with it strong obligations to safeguard its privacy and as such the Chief MoH needs to review the internal protocols and procedures regarding protecting the use of this information by public health authorities.

Chapter 7: Whistle Blowers Protection

Health care workers who disclose a public health hazard require legal protection from workplace reprisal. Whistle blower protection must apply to anyone who employs or engages the services of health care workers. The Commission recommends that whistle blowing to the local MoH or Chief MoH be protected by law.

Chapter 8: Quarantine

The spirit of cooperation was evident during SARS and this must be nurtured and promoted. The Commission recommends that all government emergency plans have a basic blueprint for the most predictable types of relevant compensation following the declaration of an emergency. The
HPPA should be amended to allow unpaid leaves for those quarantined or isolated or those caring for a dependent stricken during an infectious outbreak. The Act should also be amended to provide the power to order and enforce the isolation of a group identified as possibly infected and contagious. Wherever possible this isolation should be preceded by consultation with the group.

Chapter 9: Legal Access and Preparedness

Weakness and confusion exist in the legal machinery that enforces health protection orders under the HPPA. This can lead to delays in managing outbreaks and thereby cost lives. The Commission recommends amendments to the HPPA to address problems of: confusion of enforcement powers; procedural gaps in the enforcement machinery; overlapping jurisdictions between the Ontario Court of Justice and the Supreme Court of Justice; lack of single entry for enforcement orders; legal uncertainty in initiating and continuing enforcement procedures and the lack of a system to ensure legal preparedness of the enforcement machinery.

Chapter 10: Public Health Resources

Many reports including the Naylor Report, the Walker Report and the Commission’s first report have highlighted deep seated problems with Ontario’s public health system. Each of these reports provides direction in terms of positive changes that can be made. However, these changes and their impact will take time and resources. It will take years of sustained funding and resources to make these changes and see their impact. Without additional and sustained resources, new leadership and new powers will not be effective. Some areas in particular that require enhancements include: laboratory capacity, expertise and personnel; scientific advisory capacity and capabilities; epidemiological expertise; surge capacity; infectious disease expertise and personnel; public health human resources capacity and infectious disease information systems.

Chapter 11: Emergency Legislation

The Commission recommends that emergency legislation provide the Chief MoH with clear primary authority with respect to the medical and public health aspects of every provincial emergency. The Commissioner of Emergency Management and the Chief MoH need to address their inevitable boundary issues through cooperation and advanced planning to ensure they have a clear understanding of their authority, roles and limitations.

There is no clear distinction between public health emergencies and general emergencies, thus introducing separate, parallel regimes would result in legal confusion and administrative disorder. The government is planning to proceed with the general emergency legislation Bill 138 Act to Amend the Emergency Act and the Employment Standards Act. The Commission recommends that Bill 138 address public health emergency powers required to protect the public.
Synopsis: Chapter 2 Local Governance

Introduction

There are 36 local HUs in Ontario that serve as front line protection against infectious disease. Some units work very well and others function very poorly. With infectious disease, a system is as strong as its weakest link. Some of the challenges faced by local HUs are the result of Ontario’s split governance model where the provincial and municipal governments are both involved in the funding and governance of the local HUs. While health is a provincial program, the first line of defense against disease is the local HUs and the local MoHs. There is a need for uniformly high standards of disease protection throughout the province. Dr. Sheela Basrur, Ontario’s Chief MoH, has initiated measures to address the challenges faced by local HUs. In addition the province is planning to increase funding to public health programs and services to 75% by January 2007.

The focus of this chapter is to explore the implications of the split governance model, highlight alternatives to the status quo and suggest changes to strengthen public health governance in Ontario.

Limitations of this report include that the Commission did not conduct a scientific analysis of the opinions of the public health community and the Commission, and thus this report focuses on infectious disease as opposed to other public health concerns.

Should the present split governance model be changed?

The public health community is divided in terms of what changes should be made to the public health governance system, ranging from maintaining the current municipal-provincial split governance to uploading 100% control and funding to the province. Broadly speaking, members of the public health community’s governance preferences appear to depend on how well their health unit is currently functioning. Local HUs with supportive and proactive boards will likely prefer to maintain the current governance structure. The Commission asserts that the burden of persuasion falls on those who want to maintain the status quo. Those HUs will need to demonstrate that the governance of their unit is working well and that this functionality is systemic and protected. MoHs overwhelmed with municipal bureaucracy will likely feel a change is necessary. Thus part of the decision process of selecting the best governance structure for the province will depend on how well the local HUs are functioning and there is currently considerable variance in that respect.

A notable example of a health unit with extreme problems is the Muskoka-Parry Sound Health Unit. Their operational troubles could not be resolved and thus this HU was abolished and is now amalgamated with neighbouring health units. Mr. Graham Scott, appointed by Dr. Sheela Basrur, conducted an assessment of the health unit and published a report with his findings on October 20, 2004. Mr. Scott highlights a number of contributing factors in the demise of this HU including: there was no permanent MoH, there was BoH micro-management of the HU and this health unit’s BoH did not focus on health policy matters but on the cost of public health.
The Commission reviews three options, some of the pros and cons of which are highlighted below:

1. Continue split governance with a greater measure of central control and guidance by the Public Health Division and the impending increase of funding.
2. Upload funding entirely, but leave the local municipalities and BoHs some control.
3. Upload funding entirely, remove municipalities from public health stewardship and abolish local BoHs.

The Commission recommends:

- The Public Health Division decide by the end of 2007, after the implementation of the recommendations of the pending public health capacity review, what governance system will make the Ontario public health system work best.

Continue Split Governance

Pro: Some feel that the pending increase to 75% provincial funding, with the greater presence and enforcement from the Chief MoH, will address systematic problems.

Unclear: It is not clear if the Chief MoH and the Public Health Division have enough time, energy, will and resources to monitor and control local systems and to mediate governance disputes across the province on an ongoing basis.

Con: Since the release of the Walker Report and the Commission’s first interim report, the proportion of provincial funding has increased. Regardless, some local MoHs continue to report budgetary conflicts. A City of Toronto example is cited where officials considered using half of a public health funding enhancement for Parks and Recreation. Councillor John Filion, Chair of the BoH, is on record as disagreeing with the proposal. Other municipalities report similar challenges with using public health enhancements.

Con: Some feel that the problem is not of funding but of governance and that the problems will continue if the MoH and BoH are embedded in municipal bureaucracies.

Con: Public health is a cost-sharing provincial program and changes made at the provincial level thereby impact municipal costs. Municipal funds for public health are derived from a limited local property tax, thereby creating the municipal funding dilemma.

Maintain Some Local Control

Pro: Some people fear that loss of local municipal involvement will impact local independence and autonomy. There is also concern that the local community partnerships, which are such an important part of health promotion work, would be lost or diminished if the province exerts complete control over public health.

Pro: Some people feel it is important to maintain local boards that are balanced by effective control by the province. This suggests that control by the province will ensure provincial directions and compliance with the mandatory guidelines are met.
Con: If public health becomes 100% provincially funded, it will be difficult to get municipal councillors actively involved in public health issues.

Upload Funding and Control 100% to the Province

Pro: 100% uploading would not mean losing local community partnerships, as it is municipal staff that grow and maintain these relationships, not the municipal councillors. There are ways to retain local decision making and community participation without the existing structure of municipal funding and political involvement.

Pro: It is more efficient to administer a unitary stewardship system.

Unclear: Full uploading will require a long-term commitment from the MOHLTC to safeguard against future downloading.

Local Health Integrated Networks

Local Health Integrated Networks (LHINs) are intended to re-align the planning and delivery of health services across Ontario through 14 geographically based networks. LHINs will integrate health care at the local level, and will consolidate planning, system integration, service coordination, funding allocation and will provide evaluation of performance through accountability agreements. Governance of LHINs will be through appointed Boards of Directors and through performance agreements with the Ministry.

To date the LHINs proposals make little reference to the alignment between LHINs and the local HUs. A Capacity Review Committee has been established to explore a relationship between LHINs and local HUs. It is possible that HU boundaries will be realigned with LHIN boundaries which will impact public health service provision. It is also possible that HUs will get rolled into the LHINs structure which will impact funding management. However, it is too early to tell what LHINs will mean for public health. The Public Health Capacity Review final report is expected in December 2005.

Municipal Bureaucracies: Medical Officers of Health and Boards of Health

Some local HUs are functioning well with MoHs and BoHs that work in partnership and receive good support from municipal officials. However, local HUs face many challenges working within municipal bureaucracies. Local MoHs report working within budget constraints that prevent a proper standard of health protection and spending a considerable amount of time in conflict with their municipal bureaucracies. Examples include municipal officials moving public health staff to other departments within the municipality without notification or discussion with the MoH or BoH, reducing the public health budget with no input from the MoH or the BoH, BoH members focusing solely on reducing the budget rather than on health protection and promotion and diversion of public health funding to other municipal departments. In addition there are reports of local HUs with unfilled MoH positions and inadequate numbers of staff. The local MoH must have clear authority to manage the HU and to see that appropriate public health standards are met.
Regardless of how public health will be funded and governed, the Commission has a series of recommendations relating to MoHs, BoHs and quality control that are relevant if some level of local governance is sustained. Recommendations appear in the sections below that address the current inadequacies in these areas.

**Local Medical Officers of Health**

In many HUs, too much energy is spent on the conflict between municipal funding and the needs of public health. If split governance continues, enforcements and amendments are necessary to the HPPA by the MOHLTC:

- Ensure that MoHs have direct administrative control over the personnel and the administrative machinery required to deliver public health protection, the management of which cannot be delegated to municipal officials
- Clarify enforcement actions relating to violations of section 67 of the HPPA, which gives local MoHs responsibility over employees of BoHs and those whose services are engaged by a BoH if their duties relate to the delivery of public health programs and services
- Amend to clearly state that the local MoH is the chief executive officer of the local BoH
- Amend to provide local MoHs a degree of political independence parallel to that of the Chief MoH

**Boards of Health**

In some HUs, there is a clear lack of understanding of the role of the Board of Health. For municipal officials, it can be challenging to separate the duty to the taxpayer and the duty as a steward of the public health system. It needs to be clarified that all BoH members are bound by legal duty under the HPPA.

The Commission suggests that the proportion of provincial appointees on BoHs should be roughly proportionate with the amount of funding provided, not only because of the funding but also because public health is a provincial program. It is worth mentioning, however, that at times there have been delays in appointing provincial representatives and long standing vacancies impair the functioning of boards.

The Commission also identifies the need for all BoH members to have qualifications based on experience, interest and commitment to public health. BoH members have a duty of stewardship not only for the expenditure of public funds but also for the delivery of adequate public health services.

The Commission recommends that:

- The province appoints a majority of the members of each local BoH
- If Cabinet has not filled a BoH vacancy within 6 weeks, the vacancy will be filled by an appointment directly from the Chief MoH
- HPPA be amended to require that BoH members demonstrate experience or interest in the goals of public health and that they be broadly representative of the communities served
• HPPA be clarified with respect to the roles and priorities of BoH members, the first priority being compliance with the HPPA and the mandatory public health standards

**Accountability, Monitoring, Auditing and Enforcement**

The present health care structure depends on compliance by local public health boards with the Mandatory Health Programs and Services Guidelines. These guidelines set out minimum requirements of public health programs and services to be delivered by local HUs across Ontario. The Commission suggests that the word ‘guidelines’ be changed to ‘standards’ to more accurately describe their significance and mandatory nature. Improving the public health system requires standards that are monitored, audited and enforced on a regular basis by the Public Health Division of the MOHLTC. These guidelines are currently under review. It is suggested that:

• the HPPA include the revised Standards to give them the force of the law

Effective monitoring, auditing and enforcement will help to alleviate organizational problems and will build a uniform level of public health services throughout Ontario. In particular, random assessments can very effective at identifying trends in non-compliance which in turn can highlight changes needed to the mandatory programs and potential resource adjustments required to ensure full compliance.

Dr. Sheela Basrur clarified in her “2005 Financial Planning and Accountability Guide for Provincial Grants for Mandatory and Related Public Health Programs” that the Guidelines are to be treated as mandatory standards. This document details the requirements for the Infection Control Program, that meeting the minimum requirements is an explicit feature of transfer payments between the Province and the local health unit and that a performance management system will be implemented in 2005. Monitoring and reporting are also explicit features of the transfer payment agreements, and consequences for failing to meet the terms of the funding agreements are outlined. This Guide also advises BoHs and health unit staff that the Auditor General (formerly called the Provincial Auditor) now has the mandate to conduct discretionary value-for-money audits of local boards of health. Spot audits have become part of the regular accountability and monitoring process required by law. These audits serve as an accountability measure that encourages compliance, identifies problems at an early stage and serves as a management tool to identify and correct general trends in noncompliance. The MOHLTC will need to ensure that there are sufficient resources for the Provincial Health Division, local HUs and the Auditor General to conduct this monitoring, auditing and enforcement. The Commission recommends that:

• The HPPA be amended with published standards of the provision of mandatory health programs and services
• The HPPA be amended to require regular monitoring and auditing, including spot auditing, of local HUs, and that the results are available to the public

The MOHLTC has a poor record of monitoring local HU compliance with the Guidelines. The Ministry currently uses a Mandatory Programs Indicator Questionnaire (MPIQ) on an annual basis. At the time of the Commission’s second report, the Ministry was reviewing MPIQs for
2001. MPIQs for 2000 indicate a 78% compliance with the Guidelines. However, several limitations to the MPIQ process exist: there are no procedures in place for verifying the information submitted in the MPIQ reports; the Ministry calculates overall compliance without factoring in the relative size of the health unit; compliance is assessed as yes or no rather than in degrees and the MPIQ does not elicit data for all the mandatory programs and services. The Mandatory Programs Measurement Working Group is recommending that the MPIQ be evaluated for its validity.

**Good Governance**

This report referenced best practices principles developed by Mr. Scott and Ms. Quigley in 2004 for the Ontario Hospital Association through MOHLTC funding. Key messages included: BoHs are accountable to the communities they serve and to the province; there must be a clear distinction between the roles of management and the role of the boards; board appointments should be proportionate with municipal and provincial financial contributions; generic and public health criteria should be used in selecting BoH members; terms of BoH members should be staggered and that performance of BoHs, BoH members and MoHs should be assessed.

The Commission recommends that:

- The MOHLTC introduces a package of governance standards for local BoHs included in the 2004 Scott and Quigley report.

**For more information:**

This report is a synopsis of the executive summary and chapter 2 of the SARS Commission’s *Second Interim Report: SARS and Public Health Legislation* dated April 5, 2005. The complete report can be viewed at:

http://www.health.gov.on.ca/english/public/pub/ministry_reports/campbell05/campbell05.html

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The Board of Health also had before it a communication (October 24, 2005) from Ann Dembinski, President, Canadian Union of Public Employees, Local 79.

Denis Casey, Canadian Union of Public Employees, Local 79, appeared before the Board of Health.